ANNEX B

MENTAL HEALTH STRATEGY FOR SCOTLAND

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

Church of Scotland, Church and Society Council

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☒ ***Please tick as appropriate***

Surname

Macdonald

Forename

Murdo

2. Postal Address

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Postcode EH2 4YN	**Phone** 0131 240 2267	mmacdonald@cofscotland.org.uk

3. Permissions - I am responding as…

Individual ☐ / **Group/Organisation** ☒

Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation ***will be*** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your ***response*** to be made available?

Please tick as appropriate ☒ **Yes** ☐ **No**

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☒ **Yes** ☐ **No**

CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

We welcome the opportunity to comment on this important strategy, and commend the Scottish government for the high priority it is giving mental health

- Scotland has worse mental health (and index health in general) than the rest of the UK. Suicide is particularly high, so this focus must be supported.
- We would welcome more recognition of the important role which communities- particularly faith communities- can play in establishing, maintaining and improving mental health.
- We felt that non- specialist members of the general public (as opposed to service users or those with first-hand experience of working in the mental health field) may have found it difficult to formulate a meaningful response since the document makes repeated references to what has been done by government in the past. However, no evaluative comment is made about the impact of previous initiatives, so it is not possible to suggest what further evidence-based actions would be useful. For example, it is stated that: 'We have some successes to celebrate. We have delivered the HEAT target to reduce psychiatric inpatient readmissions, highlighting the development of community mental health services'. However, since no data are provided to substantiate this statement, it cannot be assumed that the reduced readmission rates result from improved community-based services. Instead, it could be as a consequence of a myriad of reasons, including a reluctance to re-engage with inpatient services or, alternatively an indication of the success of inpatient treatment that has prevented the need for readmission.

Improvement Challenge Type 1

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

some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

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

The challenge of delivering a cost- neutral strategy means tapping into the voluntary sector. Churches contain largely untapped pools of resource, provided by people who are committed to care and love other people. we are aware of (and have experience of) the sensitive nature of working with vulnerable adults and would not seek to exploit them.

The current cost-neutral imperatives mean this must be considered, and trust developed. We would welcome the establishment of some pilot projects to validate these approaches.

Improvement Challenge Type 2

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

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

In many areas where gaps may exist (e.g. rural and remote rural areas), the churches provide an existing infrastructure which should be used in assisting service delivery.

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Self Harm: the work done through mental health first aid [www.smhfa.com] is key, and churches are ideally placed to run courses and to train up their members and leaders. Also, a key part of working with people who self harm is not to diagnose mental illness (often people are not ill in the medical sense, rather distressed) is to encourage compassion towards the self, and self acceptance. The Christian faith exemplifies a long tradition of meditative and contemplative approaches. Projects which promote this widely developed tradition could be encouraged and empowered to form part of local responses to self harm.

Suicide: The Church of Scotland takes this issue very seriously, and has recently produced a report on suicide among young men. A booklet arising

out of this work has been distributed widely, including by some NHS agencies (please see www.srtp.org.uk).

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

We commend the inter-related aims of promoting mental health and eliminating stigma of mental illness. The promotion of positive mental health should have a preventative effect, and, since stigma prevents people from seeking treatment, its elimination will foster for early diagnosis, with consequences of more effective treatment.

Reducing stigma in employers is also important in reducing discrimination and, when providing opportunities for people to return to the workplace, is likely to enhance recovery from mental illness.

Churches are generally keen to overcome stigma against those with mental illness. The work of Mind and Soul (www.mindandsoul.info) in developing guidelines for mental health friendly churches should also be noted.

It makes sense to empower and work with the church rather than trying to start from scratch. Initiatives from the Scottish Government are likely to be well received by the church.

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

While the 'see me' anti stigma campaign has delivered high level [e.g. bill board] approaches to tackling stigma, this now needs to be embedded in local communities, where the church can often assist in being a focus.

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

Promoting mental wellbeing within communities is important. The not insignificant support often provided by families and community groups, such as church members, is probably undervalued. Such support from families and informal support groups should be appreciated, fostered and steps should be taken to further promote such activities in communities.

Mental wellbeing begins with self-esteem, and churches are ideally placed to communicate both a general sense that people are worth investing in, and more specifically the belief that God loves humanity and longs to relate to them. There is extensive evidence that spirituality is integral to both good mental health and mental health promotion.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

CAMHS is a finite resource. Whilst access is important, this should not be at the expense of investing in children at the base of the pyramid where the church is very active. Care for the Family (www.careforthefamily.org.uk) is one specialist example of the kind of work being done.

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

There is scope for better links between CAMHS and local providers of services to children, such as the many children's and youth groups run by churches.

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

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

Churches are unusual in that thousands of people sit each week to receive teaching [often on emotions], are encouraged to reflect on their internal work [usually in gracious and empowering ways], offered an existential focus [beyond their immediate problems] and meet together in small communities. It is often said that much of mental health service's energy is in making up for the lack of community in our society – churches are present and can provide community for the asking.

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

Seeking help is more than just accessing professional help. It should start well before that with becoming involved in the local community. General projects to enhance social capital of all kinds should be pursued. Mental health first aid offers a route for these local groups to direct the most needy to professionals.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Comments

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

ICPs contain a requirement to work with relatives and carers - this can often include a church family if the person attends a church

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

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

Comments

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

Comments

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

It is recognised that spirituality is a core part of mental health, and has been shown to aid recovery as understood by the SRI. Incorporating a focus on spirituality within the SRI could enhance its ability to draw in this resource.

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

Recovery is an integral component of the Christian faith. For example, we are all called to holiness despite continuing to sin. The ability to live life 'well' in the ongoing presence of difficulty and challenge has been a focus of the church for centuries. Recovery stories involving faith could be added to the growing range of stories available. SRN could work with churches and other faith groups.

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

Families often work best when supported by a wider family. If 'it takes a village to raise a child', churches can be such villages

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

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

Comments

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

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

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

Comments

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments

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

Comments

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

Historically, there has sometimes been an impression of negativity towards faith and spirituality within mental health services. As such, many people of faith are suspicious about attending 'secular' mental health services. the role of a person faith in their mental health treatment and recovery must be more than just a box that can be ticked if a question like 'do you go to church?' is asked.

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

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

Comments

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

Comments

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

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

In Scotland there are many Christian counsellors who deliver good psychological therapy to their local communities, often at no charge. This is a resource that could be developed with a relatively small investment. Suggest starting with the association of Christian counsellors. An example of good practice would be St Mungo's Life and Soul Centre in Edinburgh, which has trained up to accreditation level over 100 counsellors in the last five years.

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

Given the high rate of hazardous and harmful drinking in Scotland and the clear links between substance misuse and mental health problems, it is crucial that all frontline health workers receive training in the recognition of hazardous and harmful drinking and the delivery of brief interventions to equip them with the attitudes, knowledge and skills required to deal with co-occurring substance misuse and mental health problems.

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

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

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

Comments

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

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

Engaging with local groups which also improve peoples' mental health such as churches and Christian counselling centres

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

Comments

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

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

The mental health act makes provision in its 'principles' for equality and diversity and participation: http://www.scotland.gov.uk/Publications/2005/07/22145851/58527. Faith is included among these 'protected characteristics as it is in the new Equality Act 2010. The degree to which this is truly engaged with rather than merely assented to will affect people's satisfaction with the legislation, and ability to work towards a least restrictive option.