NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Mental Health Strategy for Shetland 2013</th>
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<tbody>
<tr>
<td>Registration Reference Number</td>
<td>PHSTR004</td>
</tr>
<tr>
<td>Author</td>
<td>Elizabeth Robinson, Health Improvement Manager</td>
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<tr>
<td>Executive Lead</td>
<td>Dr Sarah Taylor, Director of Public Health</td>
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**Proposed groups to present document to:**

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<tr>
<th>Group</th>
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<tr>
<td>Shetland Mental Health Forum</td>
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<td>Shetland Mental Health Partnership</td>
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<td>PFPI</td>
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<td>Area Clinical Forum</td>
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<th>Group</th>
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<tr>
<td>5.12.13</td>
<td>1</td>
<td>SMHP</td>
<td>PI, C/S</td>
<td>SC</td>
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<td>13.01.14</td>
<td>2.2</td>
<td>Community Health and Care Partnership Committee</td>
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<td>Social Services Committee</td>
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<td>CHCP Operational and Strategic Groups</td>
<td>PO, C/S</td>
<td>MR</td>
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<tr>
<td>27.02.14</td>
<td>3</td>
<td>SMHP</td>
<td>PI, PO, C/S</td>
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**Examples of reasons for presenting to the group**

- Professional input required re: content (PI)
- Professional opinion on content (PO)
- General comments/suggestions (C/S)
- For information only (FIO)

**Examples of outcomes following meeting**

- Significant changes to content required – refer to Executive Lead for guidance (SC)
- To amend content & re-submit to group (AC&R)
- For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
- Recommend proceeding to next stage (PRO)

*To be attached to the document under development/review and presented to the group
Please record details of any changes made to the document on the back of this form
<table>
<thead>
<tr>
<th>DATE</th>
<th>CHANGES MADE TO DOCUMENT</th>
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<tbody>
<tr>
<td>10.12.13</td>
<td>Significant editing, reordering. Further background information on each element within the strategy, updated data.</td>
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<tr>
<td>20.02.14</td>
<td>Further details of outcome and recommendations of Mental Health Review, minor revisions to factual information, format, layout</td>
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<tr>
<td>28.02.14</td>
<td>Final editing and production of an Executive Summary.</td>
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SHETLAND MENTAL HEALTH STRATEGY
2014 – 2024

Executive Summary

The Strategy aims:

- to provide direction in the way forward for mental health services in Shetland;
- to provide a vehicle for developing Shetland as a place that is free from stigma and disadvantage in relation to mental health issues;
- that promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible;
- to deal sensitively and effectively with mental illness when it does occur, working with people living with mental illness towards recovery.

It refreshes the previous Shetland Mental Health Strategy and takes account of current national policy including the Mental Health Strategy for Scotland, ‘Delivering for Mental Health’ and ‘Towards a Mentally Flourishing Scotland’. It is built on the national quality ambitions of person-centred, safe and effective, and will help to deliver Shetland’s Single Outcome Agreement priorities of:

- Reducing key risk factors for poor health outcomes
- Tackling health inequalities and
- Having financial sustainability and balance.

The strategy was developed with extensive engagement through the Mental Health Forum involving services providers, service users and carers, and drawing on local survey work as well as national guidance.

The local priorities detailed within the strategy are:

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness and distress.
- Early recognition and treatment of mental illness and disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual’s needs including their carer(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services
- Redesign of the mental health service in line with the service review.
The Strategy gives more detail and action plan priorities on the following themes:

**Tackling Stigma and Discrimination**

Our vision is: for people in Shetland with experience of mental illness or distress to live free from stigma and discrimination, in a community that is understanding and accepting, which actively supports recovery.

Our priorities for action are:

- To continue what is already in place
- To target hotspots for suicide e.g. men’s workplaces, certain areas of Shetland
- To continue to work with children and young people to promote resilience and remove the stigma of mental ill health
- To highlight examples of good practice

**Self management, self help and social prescribing**

Our vision is: for individuals to be able to support themselves and find support within local communities to promote better mental health and increase their sense of 'well-being, to be resilient and to live in recovery.

Our priorities for action are:

- To continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable
- To continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
- To offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems

**Employability**

Our vision is: for people in Shetland of working age to be in the right work, to remain in work or be able to return to work as part of recovery, knowing that this is good for a person’s health and improves their quality of life and wellbeing.

Our priorities for action are:

- To continue to work alongside the Employability Pipeline to ensure that people with mental health problems receive the support they need to remain in work/get back into employment.
- To understand the effectiveness of the NHS/SIC Employee Assistance Programme in supporting people with mental health problems
- Continue to deliver training to support workplaces in promoting positive mental health and supporting people with mental health problems.

**Crisis Prevention, Support and Treatment**

Our vision is: to have a safe and effective crisis prevention, support and management service that includes place(s) of safety and local capacity for emergency treatment, in and out of hours.
Our priorities for action arising from the recent Review of Mental Health Services are:

To promote strong leadership for Mental Health through the Director of Community Health and Social Care, with appropriate support from the Chief Executives

Recruit a second psychiatrist at staff/consultant grade

Integrate the Community Mental Health Team and Annsbrae teams into one Community Mental Health Service

Increase numbers of Community Psychiatric Nurses as a priority

Create a crisis response service from the above and establish a pool of Control and Restraint trained staff

Explore options for accommodation for crisis support

Exploring best use of resources.

Access to Psychological Therapies

Our vision is: to build on local strengths in the use of psychological therapies, to have in place an inter-agency, tiered model of support, which meets the needs of people in Shetland in terms of the speed at which people are seen and in the quality of the interventions provided.

Our priorities for action are:

the introduction of a stepped care model for psychological therapies

developing the psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions

to identify other ways of delivering very specialist psychological therapy at Tier 3

to establish a visiting psychology service

developing local information on how to access psychological therapies and about alternatives to psychological therapies, including web- and telephone based services such as Living Life.

Mental Health of Older People

Our vision is: to prevent mental ill health and to promote positive mental health and well being in older people, maintaining independence and support in the community where at all possible, and treating appropriately where necessary. For Shetland to be
a dementia friendly community, with safe and effective support and services in place for people with dementia.

Our priorities for action are:

- to develop our understanding of the wider mental health of old people in Shetland through the development of the Older Peoples Strategy
- to develop a Dementia Strategy for Shetland.

Mental Health of Children and Young People

Our vision is: a Better Brighter future for all children and young people in Shetland, where children are safe, nurtured, happy, healthy and resilient, with opportunities to reach their potential.

Our priorities for action are:

- Support to those on the Autism Spectrum where this group experiences a varied service provision
  - To be clear about pathways for young people 16 to 18 years, including links to regional and national specialist in-patient services
  - To review Tier 1 support to young people including within schools, access to advice and/or counselling, and developing resilience, with links to work within the Children’s Services Plan.
  - Internet safety which links to issues of bullying, and the vulnerability of children and young people in relation to risks of exploitation and abuse, linking to work through the Child Protection Committee.
  - To develop a protocol for responding to a young person at risk of self-harm/suicide.

Mental Health and Alcohol & Drugs

Our vision is: to provide safe and effective services to support people with substance misuse and mental health problems, to promote mental well being amongst people with problems relating to substance misuse, and to reduce the suicide rate in Shetland.

We want a resilient community in Shetland and to support people with mental health issues to find positive alternatives to substance misuse in coping with their problems.

Our priorities for action are:

- Publicising the links between alcohol, poor mental health and suicide
- Community awareness raising on what individuals can do to promote and protect mental health, with a specific focus on bar staff, taxi drivers, people selling alcohol in shops
- Broadening understanding of mental health among all health and care professionals working in substance misuse services
To ensure that the current redesign of substance misuse services takes account of the needs of people with dual diagnosis
To have mental health and drug & alcohol services working together in a coordinated way to provide the best experience and access for service users

Carers
Our vision is: that those who are caring for people with mental illness are supported to fulfil their caring role, are involved in the cared-for person’s care-planning, and consulted and engaged in decision making about the person they are caring for.

Our priorities for action are:
- Increasing use of self help and access to support information
- Boosting use of carers groups
- Involving carers in learning events
- Encouraging carers through local media to seek support and assistance
- A culture shift in involving carers from the beginning of engagement
- Making sure that confidentiality is not used as a barrier to supporting carers.

Mental health & offending
Our vision is: that mental health and Criminal Justice services work closely together to provide appropriate services liaison and referral for people in the criminal justice system, including risk management and links to the regional secure unit.

Our priorities for action are:
- To maintain appropriate professional relationships with outside organisations such as Advocacy, Moving On, and Citizens Advice Bureau
- To maintain local services with the national move to NHS provision of healthcare for people in prison and custody, and in any national redesign of criminal and community justice services across Scotland.

Suicide Prevention
Our vision is: that Shetland should be a community that is aware of suicide and suicidal behaviour, where there are appropriate responses to suicidal behaviour, and 24 hour access to support when someone is feeling suicidal.

Our priorities for action are:
- To develop community resilience and awareness raising including in schools.
- Responding to people in distress including developing arrangements for support following suicide attempts and completed suicides
- Continue to audit all local suicides to understand and act on preventative factors
- Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries).

An action plan will be developed to take forward the priorities, to show how we will measure improvements in outcomes, and how we will know when we have achieved our aims.
1. **Introduction**

A Mental Health Strategy for Scotland was published in 2012, and the Shetland Mental Health Partnership has committed to refreshing our local Strategy to reflect Shetland needs and priorities.

2. **The Challenge**

The challenge is enormous. We know that mental illness and ill health is one of the top public health challenges in Europe. We know that Shetland has a high suicide rate. Along with other places, Shetland is experiencing a period of great change, with reductions in public service funding against an aging population and increasing demand for services. We also recognise that day to day practicalities such as having enough money to live on, dealing with debts, housing issues, and employment problems can have a negative impact on a person’s mental health and can delay their recovery.

3. **Background**

Both Shetland Islands Council and NHS Shetland aspire to providing the very best mental health services within the resources available. However, in recent years there has been a growing amount of dissatisfaction with mental health provision in Shetland, including issues of recruitment and retention of staff, and a perception that more people are being moved off island because of the limitations of the local service. Shetland has currently the highest rate of suicides in Scotland, which has compounded the concern about local services, though sudden death case audits have not highlighted specific concerns about the quality of service in relation to these individuals.

There is a work programme in place to address some of the recognised gaps in service, but planned service redesign has not progressed at the pace that we would have liked.

A review of the service in its entirety was commissioned to understand what elements of local service are fit for purpose, or where there are gaps and/or risks, and how we might mitigate those risks, with options to take forward on service development / redesign.

The Review Report has now been considered by SIC and NHS Shetland and will result in a local action plan to take forward service development and redesign.

The report makes recommendations on “the essential ingredients for the development of a more robust and resilient Mental Health service” which have been included as part of this Strategy.

4. **Policy Context**

The Scottish Government has developed a National Performance Framework which is designed to focus their work and ambition. One of the Government’s strategic objectives is: ‘helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare’.
The Government has also set some National Outcomes which help to direct the Mental Health Strategy:

- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We have improved life chances for children, young people and families at risk
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs

The Shetland Community Planning Partnership (CPP) has agreed to make sure that we prioritise working with the most disadvantaged and vulnerable people in the Shetland community. In its Single Outcome Agreement (SOA), it describes a vision where the public, private and third sectors work in harmony to deliver services, jobs and economic growth. In the short term this means that Community Planning is directed towards encouraging a dynamic private sector and strong third sector to help mitigate some of the potential impacts of reduced public spending. The CPP recognises that designing efficient and responsive public services is a key component of striking a balance in this area which can be achieved through involving communities in service planning and design. We should bear this in mind as we look to develop mental health in Shetland.

Within the Single Outcome Agreement, the Shetland Community Planning Partnership has agreed the following outcomes relevant to the Mental Health Strategy:

- Reduce key risk factors for poor health outcomes
- Tackle health inequalities by ensuring the needs of the most vulnerable and hard to reach groups are identified and met, and that services are targeted at those most in need.
- We have financial sustainability and balance within each partner; and a better balance between a dynamic private sector, a strong third sector and efficient and responsive public services.

4.1 Integration Agenda

The Scottish Government is in the process of developing a Public Bodies (Joint Working) (Scotland) Bill. The idea of this is to join up Health & Social Care services to address people’s needs holistically and to ensure that resources follow patients' and service users' needs. In particular this applies to people who access many services over prolonged periods, such as people with long term conditions, older people, and people with complex needs. The idea is for:

- Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;
- A statutory underpinning to assure public confidence;
- An integrated budget to deliver community health and social care services and also appropriate aspects of acute health activity;
• Clear accountability for delivering agreed national outcomes;
• Professional leadership by clinicians and social workers;
• It should simplify rather than complicate existing bodies and structures.

This Bill will build on many years of joint working in Health and Community Care in Shetland and Mental Health is already included as one of our joint areas of working. Progress in Shetland has been achieved through the establishment of the Project Board in 2011, reporting to the SIC Social Services Committee and the Community Health and Care Partnership (CHCP) Committee. Work is also progressing through the Joint Staff Partnership Forum, the Local Partnership Finance Team and the Joint Human Resources group.

The Shetland Mental Health Partnership is the vehicle through which partners debate and agree mental health direction, strategy and spend in Shetland. The membership and terms of reference for both these groups can be found at Appendix 2.

4.2 Delivering for Mental Health and Towards a Mentally Flourishing Scotland

"Delivering for Mental Health" was the mental health delivery plan for Scotland, developed in 2006, which set out targets and commitments for the development of mental health services. This plan focused on the key elements of services that needed to be in place at each point in a journey of care with the idea that clinicians, service users and carers could be clear about what was needing to be delivered.

Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 was the government document designed to outline the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health. See Appendix 1 for more details.

4.3 A Health Promoting and Preventative Approach

The government, in its Mental Health Strategy for Scotland, proposes a healthcare system which integrates health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, the expectation is that day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

In 2011 The Scottish Association for Mental Health (SAMH) produced a report showing the economic cost of mental health in Scotland. It reported that for the year 2009/10 mental health problems had cost the Scottish economy £10.7 billion. This is broken down as follows:

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<tr>
<td><strong>Human costs</strong></td>
<td>£5,576m 52%</td>
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<tr>
<td><strong>Output losses</strong></td>
<td>£3,228m 30.1%</td>
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Human costs are calculated by looking at the adverse affect on quality of life.
Output losses focus on the impact of mental health problems on employment.
and work.

<table>
<thead>
<tr>
<th>Health and social care</th>
<th>£1,920m 17.9%</th>
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<tr>
<td>Health and social care costs includes the cost of care services for people with mental health problems.</td>
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**Total costs:** £10,724m 100%

The following table shows incidence of depression and anxiety across the lifespan as based on a British study:

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<th>Percentage</th>
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<tr>
<td>1. No symptoms in childhood or adulthood</td>
</tr>
<tr>
<td>2. Adult onset, moderate</td>
</tr>
<tr>
<td>3. Adult onset, severe</td>
</tr>
<tr>
<td>4. Repeated moderate symptoms over the life course</td>
</tr>
<tr>
<td>5. Repeated severe symptoms over the life course</td>
</tr>
<tr>
<td>6. Childhood onset with good adult outcome</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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The study illustrated that mental health problems often start in the early years, and that these tend to persist and recur over the lifespan. Research also shows that half of diagnosable mental illnesses start by the age of 14. This emphasises the need for placing efforts for prevention in the early years and children.

Although the cost benefits of mental wellbeing promotion are less clear than prevention of mental illness, research conducted in Wales estimated savings of £1 billion, by promoting mental health wellbeing across the country in one year group of children. Mental health promotion has an important role to play in public health by reducing sickness and premature death, reducing use of health care and improving mental and social functioning, which in turn, could be argued are all cost savings.

The focus on "prevention, anticipation and supported self management" is central to taking forward mental health policy in Scotland and Shetland. Services in Scotland have already reduced the number of mental health hospital readmissions by around 25%. The national strategy asks for:

- Early intervention for conduct disorder in children through evidence based parenting programmes;
- Treating depression in those with long term conditions such as diabetes;
- Early diagnosis and treatment of depression; and
- Early detection and treatment of psychosis.

There is a strong focus throughout this strategy on actions that people can take for themselves and with their communities to maintain and improve their own health. There is a good
evidence base for such approaches, in particular for the role of physical activity in maintaining positive mental health and in helping recovery.
4.4 Quality Ambitions

This Mental Health Strategy fully supports and adopts the 3 Quality Ambitions for Scotland that health and care must be:

Person centred - which is;
Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe - which is;
There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective - which is;
The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

4.5 Inequalities

We know that mental wellbeing is influenced by biological, psychological, social and environmental factors, which interact in complex ways. Environmental factors include inequalities in life circumstances; good living environments, housing, transport, education and a supportive political structure. Community also affects mental wellbeing, such as a sense of belonging, social support, a sense of citizenship and participation in society.

Populations at most risk from social exclusion are more at risk of developing mental health problems, including those with limited opportunities for employment; women; racial and ethnic minority groups; refugees; sex workers; people living with disabilities, addictions or chronic illnesses; homeless people; and older people living on reduced income.

Scotland’s Mental Health: Adults 2012 (ScotPHO)® highlighted clear inequalities in mental health within the Scottish population, by socioeconomic status, age and gender. Specifically, greater socioeconomic disadvantage is associated with a poorer state of mental health. The study highlighted three area indicators where there is solid evidence of worsening over the last decade or so: psychoactive substance related deaths, alcohol dependency and manager support at work. The trends for deaths from mental and behavioural disorders due to psychoactive substance use and alcohol dependency were noted as being of particular concern.

5. Process of developing the strategy

The main information gathering for the development of this strategy has been through the Mental Health Forum, a group of individuals with an interest in promoting positive mental health and reducing mental ill health in Shetland. A number of recent pieces of work carried out by partner agencies such as Mind Your Head and Advocacy Shetland have been extremely useful in understanding perceptions of mental health across Shetland and the challenges that face people with mental health problems and their carers. The
epidemiological information has been gathered from local and national sources; in particular the performance management system used by NHS Shetland and Shetland Islands Council, and ISD (Information Statistics Division) Scotland. The priorities for action at the end of each section are identified through local survey work, engagement with services, users and carers and what the epidemiology tells us.

6. Needs Assessment

In order to develop a strategy we need to know where we are starting from and where we want to get to. In developing this strategy, we have focused on the following three elements:

a. Epidemiological approach – using data obtained from research, surveys and studies on rates of illness and specific disorders, applied from national work to estimate numbers within the local population, and predicting likely service usage. It can take account of local demographic information about the population to record or predict specific factors that might affect local communities (such as age, other issues that might inter-act with mental health like health problems, alcohol misuse, economic or social factors).

b. Corporate needs assessment: Information from services and those working in the field of mental health – description of current services, routinely collected information on use of services, activity within services, and the views of professionals working within services, comparison with services in other areas, identifying gaps or weaknesses in local services.

c. Information from users, carers and the community (participatory / consultative needs assessment) – qualitative information – feedback on current services by those with direct experience of them, the experience of living with mental illness or distress, and the needs and aspirations of those affected by mental illness for future improvements and developments.

6.1 Epidemiology of Mental Health Problems in Shetland

As with most small areas, there is little good data on the actual prevalence and incidence of mental health problems and mental illness in Shetland, though GP practices hold registers of patients with serious mental illness, defined as schizophrenia, bipolar effective disorder or other psychoses. These indicate that between 140-150 patients are identified with these diagnoses for the period 2012/13. Practices also hold information on people diagnosed with depression, both those newly diagnosed, and those with a long term illness (Coronary Heart Disease or diabetes) also assessed as having depression.

The following chart refers to MH001 in the EMIS QOF register, meaning that the contractor establishes and maintains a register of people with schizophrenia, bipolar disorder and other psychoses and other patients on lithium therapy.

The rise in numbers between 2006/07 and 2008/09 is probably the time it took for some practices to fully populate the register, and does not appear to be a real rise in the numbers of people with severe mental illness in Shetland.
It is also possible to estimate the level of mental illness in the community by applying national rates, or the results of epidemiological studies carried out elsewhere to the population of Shetland; by understanding the nature and prevalence of underlying risk factors and by looking at use of mental health services.

The Scottish Mental Health Strategy uses European figures to demonstrate the prevalence of mental health problems in the population. Mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. Applying that to the Shetland population, it means that out of 15,000 adults aged 15-65, at least 5,000 will experience some form of mental ill health or distress each year. About 1-2% of the population have psychotic disorders (approximately 150-300 adults in Shetland, which fits with the prevalence from GP data).

The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 (approximately 200 in Shetland) and 20% of those over 80 years of age.

In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing.

**Demography**

The prevalence of both mental health problems in general and specific illnesses varies with a variety of demographic characteristics including age, gender, ethnicity and socio-economic status. For example, there tend to be high levels of depression and anxiety in disadvantaged populations, suicide is more common amongst young men and the unemployed and dementia usually (but not always) affects elderly people. These factors also affect the level and nature of services required, people with less social support in the community are likely to need increased input from services.

**Age and gender profile**
The population of Shetland has increased by 5.5% since 2001 to 23,200. 18% of the population are under 15 (approximately 4000), 64% aged 15-64 (approximately 15,000) and 18% aged over 64 (approximately 4000). Although Shetland has a relatively 'young' population compared to the rest of Scotland, it will not remain static. There is a falling birth rate, which, combined with certain patterns of migration and a falling death rate, is leading to an increase in the older age groups; in particular a marked increase is anticipated in the over 75 age group. This will have a significant impact on the levels of mental health problems that tend to affect the elderly in the population, especially dementia.

**Ethnic mix**

Approximately 1% of the total population is from a minority ethnic group (230 individuals) which is relatively low and much lower than other parts of Scotland. Despite low numbers, Shetland has seen an increase in both the number of minority ethnic people and the diversity of races and there are an increasing number of immigrants described as European or ‘Other White’. The minority ethnic population tends to be widely spatially distributed in Shetland. People from black and ethnic minority groups may have an increased likelihood of experiencing isolation, lack of social support and discrimination which can contribute to mental ill health.

There is some information on the experiences of people from minority ethnic groups from a survey carried by NHS Shetland in 2009 the Council’s Your Voice citizen’s panel, as highlighted in the SIC Equality and Diversity Framework for 2011 (http://www.shetland.gov.uk/communityplanning/documents/EqualitiesFramework2011.pdf). These include feelings of isolation and lack of support networks or integration into the community. However, many of the issues faced by black and ethnic minority populations are not unique to this group, but affect the wider community as a whole. These are housing, transport, childcare, provision of health and social care services.

The specific mental health needs of ethnic minority groups in Shetland have not been fully assessed. Though all services are required by law to understand the impact of diversity characteristics (race, gender, age, disability, sexual orientation) on access to services, data on this is not collected in a systematic way that can be used to inform an assessment of need.

**Socioeconomic status**

Whilst Shetland is not considered as a socioeconomically deprived area overall, there are individuals and families within Shetland who are living in poverty or are otherwise disadvantaged. Remoteness and can also be a significant risk factor for mental health problems, through isolation, lack of social support and difficulty in accessing services.

According to the most recent (2010) community health profile for Shetland (http://www.scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000037.pdf), Shetland compares favourably to Scotland for education and economy indicators. For example, among the working age population, only 10.4% have low or no educational qualifications (Scotland 14.8%); and only 1.7% claim Jobseeker’s Allowance (Scotland 4.4%). Income deprivation is significantly better than the Scotland average. However, an estimated 11.1% of households are experiencing extreme fuel poverty (Scotland 7.5%) and being a largely rural island area,
three-quarters of the population (75.2%) live in the 15% 'most access deprived' areas in Scotland.

**Estimates of incidence and prevalence of mental health problems and distress in Shetland**

**Suicide**

Suicide is a relatively rare event, and is often, but not always, associated with mental illness. However, it is considered as a reasonable proxy measure for the level of psychological distress in the community, and in the absence of any consistent and reliable methods for collecting morbidity data is commonly used as a measure of mental illness in a population. Furthermore, suicide rates are used to evaluate the outcomes of strategies to reduce mental illness and improve mental health services. People with mental health problems are more likely to complete suicide than the general population. 10-15% of people diagnosed with schizophrenia will die through suicide and 15% of those with major depression.

**Deaths caused by intentional self harm and events of undetermined intent, registered in Scotland, by NHS Board and 5-year time period, both genders and total**

![Suicides - Crude Rates - 5 Year Moving Averages](image)

* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time
* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time

### Hospital admissions

Admission to psychiatric hospital only occurs for a very small percentage of all the people in Shetland with mental health problems, usually those with the most severe mental illnesses, and this data is published by ISD, but at present is not reliable in its published form. The nature of many severe mental illnesses is that they follow a relapsing and remitting course, sometimes necessitating a number of admissions to hospital over time. The length of admission can vary greatly, from a few days up to many months.

### Mental health and wellbeing

The Scottish Health Survey includes a number of measures that indicate mental 'wellness'. The survey only involves a relatively small number of people in Shetland each year, but the most recent figures combine the results from 2008-11 to give a bigger sample and allow more meaningful interpretation.

#### Mental Wellbeing

Mental wellbeing is measured using WEMWBS (Warwick Edinburgh Mental Wellbeing Score), where a higher score indicates more positive wellbeing. The mean score for Scotland for all adults was 49.9, and was slightly higher for men than women (50.1 and 49.7). The figure for Shetland was higher, at 50.8, which is the highest in Scotland along with the Borders.

#### GHQ-12

<table>
<thead>
<tr>
<th>Year</th>
<th>Shetland Males</th>
<th>Scotland Males</th>
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<td>5.3</td>
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<tr>
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<tr>
<td>2008-12</td>
<td>41.9</td>
<td>22.6</td>
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</table>

Suicides: European Age/Sex Standardised Rate per 100,000 pop.

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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<tbody>
<tr>
<td>1983-87</td>
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<td>1988-92</td>
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<td>2003-07</td>
<td>30</td>
</tr>
<tr>
<td>2008-12</td>
<td>40</td>
</tr>
</tbody>
</table>
15% of adults in Scotland scored 4 or more on the General Health Questionnaire (GHQ12), indicative of a potential psychiatric disorder. Nationally, there were significantly more women (17%) than men (12%) with high GHQ scores. The average score for Shetland was 10%, which was significantly lower, with Orkney having an average score of 9%.

**Life Satisfaction**

Life satisfaction was measured on a scale of 0 - 10 where higher scores signified greater life satisfaction. The average score among all adults in Scotland was 7.6 with no difference between men and women. The highest life satisfaction score was recorded in Shetland (8.0), with Borders, Grampian, Highland, and Western Isles also having a significantly higher score than the national average (7.8). The lowest life satisfaction score was recorded in Greater Glasgow & Clyde (7.4).
7. **Key elements that the strategy covers**

7.1. Tackling Stigma & discrimination
7.2. Self management, self help and social prescribing
7.3. Employability
7.4. Crisis Prevention
7.5. Crisis services
7.6. Access to Psychological Therapies
7.7. Mental Health of Older People
7.8. Mental Health of Children and Adolescents
7.9. Alcohol, Drugs and Mental Health
7.10. Carers
7.11. Mental Health and Offending
7.12. Suicide Prevention
7.13. Recovery

Under each of these headings is some background information, relevant statistics where available, information about what already exists, perceived gaps and priorities for action.

**Note**: the Well Scotland site [http://www.wellscotland.info/priorities](http://www.wellscotland.info/priorities) gives a comprehensive guide to each of the priorities identified in the MH Strategy, offers rationale for each priority and evidence of effective interventions.

One helpful way of describing mental health services is to use the Tiered Approach described in the National Framework on Mental Health, reproduced here:

![Tiered Model](image)

This tiered model helps us to understand the principle of dealing with mental health issues and problems at the lowest possible level. There is a strong evidence base for the prevention of mental ill health and a general acceptance from policy makers, service deliverers and
stakeholders that we should be doing all we can to prevent mental ill health and distress wherever possible. There is also a strong recognition now that we should focus on recovery from mental health illness or mental health problems. Nationally the Mental Health Improvement Outcomes Framework has been developed, to help enable services to capture outcomes that are personal and social as well as clinical; the idea being that services should look beyond purely clinical outcomes to see the whole person and their social and personal outcomes as equally valid.

**Tier 0**

7.1 **Tackling Stigma and Discrimination**

The stigma of mental ill-health has been called ‘one of the last great taboos’. People with mental health problems often tell us that the reactions of family, friends, neighbours, work colleagues and employers is harder to deal with than the illness itself.

Stigma can range from being ignored and excluded to verbal and physical harassment and abuse. 81% of people with lived experience of mental ill-health told ‘see me’ (a national agency which aims to tackle stigma) that they had experienced stigma. And many people keep quiet about their experiences due to uncertainty about how people would react - 59% of people don’t talk much about themselves because they don’t want to burden others with their mental health problem.

The threat of discrimination means that people are far less likely to talk about their mental health problems or be open about them. Those diagnoses most likely to attract stigma are personality disorder, eating disorder, self-harm, schizophrenia and obsessive-compulsive disorder (OCD)\(^{viii}\)

The most common situations where people with lived-experience have had to face stigma and discrimination are: by friends and family; in employment/at work; within the local community; within mental health or other health services.\(^{ix}\) These are also the situations where people are most likely to have disclosed their mental health problems.

Recovery from mental ill-health is helped by support from family members and friends.\(^{x}\) Although this research is from 6 or 7 years ago, it is backed up by local research carried out by Mind Your Head more recently:

The Mind Your Head Community Survey from 2011 reported that many people commented on the island rural nature of our community along with ‘word of mouth’ and feelings of being

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**Recovery is often defined as a process of curing or managing the symptoms that are associated with psychiatric diagnoses. It has been argued that medical definitions of recovery overlook the creation of new debilitating conditions as a result of long-term medication, dependency on mental health services, and social exclusion. Some people who have experienced mental distress argue that recovery is a process of moving forward from symptoms, side effects, negative attitudes, devaluing and disempowering services, prejudice in society and social exclusion. Others talk about recovery as a process rather than a goal or end point and that people need to have the chance to talk about their lives - the bad as well as the good aspects - and to reflect on their life journey.**

Recovery and Resilience - African, African-Caribbean and South Asian women’s narratives of recovering from mental distress
‘talked about’. Respondents also communicated their strong desire to see MYH continue in tackling stigma within the community as well as raising awareness of mental ill health.

- 59% of respondents felt stigma was an issue.
- 60% felt the community were more accepting of mental health than it was 5 years ago.
- Attitude and stigma were felt to be the most challenging aspects of coping with mental ill health in Shetland.
- The top 3 priority areas were selected as awareness raising (specifically with teenagers), stigma reducing campaigns and increasing access to self help.
- In feedback there was a feeling that people understand what stigma is in theory but then don't practice being non judgemental in reality and there is a level of ignorance regarding mental health.  

There are a range of organisations and initiatives in Shetland which help to tackle stigma and discrimination. These include

Locally:

- Mind Your Head a local charity which was formed to raise awareness of mental ill-health. Its aim is for Shetland to be a place where
  - Mental health is supported positively within the community
  - Information and knowledge of support services is easily accessible
  - People do not feel isolated because of mental illness
  - Negative attitudes are replaced with understanding and acceptance
- A range of training is available and well attended: ASIST / Scottish Mental Health First Aid / Self-harm Awareness / Stress Less training events which give people confidence to speak about how they feel or ask others and also to answer the myths that surround mental health
- Advocacy Shetland – an independent organisation which offers support to vulnerable people who feel they are not being listened to, including people with mental health problems.
- Moving On Employment Project – supports people in overcoming barriers to employment and helps them to re-integrate into workplaces
- Family Mediation Shetland works with families experiencing separation and/or divorce or general interpersonal conflict. Using trained mediators, family group work can be undertaken involving parents, children and young people, step parents, grandparents and any other significant family members. Ongoing interfamilial conflict can cause stress leading to depression and other forms of mental ill health and this service can help to reduce the likelihood of this.
- Community Mediation Shetland uses a third party to help resolve disputes within communities. Sometimes someone with Mental Health issues can behave in ways which other people find frightening or hard to understand, and being helped to understand this behaviour can help to break down stigma and discrimination.
- Women of Worth is a group for women who have experienced emotional difficulties or problems with mental health & well being. It is run by women for women. The group offers mutual confidentiality, acceptance and respect for others.
- Shetland Link Up – a voluntary sector agency which provides somewhere safe, friendly and accepting where people with mental health problems can feel supported as they work through things.
• Shetland Women’s Aid – works to end violence against women. Clearly domestic abuse can have an impact on mental distress, and, in addition to counselling and therapeutic support, Women’s Aid work to challenge domestic abuse, the stigma and the secrecy surrounding it.

• Sexual Abuse Survivors Support Group – A Shetland based support group that supports people recovering from sexual abuse and who may have long term mental health issues related to the sexual abuse.

• There is often overlap between substance misuse issues and mental health. Community Alcohol and Drug Services Shetland (CADSS) provide support in developing self esteem and managing anxiety for people with drug and/or alcohol problems.

• Annsbrae House offers 7 supported accommodation tenancies together with a Skills centre. There is a short break flat available and social care workers provide an outreach service from Annsbrae House. The Outreach Service provides support to people with mental health conditions in their own home, whether they live at Annsbrae itself or in the community. Outreach services are tailored to individual need and are intended to support a person to live as independently as possible. Support may be provided with a variety of life and social skills such as cooking, budgeting, shopping, anxiety management, hygiene etc.

Nationally

• SAMH is the Scottish Association for Mental Health which has a number of roles including campaigning against stigma and bullying, suicide prevention, promoting the physical activity to improve mental health, and providing some community based support programmes in areas of Scotland.

• See Me – Scotland’s national campaign to end the stigma and discrimination of mental ill health. The Scottish Government together with Comic Relief are investing £4.5 million in a three year anti-stigma and discrimination national programme. Building on the legacy of the See Me campaign, SAMH (Scottish Association for Mental Health) and Mental Health Foundation (MHF) is planning to deliver an innovative programme of awareness raising and local and national activities that challenge the discrimination associated with mental ill-health.

Our priorities for action are:

• To continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable
• To continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
• To offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems
7.2 Self management, self help and social prescribing

Many local initiatives are helping support local communities and individuals to promote ‘better mental health’ and increase a sense of ‘well-being’. There are a number of information events scheduled each year, including those organised by Mind Your Head, Shetland Arts, Moving On, Shetland Link Up, Alzheimer Scotland, CADSS and many other localised support groups and networks. In addition many training events have been arranged that continue to add to local knowledge and expertise so that information is being facilitated and cascaded to those who require it the most.

Resilience is a key factor in protecting and promoting good mental health. It is the quality of being able to deal with the ups and downs of life, and is based on self esteem. Resilience is a skill that can be learnt, and there are a number of sources of training being developed in Shetland at present.

NHS Shetland Health Improvement continues to deliver Mental Health for Managers training and all courses to date have been over-subscribed. In order to achieve the Healthy Working Lives Award, businesses need to demonstrate that they are delivering a mental health promoting activity or awareness raising programme to their staff. In addition the team has delivered a number of ‘Stress-less-sessions’ across Shetland. A range of training is delivered, including ASIST, self-harm awareness, mental health first aid, and safe talk.

Mind Your Head have recently been involved in a number of ‘promise signing’ events. Similar to the See Me pledge this is a local initiative whereby local agencies/organisations sign a promise that they will encourage and support positive mental health in their workplace/organisation. Part of the promise includes agreeing to undertake mental health awareness training.

The Health Improvement team deliver workplace based health checks to specific priority groups, in particular men who are involved in more manual types of work, as these are a key target group identified through the audit of suicides and sudden deaths that we undertake in Shetland. The health check includes questions about mental health, and the men who have been involved have been extremely grateful to have the chance to talk about the issues that affect them. The aim with this type of normalising conversations about mental health and mental distress is to see an impact on numbers of people coming forward for help and eventually on positive outcomes such as reducing suicide numbers.

Priorities for action are to continue the wealth of activity in this area to promote positive mental health and support those who are most vulnerable, including:

- Continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable.
- Continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
- Offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems.
7.3 Employability

Employability is one of the strands of the Mental Health Strategy for Scotland. We know that being in the right work is good for a person’s health and improves their quality of life and wellbeing. We also know that remaining in work or being able to return to work quickly helps them to recover from mental ill health. Over the last couple of years, the local authority and partners have been working to find ways of supporting people to remain in work where possible, or to move back into work as quickly as possible. This is known as employability. Employability encompasses all the things that enable people to increase their chances of getting a job, staying in and progressing further in work. For each individual there will be different reasons why they are not achieving what they would like in employment - perhaps their confidence and motivation, their skill, their health or where they live compared to where jobs are available.

The employability pipeline is the stages a person has to achieve in order to gain employment. Some clients will move from start to finish of the pipeline, where as others may start later in the process and miss steps out. One of the main functions of the assessment is to develop a plan for the client that includes the most appropriate service to them at the right time. The starting point is to bring clients into the employability pipeline. This will involve a number of new processes including referrals from organisations whose main business is not employability as well as active outreach activity by employability organisations.

We recognise the major impact that changes like Welfare Reform will have on people with mental health problems. A range of local activities are being developed through the Fairer Shetland initiative to respond to the problems created by Welfare Reform including publicity about Welfare Reform, ways of managing a budget and where to access support and help.

Priorities for action:

- To continue to work alongside the Employability Pipeline to ensure that people with mental health problems receive the support they need to remain in work/get back into employment.
- To understand the effectiveness of the NHS/SIC Employee Assistance Programme in supporting people with mental health problems
- Continue to deliver training to support workplaces in promoting positive mental health and supporting people with mental health problems.
7.4 Crisis Prevention, Support and Treatment

Some mental health problems can be episodic in nature, with people experiencing stable periods with few symptoms, and periods of crisis with intense symptoms. Sometimes crises arise when a person's life circumstances change, or when there is a change to medication that helps to stabilise a condition. The response to this type of crisis is probably the area of service which has received most criticism over recent years in Shetland. In general stakeholders felt that there was a lack of anticipation of crises and that there were a number of things which might help to prevent crises happening in the first place. The national strategy recommends the following components of crisis prevention services:

- Routine use of lapse and crisis contingency planning for individuals who have experienced more than one acute episode;
- Integrated (cross health and social care) and person-centred care planning;
- Effective involvement of families, friends and carers; and
- Timely responses by specialist services when an individual or their carers highlight the occurrence of early warning signs.

The current Mental health Service in Shetland has grown from a single adult Community Psychiatric Nurse (CPN) in 1986 to the current Community Mental Health Service with a range of responsibilities and services, all of which can be accessed via a GP using an Electronic Single Point of Referral as part of the wider With You For You process.

The core philosophy is to ensure that people are seen by the most appropriate clinician as quickly as possible.

Services are managed within the Community Health and Social Care Directorate, with support from; NHS Mental Health Department Manager; Dementia Services Development Manager; SIC Annsbrae Team Leader and Mental Health Officer Senior Social Worker.

Community Psychiatric Service

General Adult Psychiatry, Old Age Psychiatry (excluding dementia), Emergency/Liaison Psychiatry.

Referrals for “General Adult” (16/18-65 years old), “Old Age” (65+) and Emergency/Liaison” categories are received from GPs, Hospital Consultants, and Social Work. The duties of the service are:

- To provide a clinical service in community psychiatry for adults and older people including; out-patient consultations; assessment and treatment of patients in the community and a range of care settings, emergency assessment and treatment.
- To provide assessments and advice on patients in the care of medical and surgical colleagues and those attending accident and emergency with mental health problems.
- To assess patients in police custody on request of a police surgeon (Consultant Psychiatrist).
• Fulfil the duties associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003.
• To contribute to the teaching and training of students, trainees and multidisciplinary staff groups as appropriate.

The service does not provide specialist “in person” care in the areas of Eating Disorder, Forensic Psychiatry, Old Age Psychiatry or Perinatal Psychiatry. Advice and treatment in these areas is available from NHS Grampian.

Additionally, an NHS National Service for Treatment Resistant Depression & Obsessive-Compulsive Disorder can be accessed, for patients who meet the criteria for these services.

Specialist psychotherapy services are occasionally accessed through NHS Grampian as a “tertiary” level service.

The Community Psychiatric Service provides a comprehensive service to adults (18+) in both office based and home settings, with out-patient clinics being held in health centres throughout Shetland. Services are provided by

- Consultant Psychiatrist
- Community Psychiatric Nurses
- Specialist social Worker /MHO

The review of Mental Health Services in Shetland makes a number of recommendations to strengthen this area of service:

- The report notes that demand for psychiatric services is very variable and an on island psychiatric ward would not be cost effective
- Some patients will always require admission to more specialist inpatient services off island
- There is a gap in the provision of out of hours/crisis service, development of this would avoid some unnecessary off island transfers
- Better care management would focus on early intervention and prevent crisis escalation
- Shetland requires an on island clinical psychiatric presence; the current arrangement of one stand alone psychiatrist does not provide an effective service
- Community Psychiatric Nurse (CPN) staffing levels have been historically reduced and increasing demand and reduction in staff have reduced effectiveness of the Community Mental Health Team service
- further integration of CPN and Social work services would help to make the service more robust and reduce delays

The aim should be to develop an Out of Hours/Crisis service including place(s) of safety and capacity for emergency treatment. Over the last five years, an average of 25 people per year have been admitted to Royal Cornhill Hospital Aberdeen from Shetland with 10 of these patients discharged within two weeks. Providing a service where two 2 staff, (trained in control and restraint) can be available for up to 72 hours, (the duration of an Emergency Detention Certificate) in an agreed place of safety, with appropriate clinical governance for e.g. rapid sedation, would give local services an opportunity to stabilise the situation, and provide a more
thorough assessment, reduce the number of admissions to RCH, and provide a more effective service.

**Priorities for action**

- To promote strong leadership for Mental Health through the Director of Community Health and Social Care, with appropriate support from the Chief Executives
- Recruit a second psychiatrist at staff/consultant grade
- Integrate the CMHT and Annsbrae teams into one Community Mental Health Service
- Increase numbers of Community Psychiatric Nurses as a priority
- Create a crisis response service from the above and establish a pool of Control and Restraint trained staff
- Explore options for accommodation for crisis support
- Explore best use of resources
7.5 Access to Psychological Therapies

The Matrix (2011) outlines the training that is required for the management of adult mental health problems by different NHS staff groups to deliver evidence-based psychological therapies. It amalgamates the recommendations from both SIGN and NICE guidance.

Research shows that GPs are most often the first point of call for people experiencing mental health issues, but may not have the skills or confidence to deal with these individuals. It is estimated that 90 per cent of mental health problems are dealt with in primary care, therefore having the skills to help patients is not only important for GPs but for practice and community nurses also. Allied health professionals, Dental staff, Social care workers and Housing outreach workers are in prime positions to recognise and refer on people with mental health issues. Health improvement staff have a role in prevention and promotion of mental health issues as do a range third sector providers.

The recent review of mental health services in Shetland found that talking therapies are well used but there are significant access and delivery problems. This has been a concern for some time, and work has been ongoing to tackle this issue. In particular, a Psychological Therapies Steering Group was established to help support the provision of psychological therapies in Shetland. The aim is to have in place an inter-agency, tiered model of support, which meets the needs of people in Shetland in terms of the speed at which people are seen and in the quality of the interventions provided. This includes identifying gaps in provision and developing an increased psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions.

The Psychological Therapies Service currently in place within NHS Shetland provides access to non-pharmacological interventions in accordance with the guidance provided in the Scottish Government publication "The Matrix" for people with mental health needs. It is a secondary care service, with the majority of provision being at level 3-4 of the Tiered model. Where appropriate, psychological therapies are used to complement more traditional psychiatric interventions.

The government-set target for accessing psychological therapies is within 18 weeks from referral to treatment by December 2014.
Lowering the threshold for referral to the service (December 2012) increased the number of referrals which may impede the ability of the service to achieve the target by December 2014. A number of other services in Shetland also deliver psychological therapies. These include

- CADSS for substance use and mental health for client group and families,
- Shetland Bereavement Support Service provided one-to-one counselling for people affected by bereavement and loss in Shetland, but is now closed due to lack of ongoing funding.
- Shetland Women’s Aid provides counselling and cognitive behavioural therapy style approaches to women who have experienced domestic abuse and to children who may have witnessed abuse.
- Family Mediation Shetland provides mediation where families are separating or divorcing and where there are parenting issues as a result.

**Priorities for action:**

- the introduction of a stepped care model for psychological therapies
- developing the psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions
- to identify other ways of delivering very specialist psychological therapy at Tier 3
- to establish a visiting psychology service
- developing local information on how to access psychological therapies and about alternatives to psychological therapies, including web- and telephone based services such as Living Life.
7.6 Mental Health of Older People

We often think about dementia in relation to mental health and older people, but it is only one of the strands that affect older people. In order to give dementia a separate but complementary focus and create the environment to meet the aspirations for Shetland to be a dementia friendly community, a separate Dementia Strategy for Shetland will be developed early in 2014. The headline challenges from the National Dementia Strategy are:

- To dispel the fear of dementia so that people do not delay in coming forward for diagnosis and help
- That people with dementia and their carers should get the information and support after diagnosis that they need
- That general healthcare services should always understand how to respond well to people with dementia and their carers, leading to better outcomes
- That people with dementia and their carers should always be treated with dignity and respect
- That family members and people who support and care for people with dementia should receive the help they need to protect their own welfare and to enable them to go on caring safely and effectively

The Mental Health Strategy for Shetland needs to consider the range of issues that affect mental health in older age. The determinants of mental health and well-being in old age are the same as for other adults: physical health, psychological resources such as self-esteem and coping skills, financial resources, life-style, life experiences, quality of relationships with family and friends or having a meaningful activity and role in the community.

Consequently we should be focusing on prevention of mental ill health and early intervention in older adults, in maintaining support in the community where at all possible, and treating appropriately where necessary. As people become older and less able, there may be additional issues in terms of maintaining independence, maintaining positive interaction with friends and networks and managing medication.

Some of the preventative work in this area will be best managed through locality based working and through the community capacity building work that the CHCP is engaged in.

Through the development of the Older People’s Strategy we can do further work to understand the prevalence of depression in older people in Shetland and the links to chronic disease, dealing with dying and end of life. We also need to support general awareness about mental health issues amongst staff working with the elderly.

Priorities for action:

- to develop our understanding of the wider mental health of old people in Shetland through the development of the Older Peoples Strategy
- to develop a Dementia Strategy for Shetland.
The majority of children in Shetland are, on the whole, healthy and happy, and never need specialist children’s mental health services. We recognise the need to maintain this situation, and universal services such as maternity, health visiting, nurseries and schools work hard to promote positive mental health and wellbeing in young people in Shetland.

Barnados describes the many different factors affecting resilience in children as being:

- secure early attachments
- confidence of being loved and valued by one’s family and friends
- clear sense of self-identity (personal, cultural and spiritual)
- sense of self-efficacy (being able to make decisions and act independently)
- confidence to set goals and attempt to achieve them.

The Shetland Children’s Plan is the process through which prevention and early intervention activities are developed.

NHS Shetland Children and Adolescent Mental Health Service (CAMHS) consists of three permanent members of staff (2.7 whole time equivalent) on island (the psychiatric nurse for children and adolescents, the clinical associate in applied psychology and the primary mental health worker). We have visiting consultants in psychiatry and psychology.

The model for allocation of referrals in NHS Shetland CAMHS is a multi-agency team discussion occurring once weekly. Referrals which are accepted are then allocated and triaged into the appropriate assessment slots, which may be with one of the visiting consultants. If necessary, the staff on Isle will complete a preliminary assessment before an appointment in one of the visiting consultant’s clinics; this is not always necessary when it is apparent that the first appointment will need to be with one of the visiting consultants. In the majority of cases though, young folk and their families are seen by the on Isle staff.

This triage system ensures that the children and young people of Shetland are kept waiting for the minimum amount of time before getting their first appointment with CAMHS. It also ensures that those who are not taken on are sign-posted to the most appropriate resource to meet their need, which includes self-help materials.

This triage system also ensures that NHS Shetland CAMHS continues to keep well within the current HEAT target for wait times. The model of monthly visits by specialist consultants ensures that our youngsters access more specialist support in a safe, effective and timely manner.

The Primary Mental Health Worker carries a case load which is focussed on early intervention, working with children and young people in the school setting as well as in clinic. The consultant psychiatrist is routinely involved in the assessment and further enquiry of those patients presenting with attention difficulties, mood disorders and neuro-developmental disorders and is vital to the assessment of eating disorders with rapid weight loss, sudden behavioural change suggestive of emerging psychosis and treatment refractive depression as well as those complex cases where the inter-generational dynamics and familial background necessitate the experience and knowledge of a consultant psychiatrist.

The consultant psychologist directly assesses young people where obsessive compulsive disorder may be present, concerns regarding eating disorders, complex trauma or attachment.
difficulties, complex developmental difficulties and neuro-developmental disorders. The consultant psychologist will see a case for assessment first hand when the whole team agree that the benefit of that specialist experience is warranted.

In the case of a young person being admitted to Ward 3 of the Gilbert Bain Hospital having deliberately self harmed with suicidal intent, practice is for a member of the team to see them before they are discharged home. In the twelve months from August 2012 to August 2013 there were five such patients; four were seen by the psychiatric nurse and one by both the consultant psychiatrist and the primary mental health worker together.

**Target: Faster access to Child and Adolescent Mental Health Services**

**18 weeks from referral to treatment by December 2014**

![Access to Child & Adolescent Mental Health Services (referral to first treatment)](image)

Stakeholders felt that the current service they receive from CAMHS is very good, there was concern that 26 weeks (the previous government waiting times target) is a long time to wait if you are a child or young person in distress, or if you care for a child or young person in distress. However, the data shows that no young people in Shetland have to wait this long: the service already complies with the new target to reduce waiting times to 18 weeks by December 2014.

There was feedback that Parenting Programmes, Triple P & Parent Link are helpful in supporting positive parenting and thereby promoting positive mental health.

**Priorities for action:**

- Support to those on the Autism Spectrum where this group experiences a varied service provision
- To be clear about pathways for young people 16 to 18 years, including links to regional and national specialist in-patient services
To review Tier 1 support to young people including within schools, access to advice and/or counselling, and developing resilience, with links to work within the Children’s Services Plan.

Internet safety which links to issues of bullying, and the vulnerability of children and young people in relation to risks of exploitation and abuse, linking to work through the Child Protection Committee.

To develop a protocol for responding to a young person at risk of self-harm/suicide.
7.8 Mental Health and Alcohol & Drugs

There is a distinct overlap between mental health and substance use/misuse. The ongoing audits of suicide and sudden deaths in Shetland show that alcohol is almost always a factor – either a significant quantity has been used immediately prior to death, or there has been a history of unhealthy drinking patterns. Almost 1 in 10 cases in Accident and Emergency (A&E) are alcohol related, and of these a third have Mental Health issues.

In the Mental Health Strategy for Scotland, the government describes the delivery of Alcohol Brief Interventions as being one of the key methods of tackling unhealthy levels of drinking. They recommend clearly aligning the work in place to diagnose and respond to depression with the delivery of alcohol brief interventions to reduce people’s alcohol consumption. In Shetland, A&E staff, the sexual health clinic and substance misuse service routinely screen for alcohol misuse; Primary care services, however, continue to show reluctance to engage with this tool.

A redesign of the substance misuse service is currently taking place, and within this the role of Dual Diagnosis staff will be considered.

Priorities for action:

- Publicising the links between alcohol, poor mental health and suicide
- Community awareness raising on what individuals can do to promote and protect mental health, with a specific focus on bar staff, taxi drivers, people selling alcohol in shops
- Broadening understanding of mental health among all health and care professionals working in substance misuse services
- To ensure that the current redesign of substance misuse services takes account of the needs of people with dual diagnosis
- To have mental health and drug & alcohol services working together in a coordinated way to provide the best experience and access for service users
7.9 Carers

Research conducted during 2013 by Advocacy Shetland found that carers of people with mental health problems wanted to be involved in the cared-for person’s care-planning, wanted to be consulted and engaged in decision making about the person they were caring for. They felt this would make a significant difference to their ability to fulfil their roles and work with and reassure the person that they were caring for.

A community survey recently undertaken by Mind Your Head found the following:

Carers felt that better understanding was required both generally within the community and also for carers themselves. A means by which to easily learn and understand, know what action to take, etc was often highlighted as being important.

“There is not even enough service support for those with mental health problems let alone their families and carers”

“There is a point where patient confidentiality is not in the best interests of the patient and family”

“There are some excellent support services available, but people need to be made more aware of them”

“Seems to be little help for those caring for older patients recently diagnosed with the likes of Alzheimer’s or Depression related illness”

“The carer can become isolated because of the ill person”

“Not enough information given to help public understand and be able to help people who suffer from mental health problems”

Shetland services are attempting to work more effectively with families and carers and are utilising the following initiatives; some of these initiatives are in a more advanced stage of implementation than others e.g.

- With You For You
- Carers Assessments
- Care Programme Approach
- Voluntary sector support
- Advocacy

and some are requiring review or development to ensure that they remain fit for purpose and achieve maximum benefit for those in greatest need:

- Increasing use of self help and access to support information
- Boosting use of carers groups
- Involving carers in learning events
- Encouraging carers through local media to seek support and assistance
- Culture shift in involving carers from the beginning of engagement
- Making sure that confidentiality is not used as a barrier to supporting carers.
7.10 Mental health & offending

Shetland has only a small number of offenders, though that does not prevent local services being extremely responsive. There are good links with the regional secure unit and risk management advice and training has been provided. The Scottish Government is currently considering the redesign of criminal and community justice services across Scotland (options being to have a single structure across Scotland, or local authority run service, or enhanced Community Justice Authorities). The outcome may impact on Shetland services and will be monitored as required.

The criminal justice liaison group is the forum for offender related discussions and a courts protocol for obtaining psychiatric advice was agreed shortly before the previous Sheriff’s departure. The Criminal Justice executive lead manager is located with the Community Care structure and ensures that criminal justice matters linked to mental health receive attention.

Where substance misuse issues are important for prisoners returning to the community the local services involved liaise directly.

Multi-agency Public Protection Arrangements (MAPPA) intervention for the risk management of sex and violent offenders is deployed appropriately and agencies are involved according to specific case need.

People within these arrangements suffering from mental ill-health are protected through appropriate referral and liaison with specialist services. These arrangements are often strengthened, and the support given to clients is more effective, where there are strong, appropriate professional relationships with outside organisations such as Advocacy, Moving On Employment Project, and Citizens Advice Bureau.

The recent national changes to NHS provided healthcare for people in prison and custody have not made a significant difference to local services, though planning is in place to ensure sustainability and compliance with national standards of care.

Priorities for action:

- To maintain appropriate professional relationships with outside organisations such as Advocacy, Moving On Employment project, and Citizens Advice Bureau
- To maintain local services with the national move to NHS provision of healthcare for people in prison and custody, and in any national redesign of criminal and community justice services across Scotland.
7.11 Suicide Prevention

The Suicide rate is now the sole measure used by government for suicide reduction across Scotland. Small numbers locally mean large fluctuations as can be seen from the graph. A rise from 5 suicides in 2010 to 7 in 2011 put us behind our trajectory rate and we now have the highest suicide rate in Scotland. Training continues with a wide range of service staff and the community, and the Sudden Death Audit Group examines all local cases with a view to identifying any issues/trends.

Deaths caused by intentional self harm and events of undetermined intent, registered in Scotland, by NHS Board and 5-year time period: Persons

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Crude Rates per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>12.3</td>
</tr>
<tr>
<td>Borders</td>
<td>12.4</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>15.8</td>
</tr>
<tr>
<td>Fife</td>
<td>13.6</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>12.6</td>
</tr>
<tr>
<td>Grampian</td>
<td>14.9</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>15.3</td>
</tr>
<tr>
<td>Highland</td>
<td>19.5</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>10.2</td>
</tr>
<tr>
<td>Lothian</td>
<td>12.9</td>
</tr>
<tr>
<td>Orkney</td>
<td>10.4</td>
</tr>
<tr>
<td>Shetland</td>
<td>11.6</td>
</tr>
<tr>
<td>Tayside</td>
<td>14.7</td>
</tr>
<tr>
<td>Western Isles</td>
<td>16.1</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>14.0</strong></td>
</tr>
</tbody>
</table>

* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time

A national Suicide Prevention Strategy has recently been published. We are in the process of reviewing this against our local strategy, and it is likely that our priorities will be based on the following chart:
<table>
<thead>
<tr>
<th>Theme from strategy</th>
<th>Actions in current action plan</th>
<th>Current activities</th>
<th>Possible future actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to people in distress</td>
<td>Review arrangements for post suicide attempts support</td>
<td>ASIST training delivered 4 times a year to service providers.</td>
<td>Out of hours crisis service – as per recommendations in service review report</td>
</tr>
<tr>
<td></td>
<td>Develop arrangements for support following completed suicides</td>
<td>CMHT visit patients admitted to GBH or in A&amp;E who are distressed/ suicidal. Will undertake a risk assessment and offer follow up if necessary.</td>
<td>Develop a multi-agency protocol (similar to child protection procedures)</td>
</tr>
<tr>
<td></td>
<td>Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries)</td>
<td></td>
<td>Single point of access.</td>
</tr>
<tr>
<td>Talking about suicide</td>
<td>In partnership with MYH develop a programme of awareness raising activities for throughout the year to establish a continued reminder of what support/training is available</td>
<td>In partnership with MYH provide varied activities during Suicide Prevention Week</td>
<td>Community resilience work – (helping people to respond better to each other’s “I’m fine”)</td>
</tr>
<tr>
<td>Developing the evidence base</td>
<td>Review numbers of PHQ-9 depression tests undertaken in Primary Care</td>
<td>Continue to audit all potential suicides</td>
<td>Root cause analysis training?</td>
</tr>
<tr>
<td>Supporting change and improvement</td>
<td>Develop a consistent, clear framework regarding prevention/awareness raising in school in relation to suicide and</td>
<td></td>
<td>Through the Children’s Plan.</td>
</tr>
<tr>
<td>Theme from strategy</td>
<td>Actions in current action plan</td>
<td>Current activities</td>
<td>Possible future actions</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>self harm</td>
<td></td>
<td></td>
<td>(This will include further actions identified from the recent multiagency workshop in this column once info is collated)</td>
</tr>
</tbody>
</table>

The recent Suicide Prevention Planning Event identified the following outcomes: -

- That Shetland as a community should become more aware of suicide and suicidal behaviour;
- That 24 hour support should be available when someone is feeling suicidal;
- That all Services in Shetland respond appropriately to suicidal behaviour;
- That Suicide is no longer a cultural norm;
- Reduction in substance misuse;
- That professionals in Shetland have a better understanding of suicide and suicidal behaviour;
- Reduced access to Lethal Means.

An action plan to deliver on these priorities is currently being written. **Our priorities are:**

- To develop community resilience and awareness raising including in schools.
- Responding to people in distress including developing arrangements for support following suicide attempts and completed suicides
- Continue to audit all local suicides to understand and act on preventative factors
- Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries).
8. **Strategic Priorities**

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness and distress.
- Early recognition & treatment of mental illness & disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carers(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services
- Redesign of the mental health service in line with the service review.

9. **Resources and Workforce**

As part of the implementation of the strategy, the Shetland Mental Health Partnership will think about how best to use the people and resources we have available to deliver the strategy. It is unlikely that new money will be available, so we need to think about how we use existing services, staff and resources differently. Some of the difficult questions for services include: Is there anything that we could stop doing? How do we free up time and capacity to develop and move forwards?

10. **Outcomes and Indicators including timescales and leads**

The development of an action plan will address the challenge of how we measure improvements, and how we will know when we have achieved our aims.

The aims of the Strategy can be summarised as:

- to provide direction in the way forward for mental health services in Shetland;
- to provide a vehicle for developing Shetland as a place that is free from stigma and disadvantage in relation to mental health issues;
- that promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible;
- to deal sensitively and effectively with mental illness when it does occur, working with people living with mental illness towards recovery.
Appendix 1: Towards a Mentally Flourishing Scotland – roles and responsibilities

In the area of mental health improvement the key roles of the Scottish Government are to:

- give national leadership to the mental health improvement agenda and foster a culture which encourages mental health improvement;
- set, in partnership with others, the strategic framework for action and national priorities;
- support delivery organisations to develop and implement interventions and approaches;
- take forward wider policies that will contribute towards mental health improvement goals.

Most council services, including education, community care, employment and social inclusion, are directly relevant to mental health improvement. The key roles of local government in this area are to:

- give local leadership to the mental health improvement agenda;
- develop, with Community Planning Partners and Community Health Partnerships, local plans for delivery;
- develop and implement local interventions and approaches;
- embed mental health improvement approaches into other services, building on the learning from implementing the Mental Health (Care and Treatment) (Scotland) Act 2003 and the guidance in With Inclusion in Mind.

NHScot has a lead role in health improvement as 'every healthcare contact is a health improvement opportunity'. The key roles of the NHS mental health improvement are:

- through NHS Health Scotland to provide national support and leadership for the delivery of mental health improvement;
- through local NHS Boards to support and deliver local plans for delivering mental health improvement in conjunction with Community Planning Partnerships and Community Health Partnerships;
- to embed mental health improvement into all NHS activity, but in particular in respect of those who are at risk of developing mental health problems as a result of substance misuse or other lifestyle issue, and those experiencing mental illness.

All public sector employers should demonstrate a commitment to mental health improvement and leadership in the way that they discharge their role as employers.

The Third Sector makes a significant contribution to the mental health improvement agenda both nationally and locally. Its key roles are to:

- deliver services which directly or indirectly promote mental health improvement;
- innovate in the development of new service approaches and interventions;
- act as a catalyst in promoting active citizenship and social capital to develop community capacity;
- advocate change and improvement for service users and the general population.
The actions of **individuals** and **communities** are also central to this agenda. We know that 'intentional' activities (activities over which we have control) are important drivers of mental wellbeing. Improvement may be achieved through interventions that change our behaviour, for example, taking regular exercise; our cognitions, for example, interpreting events in a positive light; and our motivations, for example, focusing on goals that reflect deeply held values rather than external rewards, as a method of improving mental wellbeing.

Such an approach acknowledges human agency. However, individuals do not make choices in isolation from the broader social and physical environment of which they are part and there is a clear role for Government in creating the social and environmental context in which individuals and communities are able to act on their own behalf. Advocating for individual responsibility and self-help in mental health improvement is therefore *set within* a framework with equal attention to the creation of mentally-healthy environments within which individuals and communities are empowered.

There is no single solution to achieving outcomes in mental health improvement and no single sector, agency or programme can deliver this agenda on its own. **Partnership working** through Community Planning Partnerships, Community Health Partnerships and other organisational structures will be key to delivering mental health improvement at local and national level.
Appendix 2: Roles & Remits of Mental Health Partnership and Forum

THE SHETLAND MENTAL HEALTH PARTNERSHIP (SMHP)

REMIT
The SMHP will take an overview of all mental health services in Shetland. In addition the SMHP will produce a new mental health strategy. This new strategy will be for the next three years and include the full range of mental health services. In the longer term, it will be used by the 2020 vision project.

The partnership will have a multi agency approach and include representatives from the Health Board, Council services and the Voluntary Sector, assisted by service users and carers.

The partnership will have an annual work plan, which will include overseeing initiatives such as Choose Life, the Suicide Prevention Action Plan and the Joint Local Implementation Plan (JLIP).

Responsibility for the strategy will rest with the SMHP. The SMHP will work with its partners to implement the strategy. When preparing the strategy consideration will be given to:

- Relevant national policies;
- Guidance for adults and children;
- The national framework for Mental Health services;
- The findings of national monitoring;
- The findings of recent needs assessment;
- Development of services including a local resource centre;
- Capacity within the Mental Health service;
- Making links to specialists services at a regional and national level;
- Agreeing joint spending plans;
- The variety of funding sources.

The Mental Health Operational Management Team (MHOMT) and the Mental Health Forum (MHF) will provide support to the partnership. In return the partnership will feed back its results to the Management Team and the Mental Health Forum.

The partnership will promote good communication between all agencies working on mental health issues.

Agreed at the Shetland Mental Health Partnership meeting on 14th July 2005.

Membership (March 2014)

- Ann Thomson  Welfare Rights Adviser (CAB)
- Hughina Leslie  Service Manager Community Care and Chief Social Work Officer (SIC)
- Simon Bokor-Ingram  Director of Clinical Services (NHS)
- Sergey Boyadjiev  Locum Consultant Psychiatrist (NHS)
- Hazel Anderson  Advocacy Shetland
The Shetland Mental Health Forum exists to support and inform the work of SMHP, by ascertaining, co-ordinating and expressing the views of service providers, service users and those in need of services. To this end the Forum is required to be broadly based, representing the interests of those who provide services in the field of Mental Health, families, carers and partners of those people who experience mental health issues and the wider community.

1: Forum Objectives

The objectives of the Forum are to:

1. To participate in the promotion of events and projects which promote a mentally healthy lifestyle and an awareness of mental health issues; This includes sharing project ideas and plans with members and working proactively to promote such.

2. To provide support for mental health awareness projects in the community.

3. Make Shetland Mental Health Forum approachable by, and of benefit to, the Shetland community by promoting the partnership and openly inviting views from the community.
4. To provide operational expertise that contributes to the wider debate and planning of the development of local strategies, for the promotion of positive mental health and access to services throughout Shetland. In particular through assisting in the development of SMHP strategy.

5. To assess the provision of mental health services in Shetland. Then promote, through the SMHP, the implementation of local strategies, and recommend the provision of the necessary resources for agencies to tackle identified problems at a local level. This includes using the Forum’s seat(s) on SMHP to this advantage whenever possible.

6. To promote multi-agency working and co-ordination between statutory and voluntary agencies at a local level, which the availability for services to provide information and updates at Forum meetings

7. To contribute to the debate on best practice and value for money and to share information and experience with others

8. To participate in, contribute to, influence and inform through the SMHP the formulation of policy at a national level

2: Duration of the Agreement

This Partnership Agreement will take effect on the date on which it is signed by all partners and will remain in force for a period of 24 months.

3: Forum Partners

Forum partners are the organisations and services that are responsible for carrying out specific Forum activities, where required, and who are responsible for representing the interests of said organisations at the Forum. At present, partners include:

Carers, Advocacy Shetland, Voluntary Action Shetland, NHS Shetland, Shetland Bereavement Service, Mind Your Head, Alzheimer’s Scotland, Moving on Employment Project, Shetland Islands Council, Community Alcohol and Drugs Service Shetland, Women’s Aid, Couple Counselling Shetland, Shetland Link up, Shetland Health and Wellbeing Forum

4: Organisational Structure of the Forum

The Forum is presently chaired by Elizabeth Robinson, and supported by Allan Wishart as Vice-Chair. The Forum and its Chairs are further supported by officers from the Health
Improvement team. The Forum Constitution should be referred to for a more detailed summary of roles and responsibilities.

The Forum will have the ability to delegate specific tasks or responsibilities to sub committees where appropriate. These tasks may include specific pieces of research, individual projects and/or events as identified by the Forum.

5: Monitoring, Evaluation & Reporting

SMHP will monitor the Forum and regular reports and updates will be disseminated to the SMHP via the Forum representation by the Chair and Vice-Chair.

In some instances the SMHP may require the Forum to undertake a specific piece of work, for which Forum partners will have a joint responsibility to complete.

6: Confidentiality

The Forum partners agree that any information/documents shared and exchanged are kept confidential, provided that one partner or the Forum itself explicitly requests such.

8: Modifications, withdrawals & disputes

Any modification to the present Partnership Agreement must be made in writing to the Forum Chair, to be given approval by the Forum partners.

Forum partners agree not to withdraw representation unless there are unavoidable reasons for it. Should one representative be unable to attend the organisation should endeavour to send another representative.

In case of any disputes amongst Forum partners, the obligation will be to work towards and amicable settlement. Disputes will be referred to the Forum, but where these cannot be resolved, the SMHP will have overall responsibility of settling disputes.
Appendix 3: Service Data and Activity

Referrals accepted into NHS Shetland CAMHS

Seventy nine referrals were accepted into NHS Shetland CAMHS between August 2012-August 13. The breakdown of who sees these referrals for assessment is in the following table:

<table>
<thead>
<tr>
<th>Clinician(s)</th>
<th>Number of Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPN &amp; PMHW</td>
<td>11</td>
</tr>
<tr>
<td>PMHW &amp; CAAP</td>
<td>10</td>
</tr>
<tr>
<td>PMHW</td>
<td>10</td>
</tr>
<tr>
<td>Consultant Psychiatrist &amp; CPN</td>
<td>20</td>
</tr>
<tr>
<td>Consultant Clinical Psychologist &amp; CAAP</td>
<td>6</td>
</tr>
<tr>
<td>Consultant clinical psychologist and PMHW</td>
<td>5</td>
</tr>
<tr>
<td>Consultant clinical psychologist</td>
<td>8</td>
</tr>
<tr>
<td>CPN</td>
<td>2</td>
</tr>
<tr>
<td>CPN and CAAP</td>
<td>3</td>
</tr>
<tr>
<td>CAAP</td>
<td>1</td>
</tr>
<tr>
<td>CPN and Children and Families social worker</td>
<td>1</td>
</tr>
<tr>
<td>PMHW and Bridges support worker</td>
<td>1</td>
</tr>
<tr>
<td>Whole CAMHS team</td>
<td>1</td>
</tr>
</tbody>
</table>

Fig. 3 Referrals from Ward 3 GBH August 2012 to August 2013.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Referrals from Ward 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012</td>
<td>1</td>
</tr>
<tr>
<td>December 2012</td>
<td>1</td>
</tr>
<tr>
<td>March 2013</td>
<td>1</td>
</tr>
<tr>
<td>May 2013</td>
<td>1</td>
</tr>
<tr>
<td>June 2013</td>
<td>1</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
</tr>
<tr>
<td>CAAP</td>
<td>Clinical Associate in Applied Psychology</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CPP</td>
<td>Community Planning Partnership</td>
</tr>
<tr>
<td>HIFRS</td>
<td>Highlands and Islands Fire and Rescue Service</td>
</tr>
<tr>
<td>MYH</td>
<td>Mind Your Head</td>
</tr>
<tr>
<td>NFU</td>
<td>National Farmers’ Union</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Patient Health Questionnaire, used as a screening and diagnostic tool for mental health disorders of depression, and anxiety</td>
</tr>
<tr>
<td>PMHW</td>
<td>Primary Mental Health Worker</td>
</tr>
<tr>
<td>SMHFA</td>
<td>Scotland’s Mental Health First Aid</td>
</tr>
<tr>
<td>SOA</td>
<td>Single Outcome Agreement</td>
</tr>
</tbody>
</table>
**Which groups** of the population do you think will be affected by this proposal?

- minority ethnic people (incl. gypsy/travellers, refugees & asylum seekers)
- women and men
- people in religious/faith groups
- disabled people
- older people, children and young people
- lesbian, gay, bisexual and transgender people

**Other groups:**

- PEOPLE OF LOW INCOME
- people with mental health problems
- homeless people
- people involved in criminal justice system
- staff

**Partner organisations working in the field of mental health.**

**The Shetland community.**

---

**N.B.** The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.

---

**What positive and negative impacts do you think there may be?**

**Which groups will be affected by these impacts?**

---

**What impact will the proposal have on lifestyles? For example, will the changes affect:**

- Diet and nutrition?
- Exercise and physical activity?
- Substance use: tobacco, alcohol or drugs?
- Risk taking behaviour?
- Education and learning, or skills?

**Intended to positively improve lifestyle in terms of mental health and risk factors to mental wellbeing. Links to substance misuse, specifically alcohol and drug misuse.**

**Includes priorities on community awareness raising and public education, work in schools and with staff working in the field of mental health.**

---

**Will the proposal have any impact on the social environment? Things that might be affected include:**

- Social status
- Employment (paid or unpaid)
- Social/family support
- Stress
- Income

**Links to employability and supported employment should improve health at work and employment opportunities for people living with mental illness.**

**The strategy also has implications for communities supporting people living with mental illness, and for families and carers.**

**The strategy is intended to reduce the impact that stress and other life factors have on mental health and well being, and to improve the resilience of individuals, families and communities.**

---

**Will the proposal have any impact on**

- Discrimination?
- Equality of opportunity?

---
- Relations between groups?

  The strategy has a priority of reducing stigma and discrimination around mental illness.

Will the proposal have an impact on the physical environment? For example, will there be impacts on:

- Living conditions?
- Working conditions?
- Pollution or climate change?
- Accidental injuries or public safety?
- Transmission of infectious disease?

  No impact.

Will the proposal affect access to and experience of services? For example,

- Health care
- Transport
- Social services
- Housing services
- Education

  The strategy includes priorities around mental health service redesign and aims to improve the experience of service users in terms of access, clearer pathways into and between services, and best use of available resources.
### RAPID IMPACT CHECKLIST: SUMMARY SHEET

<table>
<thead>
<tr>
<th>POSITIVE IMPACTS (NOTE THE GROUPS AFFECTED)</th>
<th>NEGATIVE IMPACTS (NOTE THE GROUPS AFFECTED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impacts on users of mental health services, and on people caring for people with mental illness. Positive impacts on staff working in mental health services and partner organisations working in the field of mental health. Positive impacts on communities in raising awareness of positive mental health and reducing stigma.</td>
<td>No negative impacts, recognising that change will have to be managed within existing resources.</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION AND EVIDENCE REQUIRED

Additional information is available within the body of the Strategy. No additional evidence is required.

### Recommendations

It is recommended that the Strategy is approved.
FROM THE OUTCOME OF THE RIC, HAVE NEGATIVE IMPACTS BEEN IDENTIFIED FOR RACE OR OTHER EQUALITY GROUPS? HAS A FULL EQIA PROCESS BEEN RECOMMENDED? IF NOT, WHY NOT?

No negative impacts identified for equality groups. A full EQIA process has not been recommended because sufficient attention has been paid to equality impacts within the Strategy.

Manager’s Signature: [Signature]  Date: 3rd March 2014
References:

i SAMH, 2011, What’s it worth now? The social and economic costs of mental health problems in Scotland


iv (Friedli L, Parsonage M, Promoting mental health and preventing mental illness: the economic case for investment in Wales, All Wales Mental Health Promotion Network. 2009).


vi 2011 Census release, National Records of Scotland 2013


viii A Fairer Future? ‘see me’ report into experiences of people with lived experience (2006) p24

ix A Fairer Future? ‘see me’ report into experiences of people with lived experience (2006) p25


xi Mind Your Head Community Survey 2011