PRIORITIES IN MENTAL HEALTH IN HIGHLAND JUNE 2010

What We Want our Policy Makers to Do For Us

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WHAT IS HUG?

HUG (Action for Mental Health) is a network of people who have experience of mental health problems.

At present June 2010, HUG has approximately 400 members and 14 branches across the Highlands. HUG has been in existence now for 14 years. Between them, members of HUG have experience of nearly all the mental health services in the Highlands.

HUG wants people with mental health problems to live without discrimination and to be equal partners in their communities. They should be respected for their diversity and who they are.

We should:

- Be proud of who we are
- Be valued
- Not be feared
- Live lives free from harassment
- Live the lives we choose
- Be accepted by friends and loved ones
- Not be ashamed of what we have experienced

We hope to achieve this by:

- Speaking out about the services we need and the lives we want to lead.
- Challenging stigma and raising awareness and understanding of mental health issues.

HUG’s aims are as follows:

- To be the voice of people in Highland who have experienced mental health problems.
- To promote the interests of people in Highland who use or have used mental health services.
- To eliminate stigma and discrimination against people with mental health problems.
- To promote equality of opportunity for people with mental health problems irrespective of creed, sexuality, gender, race or disability.
- To improve understanding about the lives of people with mental health problems.
- To participate in the planning, development and management of services for users at a local, Highland and national level.
- To identify gaps in services and to campaign to have them filled.
- To find ways of improving the lives, services and treatments of people with mental health problems.
- To share information and news on mental health issues among mental health service user groups and interested parties.
- To increase knowledge about resources, treatments and rights for users.
- To promote cooperation between agencies concerned with mental health.

INTRODUCTION

In December 2009 we held discussions in our network of branches across the Highlands on what key areas need addressed when looking at the lives of people with mental health problems in the Highlands.

These discussions were focussed on what we want our policy makers, including our politicians, to know when developing plans for those services and shifts in culture that are designed to help us in our daily lives.

Our discussions were informal ones but were recorded at the time and then written up to become the following report.

We had no formal mechanism for setting priorities to the points that our members raised and settled for the simple mechanism of giving a greater priority to those issues that were raised more often than others. We would welcome advice on how a wide network of people can prioritise the issues that they raise as, what may be a priority to one person is not to another, and in the absence of any other method the issues raised by the greatest number of people seemed the only way in which we could do this.

These discussions were held with 67 people. This is considerably less than usually held across the HUG network and was no reflection of a lack of enthusiasm but was simply because staff illness prevented all our branches being consulted.

These discussions were held at a time before we had become aware of how extensive Highland Council and Highland Health Board cuts might be and, we believe this makes this a valuable document, because it was created at a time when we could look to a future with a degree of hope rather than in present months where most of our members are just keen to preserve what they have already.

We hope that it will be used by community partners developing the Community Care Plan. Whilst we have responded to their own consultation we have not yet had a chance to say what we think are our main needs unrestricted by the boundaries of their own consultation. This document may fill that purpose.

We hope that our politicians in our new UK government will take relevant areas into account when discussing developing policy which will affect people with a mental illness and we hope that prospective candidates for future elections in Scotland will take our needs into account as they come to develop their own manifestos over the coming months.

KEY ACTION AREAS:

STIGMA AND DISCRIMINATION – We need continued national and local investment to stop the discrimination we face and to challenge the stigma of mental illness.

CRISIS AND OUT OF HOURS SERVICES – We need to be sure that we can get help when we need it and that, if we are in crisis, we have an appropriate safe place to be cared for until we can face the world again.

POVERTY AND BENEFITS – We need a review of current welfare reform legislation which is having and will have a severe negative effect on people with a mental illness.

EMPLOYMENT – We need to challenge discrimination in the workplace, make the workplace a mentally healthy place to be in and acknowledge the value of unpaid work.

SAFEHOUSES – We need to see the establishment of a network of 'safehouses' across Highland area.

SERVICES – We want to be sure of the security of our hospital services and to see increased investment in our community services.

THE RECESSION – We need to recognise that the fall out from the recent recession will lead to increased mental ill health and that attempts to reduce mental health expenditure would be counter productive.

For more detail and other priorities in this report please read the main section following:

THE MAIN ISSUES WE WANT TO SEE ACTION ON:

FIRST PRIORITY

- STIGMA AND DISCRIMINATION

23% of people with mental health problems have experienced negative attitudes from other people and 3% have experienced physical abuse in public. (Well, what do you think? Scottish Government 2008)

(Refer: **HUG reports –** Challenging the Stigma of Mental Illness, 2002; The Stigma of Mental illness - Drama, Young People and Mental Health, 2006; Annual Report Communications Project, 2006/7; HUG Progress Report 2008/9)

Despite a feeling that the work of 'see me' (the Scottish National anti-stigma campaign) and local initiatives (such as the work of HUG) has made a significance difference, stigma still remains a huge issue for many of us and manifests itself in various forms. It can vary from the overt discrimination and harassment that some of us routinely face to the guilt and shame we, ourselves, feel about having a mental illness. Both extremes damage our self-confidence and mean that we may be less likely to work or participate in society as a direct result of prejudice and ignorance about mental distress.

We need to see continued investment in the 'see me' campaign and additional, long-term investment in local anti-stigma initiatives. These are ideally provided directly by people with experience of mental health problems and need to include work with young people, mental health awareness training of professionals and work with the media and wider public. We also need to encourage the promotion of emotional literacy and life-skills in the population starting with young people. It would be good to get major employers in Highland to sign up to the 'see me' stigma pledge and to focus on how unacceptable overt discrimination is.

SECOND PRIORITY

- SERVICES FOR WHEN WE ARE IN CRISIS.

(Refer HUG reports: Crisis Services, 1997; A Place Of Safety, 2001; Out Of Hours and Crisis Services, 2003.)

Whilst hospital services operate 24 hours a day; community mental health teams are only open between 9 and 5 Monday to Friday. The exception is Caithness Community Mental Health Team that has just employed a single out of hours nurse. There is a Highland out of hours mental health helpline, attached to NHS 24, but as it has never advertised its existence most people are unaware that they can use it.

In crisis we need local services that we can access quickly and easily and out of hours. We also need to be able to get admitted to hospital when acutely ill. This is something that we feel is getting harder and harder to do.

The network of 'drop in centres' across Highland often provide a partial out of hours service. This is welcome but not enough. Mental illness is not confined to office hours and neither should the community services that help us be.

If we get into crisis, even life threatening distress, but are not seen as mentally ill we can find that there is nowhere for us to turn to.

We face an additional barrier if we get ill and are not already clients of a community mental health team. They can respond relatively quickly but we usually need to be referred to them and accepted by them first.

We can struggle to seek help because we are ill, because of stigma or because there are not enough locally responsive services that process referrals very quickly.

There are national helplines such as the Samaritans, Breathing Space and the Bi-Polar fellowship which are important and useful to us and need to be sustained.

Many of us do not fit easily into society and need help from professionals who can bridge the gap between their culture and ours. Peer support can be good in these situations.

We find that transport to New Craigs hospital when acutely ill can be longwinded and trying. We worry about the lack of regular out-of-hours availability of mental health officers outside of the inner Moray Firth area. They can be vital if we need detained for our own safety.

We are also very disappointed that the police cells are still sometimes needed as safe places for us when we are very ill. We should not have to be put in a police cell if we are ill or deeply distressed, instead we should be catered for in more appropriate accommodation, such as a hospital.

Although we need a prompt and sensitive crisis response we would also be very happy if we could see services developed that reduced the need for this. Simple coping and recovery skills can make a difference as can changes to our environment such as our accommodation or workplace.

Despite having a psychiatric hospital in the Highlands we are aware that it does not admit everyone who believes that they are in crisis. Too many people are assessed as not needing admission despite feeling suicidal and are then sometimes left to make their own way home from New Craigs or Raigmore, occasionally at night, and sometimes with no money for transport.

Crisis cards have been developed in other parts of the UK and could be very helpful in the Highlands.

We need community services to open on evenings and weekends, we need places to go to or contact when in crisis and at risk of being unable to sustain independent life in the community.

THIRD PRIORITY

- BENEFITS AND POVERTY

75% of people with significant mental health problems are on welfare benefits. 86% of people with long term mental health problems are unemployed. (Patient Plus)

(Refer HUG reports: Benefits; living or existing 2000 (the forthcoming HUG report 'Poverty' will be published shortly.)

The majority of our membership live on benefits because they are too ill to work. Managing on a very low income is extremely hard and damages our prospects of finding ways to provide for our families, help ourselves with our recovery or find ways of participating in the wider community.

We feel resentment that we are being given advice on how to make do whilst the richer members of society hardly seem to suffer.

It doesn't make sense to some of us that hugely costly 'services' such as nuclear weapons can be paid for when some of us can't afford an adequate diet.

Some of the houses that we live in are so inefficient that we cannot afford to run the appliances that they have been stocked with. It would be good to see practical initiatives aimed at saving local rural communities expense they can't afford.

In rural areas costs can be greatly increased through transport and expensive local shops. Credit unions may be a good option for some of us on low incomes.

Unexpected changes in income or large expenses can cause huge hardship and lead to humiliating circumstances, where we have to apply for such things as crisis loans in order that our children can visit us.

Recent moves to replace Incapacity Benefit with Employment support allowance (ESA) have dismayed many of our members.

The prospect of being forced to seek work when we don't feel able to, the trauma of constant reviews and of medicals by doctors we don't know and who seem to have a limited understanding of mental illness; the loss of part of an already meagre income and the continued media frenzy that labels us as scroungers and benefit frauds does nothing to inspire confidence in us or to make us feel welcome in our communities.

The new criteria to assess the mental health of people applying for ESA has little bearing on the reality of mental illness and means that people will be forced to seek work who shouldn't be working.

If we qualify for Disability Living Allowance (DLA) then we can have a reasonable income but we have a constant anxiety that we will lose it.

It would be good if there were some way of being seen as being able to contribute through voluntary work and so, still remaining on benefits. We worry that staff in Job Centres are much more focussed on meeting quotas and getting us back into work, whatever the cost, than on looking at the reality of our situation and needs.

It would also be good to be sure that all staff working in the field of benefits claims are trained in understanding mental health and the ways we may present ourselves to related services.

The CAB service is very good in helping us with welfare rights but we could do with dedicated services provided by them that reach out to us and have an understanding of our lives and culture.

The benefits that we get sometimes seem to be arbitrary, people with similar conditions may receive different benefits. For instance a mother who has stayed at home to bring up children may be entitled to less benefit than another person who has worked but has the same degree of disability.

The new way of gathering information to support claims has placed a heavier emphasis on the opinions of our medical health support workers. They are required far more often than in the past to provide information about our illness and the effects on us. There is a concern that the outcomes of benefit claims is being affected by professionals failing to provide enough relevant information.

We need government to review its reform of welfare reform legislation and to take account of the views of users. It is having a negative impact on the most disadvantaged sections of the community.

FORTH PRIORITY

- WORK

52% of the people with mental health problems who are working conceal this for fear of losing their job. (Department of Health 2001)
Stress and mental illness in the workplace accounts for 50% of work days lost a year. (Health and Safety Executive)

(Refer HUG reports: Employment, 1997: Employment And Mental Health May And August, 2005: A Mentally Healthy Workplace, 2008**.)**

Whilst many of us would like to work, a substantial proportion of us see the workplace as an unhealthy place to be, particularly when looking at our mental health. Too many jobs are negative and stressful. The workplace can feel like a controlling restrictive environment where we have little freedom or autonomy and therefore our mental health can suffer when we are faced with it.

Until there are jobs available for us to do, and we gain faith in anti-discrimination legislation we see little prospect of any large numbers of us being able to sustain long term employment.

When we decide to try to get back to work we can need a great deal of support. Going back to work without this can be a recipe for disaster. It can also feel as though it is very hard to make a meaningful wage when we first go back to work. The 'benefits trap' can stop us seeking out work and it can be almost impossible to get a secure and adequate income if we return to work on a part time basis.

Some of us find the attitude of job centre staff unsupportive but some are the opposite and are gentle and helpful.

We worry that if we appear 'normal' then we are likely to have go back in to work until our illness returns and we have to leave; leading to less benefits for us, worse mental health for us and inconvenience for our employers.

We need to have a proper look at 'reasonable adjustment' under the Disability Discrimination Act for people with a mental illness. This can be clear for people who have physical disabilities and need ramps to access an office but less so for people with emotional and mental health issues.

We feel that staff are more concerned about getting us off their books than into secure jobs that are right for us (e.g. offering 58 year old women work milking cows or suggesting people travel one and half hours for a job interview on transport that would not allow them to do the job in the first place, are unhelpful ideas and just breed resentment even amongst those of us that are keen to work).

There is a strong feeling that most moves to help us seek work rely far more on the use of the stick than the carrot.

Training and Guidance (TAG) Units, which provide specialist support to help people into employment, are welcome and much appreciated by people.

In an area like the Highlands it can be very hard to get work in rural areas and we may rely more on small businesses for employment. We need to support employers too, to help make the workplace more accessible to us.

Many of us enjoy the contribution we can make through unpaid work, especially voluntary work. We are disappointed that our voluntary contribution is not recognised adequately. Some voluntary work could be better seen as long-term employment that helps society albeit that the benefits agency pays our 'wage'.

We need business and government to work on making the workplace a mentally healthy one and for people with mental health problems to have an understanding of, and faith in the Disability Discrimination Act.

FIFTH PRIORITY

- SAFEHOUSES/CRISIS HOUSES

(Refer HUG reports: A Place of Safety, 2001)

NHS Highland and Highland Council have been exploring the concept of 'safehouses' for well over ten years and, so far, nothing resembling a safe house or crisis house exists. There are pilot crisis houses and services in other parts of Scotland and well established ones in England.

We would like to see facilities developed that focus on treatment and recovery but which do not have the clinical feel of hospital. Some of us would like them to be places we can go to when we are not acutely ill; places with activities we can engage in, to go to when well to help keep us well.

However, most of us think the emphasis on safehouses, rather than recovery focused resource centres, should be for people in some form of emotional crisis. The difficulty of getting in to hospital when in distress, the loss of the 'Beechwood' beds and the need for somewhere to go on discharge, that might not be our home, all point to the value of such a facility.

We believe that a safehouse network could provide a system of local short-term shelters that would stop the need for more prolonged hospital stays. If its admission criteria were sufficiently relaxed it could also provide sanctuary for those disabled by distress but not seen as having a mental illness and therefore meriting hospital admission.

We need to se the establishment of safehouses in the Highland area.

SIXTH PRIORITY

- SERVICES

(Refer **HUG reports**: Local Issues , 2008-9 and Psychiatric hospitals 2005)

We worry that there is an increasing move to stop replacing staff when they retire or change jobs which will have a negative impact on the NHS and Social Services for people with mental health problems.

If we were to look at the huge loss that mental illness places on the economy due to such things as lost talent, unemployment, benefits claims and family trauma then the case for more investment in mental health would be amply made.

Many of the services that the council provides for mental health used to be ring fenced; we worry that as mental health is not an immediately attractive option that any budget cuts will be easy to target in the area of mental health.

We don't believe that the advent of community care services resulted in an equivalent and fair increase in community investment for mental health services as the large hospitals closed. There should be increased investment in community services whilst hospital services are also maintained.

The development of Community Mental Health Services over recent years is very welcome as is the existence of our hospital, New Craigs.

However, we feel that there is still a great need for services to develop, we want the community psychiatric nursing service to be more accessible; the network of drop in centres is welcome but would be even better if they were increased and also accessible in smaller towns and villages.

Sometimes we feel a great void when we have been given time limited therapy and are then discharged from services before we feel ready to face the world on our own again. Regular catch ups could be very reassuring.

We need to be sure that there will be continued investment in both hospital and community services.

SEVENTH PRIORITY

- THE EFFECTS OF THE RECESSION

1 in ten people in work have visited their G.P. for their mental health as a result of the recession. (MIND, May 2010)

"An effect [of the recession] might be predicted of an increase in prescription of antidepressants and antianxiolitics and there is some evidence of an increase in antidepressants." (Professor Cromarty, NHS Highland)

(Refer HUG reports: Local Issues, 2008 – 2009)

We believe the impact of the recent global recession is still to have its greatest impact on local public services and communities.

As the effects filter through we believe that increasing numbers of people will suffer as a result and that levels of mental distress and illness will increase. This will place additional burdens on mental health services which already appear to be having their services reduced.

We need to recognise that increased investment in mental health services and those areas that improve resilience and wellbeing will have a positive effect on people affected by the recession.

EIGHTH PRIORITIES

- MEDICATION

The cost of psychiatric prescriptions in 2007 (England) was £552 million (MIND)
There were 4 million prescriptions for antidepressants in Scotland in 2008/9 (ISD)

(Refer HUG reports: Medication, 1998 and 2005)

Many of us rely on medication and are clear that it keeps us well. However some of us do feel that the side effects of psychiatric medication can outweigh the benefits it gives to us.

Sometimes it is hard to speak about our medication and how we want to be treated and although there is an effective information service provided by the New Craig's Pharmacy Service some of us still feel that we do not get enough information about those medications whose side effects have a big influence on our physical health and wellbeing.

Some of the medications we are given are addictive and are used by other people without a mental illness for the wrong purpose. We however can benefit greatly from such medications.

We need to improve information provision about psychotropic drugs prescribed in the community and invest in further research to reduce the side effects of medication.

- CONTRIBUTION

People with a mental illness have a great deal to contribute to the communities that they live in. They have a rich variety of talents which they can put to good use in employment, voluntary work or through their presence amongst other people.

Far too often we have little to do and few opportunities to give of ourselves and feel needed and valued.

We need to celebrate the diverse talents of people with a mental illness and make it easier for us to find ways of giving back to the society which we are a part of.

- TRANSPORT

(Refer HUG reports: 'Transport and Mental Health, 2009)

As with many other people, transport is very hard for us if we live in a rural area. As over 50% of our members do not have access to a car we tend to rely on public transport.

We are regularly given medical appointments in Inverness that we cannot attend because public transport will not get us to the city in time, or the time and stress of travelling can have an adverse effect on our mental health.

The existence of bus passes is very welcome; they enhance our health and increase social inclusion and wellbeing.

We would like to see a better transport infrastructure in rural areas as well as better co-ordination with health related appointments. We would like to see the bus pass scheme extended and for people with a mental illness to be more aware of the fact that they can be entitled to them.

- HOUSING

50% of people who are homeless have experience of mental illness.
(Edinburgh Council Housing Department)
"Good quality, affordable, safe housing is essential to our wellbeing."
(Mental Health Today 2006)

(Refer HUG reports: Housing, 1999)

Housing is as important for people with a mental illness as anyone else. Many of our members live in council/social or rented housing. It can be very hard to find somewhere to live that we want to live in, rather than somewhere we have to accept, in order to have somewhere to stay.

There should be more social housing and we shouldn't have to move away from our own support networks to obtain it. When we are ill a degree of security is really important instead of constantly having to move.

Many homeless people do not know what help is available to them especially if they are living rough. Many people with a mental illness who are homeless live in B & B accommodation which is very variable in its standards. Ideally there would be a body that could monitor and set standards for accommodation, for people who are homeless.

Some of us live in supported accommodation which can be very good but not all of us want to share with other people with a mental illness and some of us ask for the accommodation purely because we need somewhere to stay rather than because we need housing support.

We need to improve access to council and social housing and to site these developments in a variety of areas. We need to improve information provision about housing rights and find some way of maintaining the standards of B & B accommodation.

- INDIVIDUALITY

We are all individuals but often have illnesses with similar symptoms. There is a temptation to deal with the illness rather than us as individuals and our particular needs. Equally there can be confusion when one person with the same illness as another person is dealt with very differently to that person.

We need to look at our illnesses as something that may span a lifetime, with unpredictable results and no clear vision of what the outcome should be. We need our treatment to follow the view that our illness is part of a journey that we travel and that its meaning and outcome vary from person to person.

We should encourage person centred approaches to our care.

- YOUNG PEOPLE

About 1 in ten children have a mental health problem at any one time.
(Mental Health Foundation)
The nearest young people's in-patient unit for Highland is in Perth.
The nearest mother and baby mental health unit for Highland is in West Lothian.

(Refer HUG reports: Young People and Mental Health, 2008)

It is only in recent years that we have become aware of the extent to which young people and children experience mental illness and distress. Services are still struggling to identify how best to help young people and to catch up with the needs that young people have in their daily lives.

If young people have sufficient robust support networks their mental wellbeing will be enhanced and make distress less likely.
If young people are also carers they may have additional mental health needs.

We need to be sure that there are enough mental health services for young people to access with confidence that they will receive the appropriate help.
We need to be sure that young people know enough about mental health issues and services so that they can access them if needed.

- FAMILY

80% of carers say that their caring role has had an adverse effect on their health. (Princess Royal Trust for Carers.)

We are not alone in illness; our families can be completely overtaken by mental illness and may have to put all their resources into helping the family member with an illness. This may be especially hard if the family member being looked after is young.

Family members may suffer considerably but not seek out or want help despite needing it.

Families can be key to our recovery and maintenance but equally, not all family relationships are healthy or desirable.

We are keen that information about us is shared with those that we love and trust but equally many of us have family members who we wouldn't want to be told in any detail about our lives or condition.

The present position where next of kin become a 'named person' by default if we are detained and have not already chosen a 'named person' is not welcome and should be changed.

We need to ensure that families and friends have sufficient support to help them in their caring tasks and the emotional impact it has on them. We need to adopt

the recommendations of the review of the mental health act about named persons and re-engage in the debates about confidentiality.

- ## LONELINESS AND ISOLATION

84% of people with a mental illness have felt isolated compared to 29% of the general population. (Not alone. Isolation and distress. Mind 2004)

(Refer HUG reports: Local Issues, 2008 -2009)

Many people with a mental illness are very isolated and lead very lonely lives. Men are thought to be especially likely to be alone but both men and women are often friendless and not in any intimate long term relationship.

The reasons for this are varied. Our illness can make it hard for us to communicate and to form stable friendships but, equally, the effect of stigma can both cause us to avoid the wider community and make that community avoid us.

We can feel excluded and alienated and in a society where travel and money produce opportunities for interaction it is not surprising that many people literally cannot meet people or afford to meet people for friendship.

We could benefit from learning from young people who we feel are much more accepting and emotionally aware than previous generations. We could promote a society that promotes a talking environment, an inclusive community and a heart based rather than a materialistic approach to friendships.

It would also be good to recognise that people subject to trauma in childhood may find it hard to develop the skills that would help them gain friendships and relationships.

It would be good to work to create a more accepting and emotionally literate community.
Befreinders Highland provides direct befriending support as well as distance befriending this is valuable to some people.

- ## PHYSICAL HEALTH

People with a severe mental illness are likely to die ten years earlier than the rest of the population. (Rethink)

(Refer HUG reports:**:** Mental Health and Physical Health, 2008)

Our physical health and mental health are interlinked and are all affected by a number of factors including nutrition, education and the environment. Poor physical health is likely to lead to poor mental health and vice versa.

Many of our members have very unhealthy lifestyles as a result of their mental illness and/or treatment. Therefore they are likely to suffer from increased morbidity and mortality compared to the rest of the population.

Initiatives such as active prescriptions for health and regular 'MOT's' for people with a mental illness are welcome and need to be built on further.

- RECOVERY

(Refer HUG reports: Recovery, 2006)

Recovery is a concept that is now recognised across health and social services. It first originated in the 'user movement' in America and New Zealand and has been adopted in countries across the world.

We would like increased help to enable us to cope with and manage our illness/lives and a recognition of our strengths and ways in which we can contribute.

HUG members have a dream of developing a recovery house which is user-run and provides hope, peer support, creativity, group work, complementary services, a café and an eco garden among other things.

We need to ensure that recovery, as a concept, remains based in and owned by the user movement, but continues to spread to people connected to mental health services.
We need to ensure that services are person centred and recovery focused.

- TALKING THERAPIES

In two areas of NHS Highland waiting times for psychological therapies were between 58 and 77 weeks.
(Audit Scotland 2009)

(Refer HUG reports: Our Needs 2007, Local Issues 2008- 9)

Many of our members have reported how much they have appreciated the talking therapies provided by psychologists and other people. Cognitive behavioural therapy and Dialectical behavioural therapy have both been proved to be very effective treatments in recent years as have a range of other therapies.

However, we have a shortage of psychologists in Highland and across Scotland as well as a shortage of other workers trained to deliver talking therapies. We are disappointed that waiting times of 18 months to see a psychologist are still possible whilst such waits for physical illness would be seen as unacceptable.

We need a similar investment in psychological services in Scotland as has been seen in England and Wales as well as an increase in the training and recruitment of people able to deliver these diverse therapies.

- VOLUNTARY ORGANISATIONS

We believe that many of the most innovative, creative and efficient services originate in the voluntary sector and yet find that their funding situation is always precarious.

We would like security for the voluntary sector.

NINTH PRIORITIES

- COMPLEMENTARY THERAPIES

"Research …. shows that mental health service users want greater access to complementary therapies and that where these are provided they are found to be well-received and helpful." (Mental Health Foundation)

Many of our members have reported a great deal of benefit when using alternative and complementary therapies. Some such as acupuncture, relaxation and yoga are well accepted in the NHS and others such as reflexology, reiki, shiatsu and aromatherapy are gaining a wider recognition.

We need to recognise that reported benefit and increased wellbeing are key components of recovery and that therapies such as this can be helpful without having to lesson the actual symptoms and conditions of illness.

In addition many therapies are based in different cultures and ways of seeing illness. Many of these different concepts of illness may be just as valid models to help us to understand and come to terms with our conditions as the Western models used widely nowadays.

It is hard to get therapies such as these in hospital or the community and most of our members cannot afford them privately.

If we are to build on the direct experience of people with a mental health problem about the value of such therapies we should invest in and support increased use of reputable therapies both within and outwith hospital.

- ACTIVITY

"Consider the additional burden that lack of meaningful activity brings to those with mental ill-health: unemployed people do not exploit the extra time they have available for leisure and social pursuits. Their social networks and social functioning decrease, as do motivation and interest, leading to apathy." Royal College of Psychiatrists

(Refer to HUG Reports: 'Local Issues,' 2008 -9)

Getting us involved in a range of activities gives shape and structure to our day. It helps provide purpose and meaning and is good for our health. Things such as gardening, horse riding, exercise, walking, visiting places of interest , going to the cinema or out to eat all make a huge difference in our lives.

There are regular opportunities for occupational therapy in New Craigs hospital but less in the community. Engaging in everyday activities can be expensive and sometimes off putting as we do not always feel comfortable in the wider community.

We need to expand access to occupational therapy in the community and continue to provide low cost activities for people on a low income.

- PEER SUPPORT

"Peer support… would be beneficial to service users, peer support workers and mental health teams.." (Scottish Government, 2009)

(Refer to HUG Reports: Peer Support, 2008)

Our members have said for many years that the shared experience and skills that we can offer each other for self-management and recovery are invaluable in our treatments and therapy.

Peer support overcomes the barriers that we may feel with the general population and offers us a very real and tangible connection with people on a similar journey to us.

Peer support is an informal part of life in Highland but has been formally developed internationally and in successful pilot sites across Scotland.

There is no peer support project in Highland we would like to see one.

- SUICIDE

"More people died by suicide than by road traffic accidents in Scotland in 2008." BBC news

(Refer to HUG Reports:: Suicide, 1997)

The suicide rate in Highland is a worry to all of us. We are particularly worried about suicide in men.

We believe that men are less likely to seek help than women and frequently use alcohol as a negative coping mechanism. Culturally illnesses such as depression are not seen as the sort of thing that men should suffer from or deserve help for.

We would like to see more male support workers, more work targeted at enabling men to access help and more help to reduce an unhealthy reliance on alcohol.

- VETERANS

Since 2005 there has been an increase in the number of people seeking help from 'Combat Stress' of 72%. (Combat stress website)

(Refer to HUG Reports: 'Local Issues', 2008-9)
The current conflict in Afghanistan and recent conflicts in Iraq and Northern Ireland have amply revealed the emotional costs of combat on our armed forces. Such people often have a need for specialised and separate services. These services are increasing in number as is the education of the forces personnel on stress and armed conflict. This is welcome.

We need to be sure that rehabilitation and treatment centres exist in sufficient numbers to help returning members of the armed forces.

- RESPITE

Respite used to be provided in psychiatric hospitals but no longer is. In local authority funded facilities the cost is means tested which is beyond the means of some of our members.

(Refer to HUG Reports: Respite Care, 2002)

Life with a mental illness can place an intolerable burden on people with a mental illness especially if they live in harsh communities. Equally it can create huge demands on families and friends.

For all these reasons people can have a great need for a break from their everyday situation. This could be in centres that exist for the purpose or maybe

provided, sometimes in a cheaper form, with breaks in the form of the occasional holiday.

We need to be sure that we can obtain affordable and pleasant respite care in places that we would like to stay in, at times that we need it.

- G.P. SERVICES

Up to 30% of G.P. consultations are to do with mental health.

(Refer to HUG Reports: G.P.'s and Health Centres due to be published shortly)

G.P.'s are often the first people we turn to for help but we, and they, often don't realise that we have a mental health problem. We need more investment to help G.P's pick up on the warning signs of mental illness.

In rural areas we rely on small practices with a small number of G.P's. This can be fine because we know them better and tend to be given more time with them but if they lack expertise in mental illness it can be a problem.

We need to enhance the awareness some G.P.'s have of mental illness

- EQUITY

(Refer to HUG Reports: Local Issues, 2008-9)

We are still unclear how resources are allocated for mental health services.

What is the influence of the prevalence of mental illness in a particular area? Or different risk factors for different communities? How does the rural dimension affect services and mental health or deprivation in urban communities?

Is the pattern of resource distribution worked out on equitable lines taking factors such as this into account or is it more a matter of historical accident?

How is the spend on mental health services calculated when compared to physical illness? Is mental health still the cinderalla service of the NHS as has been said in the past or are there ways of calculating an equitable proportion of spend in these areas?

These are all questions that at present we have no answers to.

We wish to be reassured that the spend on mental health services is fair and equitable.

- ADVOCACY

Advocacy is a right to anyone with a mental illness under the 2003 Mental Health (Care and Treatment) (Scotland) Act. The review of this Act calls for greater access to collective and individual advocacy across Scotland.

In Highland, mental health advocacy is well established in the form of Advocacy Highland (providing individual advocacy) and HUG providing collective advocacy. However there are many areas in which coverage could be improved such as with young people or people in prisons.

It would be good to see continued development and security for mental health advocacy services.

- SUSTAINABILITY

Climate change and growing global environmental chaos are going to have a huge impact on this country in the future, unless action is taken soon. The negative affects of this will include a huge decrease in the wellbeing of the population and of its mental health.

It is important that all services play a part in reducing needless energy and resource expenditure.

We need the NHS, Council and voluntary organisations to take responsibility for reducing their carbon footprint and waste.

- CREATIVITY

"The importance of creative expression to healthy human development and recovery from mental distress is well established across cultures."
(Mental Health Foundation)

(Refer to HUG Reports: Local Issues, 2008-9)

We believe that creativity is a wonderful form of therapy and self-expression. It provides a product, a connection with other people and a way of both dealing with trauma and celebrating life. Many of our members are artists of one sort or another and shared opportunities to create and display artwork can be invaluable to our self esteem and sense of community and purpose.

It would be good to promote more opportunities for people with mental health problems to engage in creative activities. A café that has music and other forms of creativity on offer would do a great deal to increase community wellbeing.

- OLDER PEOPLE

Depression affects 1 in 5 of older people living in the community and 2 in 5 living in care homes.
(Mental Health Foundation, 2002)

We worry that the cultural negativity to older people transfers into care and health services. We believe that dementia is a grossly neglected and a horrific illness. We worry that too many older people have unidentified mental health problems and that there are not enough services targeted at older people. Some of us have worked in nursing and residential homes for people who are older and have been shocked at some of the ways that residents are treated.

Decreasing family cohesion and the difficulty of living on a low income will all have an impact on the mental health of older people.

We need to focus on providing better resources for people with a mental illness who are older and on decreasing the social injustices faced by older people.

- DIAGNOSIS

(Refer to HUG Reports: Being Diagnosed with a Mental Illness, 2009)

A diagnosis of a mental illness is not just a means of deciding on treatment; it can carry its own social burden and stigma. A change in diagnosis can be very confusing and alarming and the support we are given at diagnosis can be inadequate.

We have particular concerns over the diagnosis of Borderline Personality Disorder. An increasing number of our members are being given this diagnosis with the consequence that they find increased stigma, increased difficulty in getting admitted to hospital and reduced options for treatment.

We would welcome information on whether diagnosis of this condition is increasing and why.

- ADDICTIONS

30% of people with a serious mental illness also misuse drugs or alcohol.
(Pulse magazine 2007)

(Refer to HUG Reports: Local Issues, 2008-9)

Many of our members have both an addiction and a mental illness. Sometimes this means that services feel less able to deal with one problem or the other.

We feel that there is a great need for investment in addiction services and worry that the wait to get help with addictions is too long. In addition, people with alcohol problems have been diverted from police cells to Beechwood House for a number of years now. This welcome resource has avoided much unnecessary hardship but has now been stopped due to cuts in funding.

We need increased addiction services including recovery focussed ones and need to be sure that all the functions of Beechwood House are maintained or reinstated.

- THE BUILT ENVIRONMENT

"The environment in which people live and work can influence their health directly… or indirectly… and through affecting health and wellbeing…"
(Scottish Health Observatory)

(Refer to HUG Reports: The Closure of Craig Dunain, 1996 and A Place of Safety 2001)

We believe that the physical environment in which we receive help and treatment in has a great effect on our health and wellbeing. We worry that too many mental health facilities do not incorporate this idea into their premises.

We need premises to be designed, laid out and decorated in a positive fashion.

- HOLISTIC APPROACH

"A spiritual assessment should be a part of any mental health assessment."
(Royal College of Psychiatrists)

(Refer to HUG Reports: Mental Health and Physical Health 2008, Spirituality and Mental Health, 2007)

When we look at our health and wellbeing we tend to look at our bodies and our brain. However wellbeing and mental health are deeply bound into not only disorder but our minds, spirituality and physical health. We need to look at all these aspects of our lives in order to treat people effectively. Compartmentalising services may give focus but can distract from the wider picture.

Sometimes the solution to our distress does not lie in the material world but may involve finding those personal reasons that would allow us to seek happiness.

We think that if we look more widely we would be able to see that there are alternative ways of thinking and living that are just as satisfactory as conventional measures of a fulfilling life and these can involve a culturally diverse view of faith, spirituality and community that doesn't always sit easily in mainstream western society.

We worry that most advances come in the areas of drug treatment, not because it is the only way in which solutions can be found but because we rely on the huge research power of pharmaceutical companies and do not invest heavily in other forms of therapy.

We need to look at mental health and wellbeing in a much wider sense and encourage the debate about the wide range of interventions that may increase well being in ways that we do not fully understand at the moment. We also need to encourage greater investment in therapies that are not purely medication based.

- COMMUNITY

"Many felt that labelling their illness made them into non citizens with no rights, no respect, no credibility and no redress."
(Mind - Creating Accepting Communities 1999)

(Refer to HUG Reports: Inclusion, 2007)

Many of us feel very isolated from mainstream communities. Our community may be a geographical, activity based, mental health or other form of community. Many of us don't feel a part of any community but we do feel that if we could re-engage with our communities we would find a greater sense of wellbeing and inclusion.

The lack of involvement in any community can lead to extreme isolation and loneliness and can perhaps be evidenced by our impression that many, many people with severe mental illness live alone and have no form of intimate or long term relationship.

Our mental health community can provide a sense of equality and togetherness and is extremely valuable to us. Many of us feel great relief and the ability to relax when in company with our peers.

However we need wider communities of friends, neighbours and family to help us. When we are getting ill we are often reluctant to seek help and rely on our wider community to obtain the support and help that we may desperately need.

In order that we can feel more included in mainstream communities we need to encourage everyone to accept that almost everyone has problems with their mental health at some point in their lives. We also need our sense of otherness and alienation to be offset by the acceptance of difference. A successful geographical community would ideally include the great diversity of people that our society is composed of instead of excluding those that it doesn't approve of.

- SEEING THE GRASS ROOTS

Many of us who face life with a mental illness on a daily basis can feel alienated not only from society but from the planners and policy makers who are there to develop and deliver our services.

We would like to see politicians and officials in the NHS and Council to do all they can to meet workers and people who have experience of mental illness in their own communities and workplaces.

- PET THERAPY

"Pet therapy can help people with schizophrenia feel more motivated and improve the quality of their life"
BBC News 2005

This may seem like a trivial issue but in a world where many of us are deprived of such basic necessities as touch and affection the existence of therapy pets that we can feel and find 'friendship' and connection with can make a huge difference to our lives but does highlight just how deprived of everyday affection so many people with a mental illness may be.

- CAUSES

We can be relatively good at dealing with the symptoms of mental illness but very bad at dealing with the causes whether they be environmental, social, genetic or based in trauma and abuse. If we could address these causes we would be better able to reduce mental ill health in our population.

- LABELS

The 'see me' campaign says "see me I'm a person not a label" we feel that people are still seen in terms of the illness they have rather than as individuals, both by the public and professionals.

We wish this to change. Mental health awareness training is one way of doing this

- CONTINUITY

Too many of us find that we constantly have to repeat our story (which may be traumatic) to an ever changing series of professionals. In addition the services we get can change and it can be very hard to get replacements to stand in when people are off sick or leave their jobs. Even when there are replacements it can be hard to see strangers about very personal issues.

We need to find ways of filling in staff absence and of passing on our history in a fashion that doesn't need repeated but in a way that still caters for therapeutic help.

CONCLUSION

This report offers a snapshot of some of the key issues facing us in 2009-2010.

We very much hope that policy makers including those politicians who will ultimately be responsible for many of the policies that influence our lives can pay attention to these issues and try to find ways of letting us know how they will respond to them in the near future.

Equally we hope that officials charged with planning services use them as a way of discovering what the key issues in mental health are, from the perspective of users of services, and in turn use them when deciding on the services that they plan.

The means by which we prioritised these points were extremely crude but we are not aware of any effective methods of creating priorities with issues such as this. We offer these areas for work as a rough guide to the key places in which we would like to see developments happen. We are happy to engage in other ways of working out how to plan and possibly prioritise future services.

APPENDIX 1

PRIORITIES IN ARGYLL

In recognition that people in Argyll are covered by a different Council than those of us covered by the rest of NHS Highland we held a meeting along with Acumen to look at what people with mental health problems thought the priorities for development were in their own area. These are listed below:

STIGMA

This pervades all the other areas for work that are mentioned below. We are subject to prejudice from the public and mental health professionals and also often stigmatise ourself.
We need to see increased work to challenge stigma with the education of young people taking priority.

WELFARE REFORM/BENEFITS

The continuing pressure to take people off of benefits when they do not feel that they are capable of working is causing great anxiety to people. We have huge fears about the future of the welfare system on which many of us rely.

CHARGING FOR SERVICES

We have to pay for some Council services such as respite care. We do not think this is right.

EMPLOYMENT

If we are to work we need flexible and accessible employment opportunities. The present system where we are either in or out of work is unhelpful. Many of us find that sometimes we can work and other times not. The employment market doesn't cater for this.
Employment opportunities such as those provided by social firms should be encouraged.
Young people with mental health problems may benefit especially from employment opportunities

HOUSING

We need housing options that suit peoples varying needs

LEISURE AND RECREATION

Access to activities and things to do is very important but we may be prevented from doing so due to lack of motivation. There should be dedicated budgets for activities such as these that we can access.

TRANSPORT

Concessionary bus passes are helpful but only helpful in areas where we have regular public transport.
It can take a long time to travel to access mental health services.

ISOLATION

This is a big problem for many people

USER VOICE

The importance of user groups such as Acumen and HUG needs to be recognised.

SAFEHOUSES

We need a friendly safe place to go to when in crisis

CRISIS LINE

We need access to a person that we know and trust when in crisis

INFORMATION

We need local up to date accessible information for people. Especially for people coming to services for the first time.

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