



VOX Scotland Lived Experience Stakeholder Report to inform the

Scottish Mental Health Nursing Review

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Scottish Mental Health Nursing Review

VOX Scotland Members' Lived Experience Report

Who we are:

Voices of Experience (VOX) Scotland is a national membership-led charity run *by* people with lived experience, *for* people with lived experience of mental ill health. We represent our members' views to Scotland's politicians, health professionals and other bodies to try to ensure the laws and services provided reflect our members' needs and interests.

VOX Scotland welcomes the Scottish Mental Health Nursing Review and appreciates the desire to listen to and learn from people with lived experience (PWLE) on this important issue. We hope the experiences, views and recommendations of PWLE within this initial report will help to inform the direction the review takes and the issues that are then examined. We are happy to be involved in the steering group for this review and hope that the review will ultimately lead to change and improvement both for the mental health nursing workforce in Scotland and for the people receiving (or trying to access) mental health nursing care in Scotland.

Who we engaged with:

During January and February 2024, we reached out to VOX Scotland individual and group members. We did this in various ways to engage with them on their experiences and views of mental health nursing care in Scotland in both in-patient and community settings. While our group and individual member feedback did not cover all areas of Scotland, we were able to hear from individuals in the majority of health board areas. Unfortunately, this did not include Shetland, Orkney and the Western Isles on this occasion, where experiences and challenges relating to mental health nursing may be different and possibly more acute due to their remoteness and particular issues of services, staffing and transport, with similarities to other rural areas of Scotland.

VOX Scotland Group & Associate Members who contributed:

- Mental Health Network Greater Glasgow
- Dundee Volunteer & Voluntary Action
- Plus Perth
- Lanarkshire Links
- Bipolar Scotland

Methods for engaging with our members:

During our engagement we heard from 38 individual members through the methods outlined below and also received responses from group and associate members reflecting the views of at least 60 people with lived experience of mental ill health and mental health nursing care.

We were as flexible, supportive, and inclusive as possible in the ways in which we gathered people's views and experiences of mental health nursing care in Scotland. PWLE were able to speak on a one-to-one basis in person, by telephone or online about their experiences. They were also able to email their thoughts directly if they preferred. VOX Scotland facilitated two online group sessions and two in-person group sessions and arranged for group member organisations to consult with and provide feedback from individuals in their groups, where this was more appropriate and comfortable for participants. To allow as many members as possible to take part, we also provided a survey link, where people were able to answer questions in their own time, giving as much or as little information as they wanted.

In each engagement, background from the Scottish Government Nursing Review team was provided to participants and four open questions were focused on to help facilitate discussion. These were not regimented in order but helped to guide and focus discussion; the questions were broad enough to allow scope for what people felt was important to include. These questions and the review background information can be found at the end of the document, but groups and individuals also volunteered information on what they thought **should** happen or what good nursing looks like. It was ensured that people participating felt it was a safe and supportive space, that they did not need to share anything they were not comfortable with, and that answers would be anonymised. It was also ensured participants had access to mental health support helpline numbers in case these were needed.

It is hoped the responses to the questions in this first part of the stakeholder engagement will help the review team meet the aim of understanding how they can best develop and match mental health nursing skills to the needs of Scotland's population going forward.

Our Findings

“Most helpful” elements of mental health nursing care received

Members were invited to reflect on their experiences of receiving mental health nursing care and identify what it was *about* that care that was most helpful for them. There was much congruence in people’s responses and between experiences within mental health wards and in the community. The impact and value of positive mental health nursing experiences for individuals’ lives and outcomes was made clear. Key “most helpful” elements people highlighted are outlined below, followed by some quotes from those who contributed.

- Empathetic, compassionate, caring attitude and behaviour
- Trusting relationship built up and maintained through regular consistent contact
- Persistence in trying to relate and finding out what works for the person - flexibility
- An equal relationship based on humanity
- Taking the time to really talk and genuinely listen to the person
- Person-centred care looking at the whole person and affording the person agency
- Clear communication of how the mental health nurse can help and support
- True consultation & collaboration between the individual and the mental health nurse
- Awareness and willingness to co-write a care plan which is taken notice of
- Understanding of other systems and agencies they should liaise with to help the person, and helping put these into action to support recovery
- Ensuring the person is really well enough and ready for discharge (in-patient to community or out of community care) through a gradual transition process that prepares someone properly, along with practical measures that ensure they will be safe and supported in their new situation
- Awareness of appropriate and helpful signposting to support the individual
- Understanding of side effects of medications
- Trauma-informed care
- Able to contact when needed – available and accessible
- Use of positive encouraging non-judgmental language and body language
- Have techniques and methods apart from medication that can help the individual including training in talking therapies
- Face-to-face home visits where person feels comfortable and nurses can pick up on signs of someone coping or struggling (choice of where/how engagement takes place)

Empathy, Time, Collaboration, Trust, Communication, Consistency & Practical Support

“Every day Nurse R came even though I never communicated for six months but he kept talking to me, reading newspapers, walking me up and down the corridor and then outside as well. He was persistent. Brought his wee dog one day and I started talking to the dog. And he asked why I didn’t speak to him, and I said ‘hey, I’m trying to talk to the dog here!’. It was a positive experience because of Nurse R.”

“The difference at that programme is the mental health nurses have the time and take the time to talk to you. They see what you’re interested in to help you recover and offer different activities along with peer support.”

“I’ve had a good experience because I’ve just had two CPNs in 23 years, that consistency, and they’ve been really good. We know each other well, I would see them regularly for my depot and have a talk, and I can phone them when I need to. It’s been a collaborative decision and I asked to be discharged. They talk to you like a normal person.”

“It does help you – that regular contact with someone trained to understand what you need. I had a CPN for 15 years, it was consistent, I knew and could trust them. They used to say themselves ‘it takes at least a year to get to know each other’ (patient and nurse) – building relationships takes time.”

“The CPN helped me to get better – helped me get work on a farm but with no pressure on me. Helped me greatly.”

“There have been times mental health nurses have gone above and beyond, extra supportive things that leads to a bond. Take you to a shop or a café, still talk on the way. They get satisfaction in seeing you get well. “

“Opportunities to be involved in decisions is important. For example, the mental health nurses within the perinatal team facilitated lived experience involvement in decisions for the interior decoration of the Perinatal Unit.”

Flexibility, Language, Accessibility, Encouragement, Continuity, Messaging

“I received support from mental health nurses following a bereavement. Initially it was daily support from the crisis team, then ongoing support from a CPN. It was a very positive experience, very flexible and recognized and understood mental health needs well.

At a later date I received support and it was from the same CPN (by coincidence). That meant really good continuity of care which is really important and has made a positive difference. Visits are at home which is also important as getting to appointments would otherwise be challenging due to mobility.

The CPN regularly highlights the crisis and duty support available. This is really important as the repeated messaging is clear and stresses support is not just there for a crisis but to help prevent a crisis...This is reassuring and more likely to encourage someone to feel able to contact duty or crisis.”

“They can give someone hope and faith that they will get better – I didn’t believe him at first, but he was right, and it helped give me encouragement.”

“In the (programme) it’s been different – felt safe and listened to by the nurses. If I didn’t feel great, I could just go and talk – the role of the nurse there is to talk to you. You’re able to see them – accessible.”

“Language is really important - I had a nurse who was not judgemental and was light-hearted and had a kind way of describing others when they were not well. She wasn’t critical.”

“A positive experience I’ve had is when the CPN would say well done and give me affirmation and praise when I had done something positive – that really helps. Reminded me I have a lot of positive aspects, abilities and skills. It really empowered and encouraged me and now I do that for myself.”

“I had person-centred care, listened to as a person with lived experience. Helpful guidance how to get through a crisis.”

“Need to recognise how important good nurses can be – inpatient and outpatient – you interact much more with nurses than you do with doctors, and it can make a vital impact on someone’s life – such an important profession that needs the right people doing the right things at the right time for those in their care.”

Less helpful elements of mental health nursing care received

Members spoke about the less helpful and sometimes very negative aspects of mental health nursing care they have received. They explained how unhelpful attitudes and behaviours in mental health nursing care have negatively affected them and their mental health, with much focus on lack of empathy, respect, choice and flexibility.

Members taking part in engagement for this review also talked about how issues relating to continuity, transition and communication have impacted their care and recognised wider system issues relating to waiting times and length of engagement, which many felt were to do with staff shortages and increasing demand. Many members reported experiencing instances of the “most helpful” elements mentioned previously and in complete contrast, also the “less helpful” elements outlined below, from different members of mental health nursing staff or at different times. They described the difference in impact between the two. Quotes from those who contributed follow the key points raised.

- Lack of empathy, compassion and care in attitude and behaviour
- Dismissive, clinical, cold, disdainful, or mocking behaviour and language
- Prejudice/stigma displayed around mental illnesses and/or substance misuse
- Lack of respect for the person or their rights
- Unwilling/unable (within constraints of role) to consider a person’s wider/whole mental health issues or history - working in silos (e.g. perinatal mental health nurse not able to talk about bereavement or PTSD with person, strictly perinatal issues)
- No clear communication with person on the role of the mental health nurse
- Following long waiting times, experience of inconsistent, short term or infrequent contact with nurses meaning no trusting relationship built up/no progress made
- Lack of agency and choice in the methods used for engaging with nurses in the community – (e.g. face to face at home not an option anymore/particular clinic assigned even if difficult for the person to get to with no transport help/only given video or phone call appointment when prefer face-to-face)

- A power imbalance where the individual feels they have no control or agency in their own care and the nurse is the 'custodian' or 'gatekeeper'
- No time taken to talk and really listen to the person receiving care
- No care plan written or no involvement in writing of a care plan with nurses
- Lack of awareness or acceptance of people's right to the use of advocates
- No joined up thinking, planning and liaising with other agencies to get the best outcome and support for the person
- No assigned 'key' worker or nurse for an individual for continuity of care and accountability/co-ordination
- Individual discharged from hospital care without gradual transition process, without practical elements and support being set up for returning home, and without communication between mental health nurses in hospital and community mental health nurses and other agencies to ensure important information is passed on and support is available, often leading to the person being admitted to hospital again
- Individual is discharged from community mental health care because they are assumed to be 'well enough' or 'better' when they do not feel ready and need support in order to continue to recover or stay well, often leading to further crises
- Individual is discharged from community mental health nursing care without warning, conversation, or constructive 'ending' between them and the nurse
- Individuals receiving one or two appointments with community mental health nurses and told their cases/mental health issues are 'too complex' or there is nothing the team can do to help, without giving a further referral or sourcing help for the person
- Lack of Trauma-informed training and care
- Discrimination based on colour and race
- Lack of cultural awareness and understanding
- Individuals not being able/allowed to contact community mental health nursing teams when they need them out-with appointments or following discharge
- Lack of training/knowledge/use of techniques and methods that can help the individual (e.g. talking therapies, ways to engage people with meaningful activity)
- Lack of signposting to other services/support people can access
- Failure to reassure relatives and friends when they are seeking help for a loved one. Seem rude and abrupt in manner.

- Feel that the bar is set lower than the level of care expected in general nursing. Many receiving mental health nursing care feel they just have to accept poor treatment and do not complain or blame it on staff shortages.

Time, Attitudes, Empathy, Prejudice and Respect

“Nurses should spend more time with their patient and families, more therapy and why the patient feels the way they do, instead of being ignored and a waste of space. More actioned needed in care. I remember the nurses sitting in the office most of the time and I was so embarrassed having to knock at the door and ask for personal things.”

“With some (mental health nurses) you feel that empathy, care and niceness and others you feel they are just treading water and don’t care.”

“The student nurses were far nicer and treated you like a human being. They spent time with you and that helped a lot. One Christmas day when I was in the ward my OT came in especially to see me. She had build a relationship with me and I trusted her. We played Scrabble which I loved to do. I wouldn’t get out of bed for much else. The difference between the nurses and the others you came into contact with such as OT’s was huge. I felt many of the nurses had become hard, didn’t respect me at all, and it seemed to get worse the higher up they got. Student and bank nurses were different though, they were good and more likely to listen to you. “

“There are nurses who make fun of patients’ drug problems – mocking them by making loud sniffing noises as they go past.”

“There are those mental health nurses who care, those who just do the job and those that wish you didn’t exist.”

“Pressure to finish a session or even some discussions about them being so busy/ many clients, etc. Putting you off. Attitude & lack of focus on me as a person.”

“In hospital there’s a huge divide between those staff that cared for me and gave me the time of day and those that wouldn’t.”

“Some nurses get annoyed if you appear on the ward again. They obviously don’t enjoy the job and wish you weren’t there.”

“What it’s like now – it’s totally clinical. I phone the duty worker at CMHS because I’m struggling and most times I’m treated like I’m a nuisance. The receptionist asks what I’m phoning about. Very occasionally I feel reassured by the voice at the end of the phone but often as not it is harsh with an air of superiority, certainly no listening properly to me. And the nurse if often quick with ‘eat an apple’ or ‘go for a walk’. Anything to get me off the phone. I don’t think there really is any care anymore. I have been in the mental health system for over 40 years and it is a lot less human.”

“I think nurses can be very dismissive of what you’re going through. When I was in the ward there were a few comments saying I was ‘too happy to be going up the hill to get ECT’. I thought ‘have they never heard of humour as a way of coping?’. I realise nurses are under immense pressure but they can easily forget that so too are the patients and often a smug remark or thoughtless comment can be a matter of life and death for some patients....I personally avoid the centre crisis line because of this (people being overworked and stressed) and prefer to use charity helplines as they have volunteered to support people and it’s not just ‘a shift’ for them.”

“I’ve experienced discrimination based on colour and race. You feel you’re not worth paying attention to – that’s happened with a number of persons, not everyone. Proper training needs to be given to nurses on bias and discrimination.”

Choice, Flexibility, Continuity, Communication, Wait for/duration of care

“The support from the perinatal mental nurses was community based (home visits). It was generally good however it was very rigid regarding what could be talked about and nurses wouldn’t stray from discussing only perinatal care. They would not talk about other complex mental health issues, for example things connected to a long-standing diagnosis of OCD. It would have been more helpful if a more holistic approach was taken and they recognised all the mental health needs experienced at that time. Working in silos in unhelpful.”

“There was no continuity or conversation, no gentle tailing off to minimum contact. There are no key worker nurses for your care – need that link.”

“I got a CPN eventually, but she left to go on maternity leave after 4 weeks and they never replaced her or communicated with me about it. I just sorted myself out.”

“In rural areas you have to travel so far to see a mental health nurse if you’re even given that option and public transport is not good. They offer ‘Near Me’ but people don’t trust it and depends on people being computer literate. Makes you feel unsafe and insecure. Face to face always better because can see people’s expressions properly. People can mask their feelings and situation online.”

“The CPN always came to the house for a visit but now you’ve to go to (town) for a 10 minute appointment. Why do the dynamics change in regards to supporting the patient”

“It’s exhausting having to start all over again with each nurse or clinician. I know people won’t read my file in advance. It’s drumming it up all the time when you’re trying to get over it. I only get a phone call to check on my medication about every 6-9 months, they ask how you are. I would like a check in about once a month.”

“It seems so long since I had any type of contact with any of the mental health team, not even a question to ask how I’m doing, but I do remember the nurses were always cheerful and helpful.”

“They say they will phone you back and you don’t get a call or you have made a mistake and you got it wrong – that has happened a lot. You can’t really argue or complain as no-one believes you.”

Advocacy, Eligibility, Language and Clarity on Role

“It is sometimes obvious a person is really unwell. But if someone is presented well, then they think he is okay. And it’s only once chaos ensues and they’re in trouble with the police that something happens. Such a waste of resources and the patient is really really unwell by that point and it takes them much longer to get well again.”

“The community mental health nurse did not like me using an advocate. I think they felt threatened or worried and uncomfortable about me advocating for myself but it really helped me to have the advocate.”

“Words are powerful – a client should have the right to say to the nurse that they’re upset with what was said without them being prejudiced against them or feeling defensive.”

“A lot of people won’t really know what a CPN is or what they do or what they can provide. What can we do for you? What are the options? What is your role?”

Highlighted Issues

It is clear from both the 'most helpful' and the 'less helpful' elements feedback that empathy, compassion, communication, encouragement, support, listening and giving of time are crucial to those receiving mental health nursing care, and that where these are lacking people feel not only are they *not helped* in their recovery but are actively hurt and impeded when they are at their most vulnerable. It is also apparent that in these situations people become fearful and reluctant to engage and trust nurses in the future.

Members were also invited to consider more generally what it feels or felt like to receive mental health nursing care, including any views on availability, accessibility and transitions between different parts of the system. Some of these have been mentioned already, particularly in the 'less helpful' elements section. Issues of waiting times and eligibility for mental health nursing care were demonstrated, along with issues of lack of choice in how/where engagement occurs. The difficulties caused by very short-term care, lack of regular contact and communication, and lack of consistency and continuity of care were also highlighted. The vital importance of well-planned and communicated transitions in terms of logistics, practical and psychological support was also a key feature of discussions.

The sections below will focus on particular areas of concern that were brought up by many members participating.

Transitions

Members spoke about the importance of transitions throughout engagement. This included transitioning into community mental health nursing care on their first referral, where it was felt communication in introducing individuals to the service could be clearer on what to expect from the nurse, what their role includes, what help they can offer, how regularly individuals could expect to see them and what choices and options the individual have. Transitions that concerned a change in the nurse who would attend to the person were also seen as difficult, and it was felt where this needed to happen, there should be better communication, opportunities to say goodbye and a smooth handover with acknowledgement that it would take time to build up trust with the new nurse again, including transition from child to adult services.

The ending of care from community mental health nurses was also brought up as significant. Individuals spoke about the shock, disappointment and worry it had caused them when their care came to an end (they were discharged). For many, this was very distressing as they felt they still needed the support and were worried they would become more unwell again without

it. However, the manner in which these ‘endings’ took place for many made it much more difficult to cope with. Individuals explained contact was stopped without explanation or a conversation with their nurse to give them a sense of closure. People also felt they were being transitioned to ‘nothing’ as no other support was put in place, or mechanism to allow them to contact the service again, should they need it.

For individuals who had been in a mental health ward and transitioned to community mental health care back at home, a multitude of difficulties were raised. Crucial practical issues showed lack of planning and communication between different teams and agencies. Members described being discharged to home where there was no food, bills piled up to be paid, electricity or gas cut off, or even their property boarded up. Individuals also explained that on arriving home you might have been told that the community mental health team will be in touch, but you don’t know when that will be or who it will be, leaving you worrying and without support in many instances. Members also highlighted the importance of making sure they were ready to go home and had been prepared with gradual steps towards being at home again. This process did not happen for many members, leaving them psychologically and practically unprepared for the change. Many members who had experienced this transition felt that having a ‘keyworker nurse’ to coordinate their care not only in hospital but for transitioning back home would make it a much smoother process, where that nurse could liaise with different agencies and teams and keep the person involved and updated, take them through a gradual process, with an information handover, and ideally allow them to meet with the CMHT nurse ahead of transition, then arranging a date and time for the next session of support.

Having supports, structures and meaningful activity in place was seen as vital for a successful transition. Where this kind of support has been provided it is apparent the difference this made to the person. Supported and smooth transitions were commented on as being something that had been better in the past, or a matter of luck (depending on where you lived/what teams).

“After 2 years in (hospital), I was discharged to the (named) Resource Centre. My CPN got me to do the gardens, back reading books. This helped my concentration, cookery classes and gardening squad. Structure and routine. An OT took me out buying messages then on to supported accommodation under (a local charity). They found me a house. They went above and beyond.”

“The transition between hospital ward and home – it was a gradual process – out for an hour, then 2 days, 4 days and then out. You start to feel strange in your own house when you go back. It makes you feel uneasy if you have schizophrenia and you get used to your surroundings. I felt there was no support for the change to being back home. “

“Some areas have a crisis team coming to check on you – they need to standardise the system – it’s a postcode lottery. Whether people get that transition service and what support is set up for them at home.”

“The practical things when you’re in hospital and coming out of hospital are really important. There is life admin that builds up that you need support with, especially if you live alone. Coming home from hospital to no food in the fridge, being discharged late at night – these things aren’t thought of or catered for and can cause you to go into crisis again. You don’t know when your CPN will be in touch with you once you’re home – it could be the same day, a few days or much longer.”

“Being discharged from support was sprung upon me very quickly and the support from the mental health nurse stopped very suddenly. This was driven by a decision from a psychiatrist and resulted in me not having the chance to speak with the mental health nurse again. Endings are difficult and important for both patients and staff. There should have been an opportunity to discuss discharge with the nurse and to end support in a more constructive way.”

“I was discharged from the children’s team when I turned 18 and there wasn’t a handover and no support to deal with it even though I still had a mental illness. There wasn’t a transition and I couldn’t cope. It led to a relapse.”

“There is so much focus on ‘stabilising’ people enough and getting them out (of the hospital) but it’s a revolving door then as no support once they’re out.”

“We spend so much time telling people our story again. There needs to be inpatient to outpatient team communication – they should get a briefing and knowledge of what you’ve been through and what should happen next.”

“I’m now 48 and was diagnosed at 25 and my experience has shown me that trust is a big thing for people who are suffering from an episode and the trouble is that the people who are working with you out in the community are usually the most trusted people in your care, you don’t see them in hospital wards which means that most people who have got to the point where they are either in there voluntary or sectioned under the mental health act won’t really open up with the people who are responsible for their care when they are in which is a lost opportunity and costly at that.

I think, personally, that a better emphasis on care in the community will not only help patients be directed to correct departments but also lessen the need for the patient to go into a hospital ward in the first place. I’m not saying it will solve everything and in some cases there will still be a need for admitting, I think what I’m trying to say is that better care in the community would catch so much more than waiting to a patient is at the point of crisis and needing many months of treatment in a hospital ward.”

Waiting times and Communication

As mentioned earlier, members raised significant concerns over the lengthy waits to be seen by community mental health teams. People repeatedly reported being on waiting lists so long that their mental health condition had changed and worsened by the time they were seen or that they had actually spiraled into crisis before receiving an appointment. Members reported having very little communication on how long they would have to wait or on any help they could access in the intervening period. Many had also had experiences of missing a phone call or a letter by mistake and this resulting in them being taken off the list. People seeking support expressed how fearful and anxious this possibility made them, while feeling that the same rules did not apply to the team in the way patients are treated, where individuals reported being promised phone calls or appointments and then not receiving them. People felt the onus was on them to chase up appointments, which some felt unable to deal with.

“The CPN kept cancelling on me and six months later they gave me my final appointment.”

“Took me 3 years to see a CPN and there’s just one locum psychiatrist across (the city). You’re back’s up waiting so long, more and more unwell and then not much they can do to support you. Not their fault.”

“The issue on assessment taking so long even after the long waiting times – your needs may have changed by then. And your mental health situation may have got much worse while you’re waiting.”

“Having to wait on an extended waiting list before being seen was very difficult, by the time I did get intervention my issues were more difficult to deal with. I had to chase up appointments, twice. Otherwise, I wouldn’t have been seen.”

“I was in crisis and was given support from a mental health nurse in the community but it wasn’t quickly enough. It needed to be faster. It was helpful but it really wasn’t for a long period of time, leaving me at risk of another crisis.”

Eligibility, Access, and Transparency

Eligibility to access community mental health nurse support was also a frequently mentioned issue. Some individuals mentioned that referrals from GPs were turned down by the community mental health team and they did not understand the reasoning behind the refusal, or where else they should seek the support they felt was needed. For many the issue of alcohol or substance use or dependency made them ineligible for mental health care, while it is noted that better integration is beginning between the two areas, there are still individuals with interacting issues left without the mental health care they needed, making it more difficult to deal with drug and/or alcohol dependency. It was felt that the whole person was forgotten and issues and specialisms were still being kept in silos when integration is needed.

Some members mentioned that better understanding of the mental health needs and intersections for people with a dementia diagnosis was needed, to ensure the right support was given for both and the whole person looked at. In terms of eligibility and access. Members also talked about the 'increasing lack of inpatient beds' meaning that some members were placed in inappropriate settings, including prison, temporarily, or in hospitals too far away from home, family or friends. It was reported there was a pressure once in hospital for staff to 'free up beds', meaning discharges happened too soon.

Other members explained that, often after long waits, they received an appointment with a mental health nurse, only to be discharged after a short period of time (sometimes only one or two sessions) or at a time when the person felt they were not well enough and still needed the support to help them recover or keep them well. The reasons reported for early or unwanted discharges included nurses saying there was nothing they could do for the person, their case or mental health was too complex for the service, they were coping well, were better, were stable on their medication, did not need the service or did not need it as much as other people in crisis on the waiting list. In some cases, people reported no reasons being given, and the way these 'endings' occurred could be traumatic, confusing and worrying for the individual as explored earlier with regards to transitions. Members reported feeling again that there was a lack of communication, transparency, consistency and clarity over what mental health conditions, recovery stages and situations are and are not 'eligible' and appropriate for mental health nursing care. Many also reported feeling that their thoughts, experiences

and views were not being asked for or taken into consideration in the decision to discharge and that there was no understanding of fluctuating needs in the mental health recovery process.

“The lack of integration between mental health and substance abuse is a real barrier because in my experience you can’t access mental health care until you’ve had your substance abuse issue ‘fixed’ or sometimes it’s a choice between the two.”

“The first CPN I had rejected me after two sessions, saying they couldn’t do anything for me. There was no signposting to make sure you know what’s there.”

“The way people and the system see recovery is still as a nice linear process, like a broken leg – you get better and they discharge you. For a lot of people in mental health wards that will never be the case. It should be keeping people well as a focus for nurses instead of people being dismissed from caseloads before they’re actually ready. Need to see from the person’s point of view and also would be what is best for resources – with fluctuating conditions you can spiral if you don’t have the support you need and then you’re ill again. It’s about keeping people well.”

“I just feel as a patient if they have an inkling that you’re getting better they just discharge you. You’re told if you’re struggling you’re signposted to counselling.”

“10 sessions and that’s your lot, whether you’re feeling better and are supported or not. It’s not person-centred or flexible around the person’s needs at all.”

“It must be difficult for people working in psychology and psychiatry and imagine they often don’t want to get moved around, or take people off their caseload when they aren’t ready.”

Training, Recruitment and Retention Impacts

As is evident from this last quote and underlying many of the contributions discussed so far, individuals receiving or trying to access care, have insight into and sympathy for what they feel is the predicament the majority of mental health nurses are in at the moment. Members talked about the severe workforce shortages, the high turnover of staff, the difficulty training and recruiting mental health nurses, the huge caseloads and the lack of inpatient beds. Many members said that there were really good mental health nurses who wanted to have time to spend with people under their care but were unable to because of pressures mentioned and were under pressure to discharge patients so they could work on the long waiting lists, despite this causing a revolving door or patients and more expense in the long run. Members also mentioned the lack of psychiatrists and psychologists and the tendency to use locum psychologists and psychiatrists in many areas, which they felt would not only be bringing up costs but also putting more pressure on mental health nurses.

There was acknowledgement that the difficulty recruiting, training and retaining enough mental health nurses to meet demand is a major contributing factor to many of the negative experiences and damaging impacts members have experienced. Members felt that it impacted on waiting times, length, regularity and quality of services received, continuity and consistency in their care, and also the attitude, flexibility and compassion some nurses then displayed. Many members mentioned ‘bad conditions’ for mental health nurses, ‘burnout’ and ‘compassion fatigue’ as issues which impacted the nurses’

ability to provide good care. Difficulty of recruiting and retaining mental health nurses in rural areas was a particular issue raised and it was felt more needed to be done in terms of housing availability and attractive conditions to encourage mental health nurses into rural areas and retain them. Members felt that had no option but to accept the negative consequences on their lives and care caused by these issues.

“Staff turnover is a huge problem – you just get to know someone and then it changes again. They need to look at the whole system – why are people leaving so much and why won’t they work or live in certain areas?”

“When you finally see someone, you might not see them again for six months which is not therapeutic. They have massive recruitment issues and so they’re using expensive locums and agency staff and you’ve got to tell your story again and again which is traumatic and a waste of time. No consistency.”

“Without an increase in funding and strategy that gives a sustainable increase in staff they can’t increase the care or make it better. They physically can’t do more without that. Need to spend the money for support to keep people well in the community, not on locums.”

“My nurse was fantastic but that’s one nurse in a great shortage of mental health nurses. I recognise that the nurses are up against it and there will be really good nurses, but they are overworked, unmanageable caseload, pressure from management to free up spaces, lack of beds. I’ve seen my nurse once for medication review and never again. They can’t provide a holistic approach to care and then the third sector has to try to fill the gap but they don’t have resources.”

“There are some lovely good nurses who want the best for you but they don’t want to stay in the profession and we can appreciate that. If you don’t feel valued and protected at work and can’t get to care for patients consistently and therapeutically, why would you stay?”

Choice, Flexibility, and Barriers to Accessing Care

As mentioned in the 'less helpful' elements of care received and connected to other highlighted issues, members talked about the lack of choice and agency in the mental health nursing care they received. This was talked about in terms of what kind of appointment they received – in person at home, in person at a clinic (and which clinic this was), on near me or by telephone. Many members said there was supposed to be a choice to fit their needs but increasingly, especially since the covid pandemic, they had no choice which had detrimental impacts on accessing the care needed and on how helpful that care was. Many members talked about the benefits of what they saw as 'the way things used to be' of having in person home visits and many felt that signs and cues could not be picked up on by phone or virtual appointments. Others would have liked to have that option open to them rather than traveling to a clinic which may not be easy for them to get to and which may cost them money they can ill afford.

“You’ve got to travel extensive distances without help or money, when you’re already vulnerable just to get to an appointment and if you miss one or they cancel it, it doesn’t get rescheduled. The onus is all on the patient, and people aren’t in the position of power to fight.”

“More awareness from management around the need for flexibility regarding sessions and length of them for each individual although obviously there is not an unlimited budget for this.”

“Not given a choice of how you would like to engage after you leave hospital. It’s you must go to them or nothing.”

“If you turn up at the mental health hospital or crisis service when suicidal you get told to phone 111 or no-one answers the door at all. When you’re in crisis it’s hard to follow these procedures. It’s supposed to be ‘no wrong door’ but that’s not happening. You end up at A and E or with the police which isn’t appropriate but you’re left no choice. People complete suicide after not getting seen.”

This was seen as indicative of the system where members felt they were generally not afforded genuine agency in how they and their mental health are treated. The desire for mental health professionals to collaborate and listen to individuals, and where appropriate, family members, as experts in their own experiences and needs was clear. Members spoke about the need for joint careplans to be written and the importance of raising understanding and awareness of advocacy and advance statements, particularly in community mental health nursing. Members talked about the need for nurses to understand the impact of medication side effects. They also talked about how helpful different techniques, ‘social prescribing’ and talking therapies were where mental health nurses had those skills, experience, or flexibility, particularly with the shortage of psychological practitioners.

“You hear in the ward about the right to have an advocate and right to an advanced statement but not in the community. We need more advocacy workers – they know about the law and rights and can be calm and empathetic. We need for community mental health nurses not to be threatened by them.”

“You want to work on something that will really help you, not just have your medication checked. Help to find other support and activity was part of that but also some CBT methods helped me.”

What Members Think ‘Good’ looks like in Mental Health Nursing Care

- **A sustainable workforce strategy for mental health nurses**
 - where training, recruitment, retention are considered carefully and for all areas of Scotland, mindful of unique needs and wider issues such as housing and transport and cultural contexts and representation (incentives to attract staff)
 - where mental health nurses have good conditions, consistency, support for their own mental health and wellbeing, access to professional development
 - where recruitment makes the role of the nurse clear and also has a focus on empathy and communication – how to talk to patients as equals
 - where training for mental health nurses includes input in some way from those with lived experience (both initial and ongoing)

- where training includes suicide prevention, trauma-informed care, anti-racism and unconscious bias training
 - where specialisms and techniques like CBT are available for nurses to train in
 - where resources are invested in permanent posts rather than in locum and agency staffing for nurses and other clinicians
 - where the workforce strategy in action ensures there is much better continuity and consistency of care for people receiving it and good practice is shared across the country
- **A transparent and well communicated referral, eligibility and waiting list process is put into place (while the wait should be shorted if workforce strategy is working!)**
 - where people know if and why they are eligible for MH nursing care or not
 - where people are aware of how long they may wait and are kept updated
 - where the onus is not on the person to chase to get an appointment
 - where there are supportive options to help people if and while they are waiting
 - where there are clear and helpful alternatives people can be referred to or can access if they are not eligible for mental health nursing care
 - where addictions teams and mental health teams work together for the person
- **A system which affords people their human rights, choice and agency**
 - where there is a genuine choice of how to see your mental health nurse
 - where there is collaboration and conversation on needs, careplans, medications and how regularly someone needs to be seen or contacted by their nurse
 - where the right to advocacy is encouraged and understood
 - where people are included and supported in meetings about their care in hospital or in the community
 - where people are involved in any decision-making around being discharged from hospital or by community mental health teams
 - where people's needs & concerns are listened and responded to appropriately, with a clear trustworthy feedback, accountability & complaints process
 - where there is a lead person for the person's care who can be contacted and communicated with without gatekeepers or difficulty accessing
 - where staff are aware and adhere to the patient's charter

- where individuals are treated with respect and as equal human beings who can bring something important to their own care and recovery
 - where provision made for access to in-patient beds in area when needed
 - where accurate data is appropriately shared and read to minimise trauma
- **The role of the mental health nurse in any setting is clearly defined and communicated with skills, empathy, therapeutic approaches and flexibility to give person-centred care, recognising the importance of the relationship and of trust, compassion, collaboration and the giving of time.**
- **Transitions are given the significance and attention they deserve, to make them smooth, supported and positive for the person**
 - Individuals are provided with a **'key nurse'** who is their main point of contact and co-ordinates their care with them
 - Where the 'key nurse' changes or is not there, there is a clear plan in place and good communication and handover takes place (accurate notes and reading of people's files in preparation, along with listening to them without assumptions)
 - The importance of 'beginnings' and 'endings' is considered in how people are introduced to mental health nurses caring for them and the conversation that should happen if and when a relationship with a mental health nurse ends
 - An overhaul in how transitions from hospital to community are managed to ensure people have: the practical issues already solved - a secure home with heating and lighting, no pile of bills or debt, adequate food and other essentials in their home and the psychological and social supports in place quickly
 - **Ideas for how this transition process could work better include:**
 - the key nurse being responsible for coordinating the person's care
 - a gradual transition process that builds someone up for being able to cope back in the community
 - real communication, planning and coordination between agencies involved
 - programmes like those mentioned in 'most helpful' elements are examples of good practice that should be available consistently across Scotland – 'Restart' for example where mental health nurses have time to talk & listen, and there is meaningful activity and peer support to help people in their recovery
 - a system that allows the person to meet with the community mental health nurse while they are still in hospital to prepare them and start that relationship

- **think radically and logically about the role of the mental health nurse** – the qualities and skillset are the same across hospital and community settings, so there could be a model where nurses spend time in both settings and can provide that consistent care when people transition

“The notion of some nurses in hospital and other nurses work in the community doesn’t make sense to me – it’s all the same core skills – why don’t staff do a bit of both?! Give each team more understanding of the other situation and lead to continuity of care. The CPN can meet you in hospital in advance of you coming home.”

- Models of good practice where peer workers are employed in helping to provide transition support in certain areas of Scotland is invested in properly, available consistently across the country and managed well through coordination by a key nurse in each ward for example

“They did employ peer support workers in Glasgow but now most of them are gone, they dumped the project after two years. Happens with anything that works. The role helped with preparing for discharge, making it less traumatising and liaising with the community mental health team. Was just one-off funding and not renewed after covid.”

- Transitions from children’s to adult teams are also carefully planned, managed the person supported with what they need – communication, collaboration
- Support is put in place if someone is discharged from community mental health care so they can keep well but also have a way back in to receive care again if they need it, rather than being left to spiral into crisis, adversely affecting their life as well as costing much more in emergency/hospital services

“We need to stop situations where someone is discharged from hospital unaccompanied, sometimes at night and get home to find it boarded up or with no heating or food, and have to ask to be let back into the hospital.”

“There needs to be continuity, particularly in community teams. People are always saying they never see the same CPN twice, so you’re starting from scratch, and they don’t know you, there’s no trust and they don’t know your needs or preferences.”

“I think CPNs should be more involved in the transition to the community aspect in the discharge process from hospital. It’s hard for people to get back to their ‘normal life’.”

“Nurses are really great on mental health wards but they don’t have enough time to spend with patients – with all the admin and paperwork. If they could re-balance their time and find out what works for each person and what doesn’t work it would really help.”

“The difference a good mental health nurse makes, who cares and asks you what you need and wants to offer their skills, it’s massive. It can change your life. That’s the power it can have, but they need to care, and they need to have the time, training, and skills to let them do that.”

Wider recommendations from Members

- 24 hour drop-in community mental health/wellbeing hubs in every locality with trained staff/peer workers and no referrals needed (look at good practice and expand it across the country so there is no more postcode lottery, no more 'pilots' of what works. Take the recommendations of the Scott Mental Health Law Review)
- More investment, **not cuts** in mental health services and support
- Better resourced primary health care so people can see trusted GPs regularly and Community Link Workers are trained, resourced and available
- More access to psychological therapies and interventions
- Consistent funding for third sector groups and advocacy services filling the gaps
- Realisation of people's human rights as per the Mental Health Law Review
- Consideration of wider difficulties people with mental health issues face in accessing services and meaningful activity such as poverty, transport, physical health, and the need for a holistic look at people's needs, with **inter-agency communication**. This also relates to recommendations in the Mental Health Law Review, HMICS Review & to the Mental Health Moratorium, National Care Service Bill and Human Rights Bill.



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The Scottish Mental Health Nursing Review

Stakeholder Engagement

Introduction

The [Mental Health and Wellbeing Workforce Action Plan](#), published on 7 November 2023, sets out the Scottish Government's commitment to review Mental Health Nursing in Scotland.

The last review of Mental Health Nursing in Scotland - *Rights, Relationships and Recovery*, was published in 2006. There have been significant developments to the type of mental health services delivered and to the way services are delivered since the last review. There have also been many changes in mental health nursing roles, in areas such as specialist and advanced practice.

The new Scottish Mental Health Nursing Review will focus on the unique challenges and opportunities faced in mental health nursing. It will consider what more needs to be done to attract, grow, support, and develop the mental health nursing workforce, and ensure this workforce helps meet the mental health and wellbeing needs of the people of Scotland. It will also take into account factors such as wider changes to the public sector and service delivery, and potential changes to legislation in areas such as mental health law.

The Review will likely consider key themes such as voice, leadership and professionalism; workforce skills, education and research; the mental health nursing contribution to health promotion, prevention, and service provision; and the mental health nursing role in ensuring the quality and

safety of patient care. However, these themes need to be informed and confirmed through engagement with a range of stakeholders.

Stakeholder engagement with people with lived and living experience

Throughout the Mental Health Nursing Review, we will engage with groups of stakeholders to inform the review process itself, and to help us identify which areas we need to focus on in more detail.

For the first part of our stakeholder engagement we wish to engage with people who have lived and living experience of mental health nursing care, with the overall aim being to understand how we can best develop and match mental health nursing skills to the needs of Scotland's population.

Engagement questions

During February 2024, we would like individuals and/or groups of individuals to help us through answering four questions:

1. **What does (or did) it feel like to receive mental health nursing care?**
 - *Views about availability and accessibility of mental health nursing care, including experience of transitions between different parts of the system e.g., primary and secondary care, hospital-based and community care*
2. **When you have experienced mental health nursing care, what was it about that care that was most helpful for you?**
 - *Detail about what people value and find supportive.*
3. **When you have experienced mental health nursing care, what was it about that care that was less helpful for you?**
 - *Detail about what people find unhelpful or less supportive.*
4. **What else do you think may important for us to know about from your experience of having contact with mental health nurses?**
 - *Opportunity to add any additional detail or observations with regard to mental health nursing roles and their impact.*

The feedback from this engagement will be collated and themed, and will be used to inform future engagement with mental health nurses, and also to inform what areas the Mental Health Nursing Review should explore in more detail and seek to make recommendations on.

All comments and feedback will be anonymized, and no comments will be attributable to individuals or services.

A copy of the feedback report will be made available to all participants in this engagement exercise, and should be available by the end of March 2024.