

MSP guide to mental health & mental illness



What to know, what to do
and signposts to support

Foreword

Dear Members of the Scottish Parliament,

Conversations with MSPs show us that you are aware of the rapidly rising need for mental health support, care and treatment in Scotland, and that you seek ways to support your constituents.

We have prepared this guide especially to provide information for MSPs and their staff about mental health and mental illness. It is intended to give some practical advice as well as highlighting accessible information that can be readily shared.

We are grateful to colleagues at the RCPsych in Wales who conceived the idea of providing information for parliamentarians and gave us permission to adapt this document from their original guidance.

We hope you will find this guide helpful in supporting staff as well as your constituents, and welcome your feedback to help us update and improve it in future versions.

*Jane Morris
Chair*

*Royal College of Psychiatrists in
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Royal College of Psychiatrists in Scotland

As the professional medical body for psychiatry in Scotland, we set standards and promote excellence in psychiatry and mental healthcare.

We lead, represent and support psychiatrists nationally to government and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities.

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Mental health ...

is an element of everyone's overall health. It includes our emotional, psychological and social wellbeing. Mental health can be positive or negative, and fluctuates throughout our lives - just like physical health. Whilst everyone has mental health, not everyone will experience mental illness - the two terms mean different things.

Mental illness ...

refers to problems of the mind that are debilitating and substantially impact or limit lives. Mental illnesses can impact a person's mood, thinking, and behaviour - and can range from moderate to severe.

Vulnerability to mental illness may begin very early in life and can explain why some people develop a mental illness in response to conditions that do not affect others. Every individual is unique. Whilst the vulnerability may persist, modern treatments are increasingly effective - and when managed and monitored properly, recovery *is* possible.

Mental health and mental illness are influenced by a range of biological, psychological, and social factors - as well as by life experiences. When psychiatrists diagnose, they consider all of these factors.

It is vital to acknowledge and challenge the huge and unhelpful stigma associated with mental illness. Some of this is driven by historical narrative and media portrayals - and by the fear that mental illness is not treatable. However, in fact, support and treatment are available, and effective.

The role of psychiatrists and the multidisciplinary teams around them is to restore and maintain our emotional, psychological, social and physical health.

Neurodevelopmental conditions (NDCs)

Modern society increasingly recognises that both adults and children show a spectrum of diverse thinking styles, sensory preferences, and needs for predictability or change. Terms like '*neurodiversity*', '*neurodivergence*' and '*neurodifference*' are often used. Whilst these may be used technically in research and practice, it is best to ask individuals what term they prefer.

Neurodevelopmental conditions (NDCs) refer to brain function patterns that differ from typical development - affecting social, cognitive, and emotional functioning. The most common NDCs are **autism spectrum disorder (ASD)** and **attention-deficit/hyperactivity disorder (ADHD)**, affecting an estimated 10-15% of Scotland's population.

ADHD is characterised by difficulties with impulsivity, maintaining attention and restlessness. Once thought to affect only children, awareness of ADHD in adults is growing. ASD is characterised by social communication difficulties, focused interests, and repetitive behaviors.

NDCs impact many aspects of life, carrying emotional, social, and health challenges. Access to timely diagnosis, support, and, in some cases, medication is crucial.

People with NDCs can become stressed by the need to adjust to environments that have not been designed with their profile in mind, but which cater to the needs of the 'neurotypical' brain. We encourage adjustments in homes, schools, and workplaces to support diverse ways of functioning.

While NDCs are not mental illnesses, they can increase vulnerability to them. Around 70% of autistic people have an additional diagnosis, such as a learning disability, ADHD, depression, anxiety, or even epilepsy. With the right support, individuals with NDCs can thrive.

Mental illness and inequalities

People with severe and enduring mental illnesses (SMI) die on average 15–20 years earlier than those in the general population, with preventable physical diseases being a significant contributor to this health inequality.

For instance, compared with the general population, people with SMI are 2 times more likely to develop diabetes, 85% more likely to die from coronary heart disease and 10 times more likely to die from respiratory disease.

Modifiable risk factors, including physical inactivity, poor diet, obesity, smoking, alcohol consumption and the side-effects of psychiatric medication, also contribute to this health inequality.

People with SMI are also less likely to seek help for their health problems, less likely to participate in screening programmes, and can struggle to engage with treatment. All these factors further contribute to increased health problems and poorer health outcomes.

It is estimated that for people with SMI, 2 out of 3 deaths are from physical illnesses that can be prevented.

Environmental and economic determinants are also important, considering that people with SMI can often have limited access to green spaces, and can experience financial and social inequalities and adversity.

**how to help
constituents**

Helping constituents in distress

- Ensure that both you and your constituent are physically safe with obvious exit routes, plenty of personal space, and someone to call for help if needed.
- Acknowledge how the person is feeling.
- Listen sensitively.
- Use open questions: how, what, when, where, who, why.
- Use a reassuring tone and display responsive body language.
- Avoid focusing on negative options or language.
- ‘Reflect back’ information.
- Acknowledge a person’s anger, even if unfairly directed at you.
- Present any advice you give as a series of options. Introduce signposting to allow constituents to make their own choices.

Setting boundaries

- Agree your remit between MSPs and staff: what you can help constituents with, what you cannot, and what to do next.
- You are not expected to diagnose or resolve a constituent’s mental health problems, or provide psychological support to someone in distress. The best thing you can do is to listen and signpost them to more appropriate services.
- Agree an office procedure for handling challenging encounters.
- Do not disclose a person’s mental health problem to others without their permission.
- However, the right to confidentiality and privacy must be overridden if the person’s condition puts you, themselves or anyone else at significant risk. In such cases, you should urgently inform whichever service can best manage that risk. In some cases this will be police - in others, medical services.

Rather than trying to diagnose or resolve a constituent's mental health problems, the best way of supporting someone is to listen sensitively and signpost them to more appropriate sources of help.

To do this effectively, it may help to know about:

- **Setting boundaries** – to ensure you look after yourself emotionally and do not devote too much time to one person.
- **Suggesting that your constituent seeks tailor-made help for their concerns and needs** – depending on a constituent's individual needs.
- **Establishing supportive office practices** – to support yourself and your colleagues.
- **Confidentiality and data protection** – how to comply with these requirements.

Guidance on talking to someone in distress can be found in the next chapter.

Setting boundaries and building confidence

It is important to establish boundaries with your constituent early on so that they know what you can and can't do. This will help avoid situations where your constituent becomes overly dependent on you. Dependent relationships will not help you or the constituent in the long run.

Having clear boundaries will also help build your confidence to help people.

You could set out:

- How much time you will be able to provide.
- How regularly a constituent should contact you, and how.
- Which problems you will be able help them with and what you can't.

Suggesting that a constituent seeks help for their mental health

It can be hard to know whether you should suggest that your constituent seeks professional help for their mental health. Not everyone in distress will have a mental health problem, so signposting to medical help may not always be appropriate.

There is no hard and fast rule for when you should bring up mental health services. If you do decide to, think about the language you use – it is important to act with sensitivity and respect.

For example, suggesting that somebody

“has a lot to cope with and might benefit from talking to somebody about it”

is different to directly suggesting that the person has a mental health problem.

Establishing supportive office practices

It is important to consider the impact of these encounters on your own health and the health of your colleagues. A small amount of preliminary work can help create a supportive working atmosphere. As soon as you can, take some time to establish the following in your office:

- **An 'easy reference' job description** – MSPs and staff should agree on what you can and can't help constituents with. You can write this down and refer to it if you are asked to do things that are outside your remit.
- **A procedure for handling challenging encounters** – the next section has guidance you can use to draw up an office procedure for staff to follow. This could include when MSPs should intervene in challenging encounters.
- **An agreement to discuss challenging encounters** – debrief with colleagues. Seek reassurance and feedback about the approach you took and the guidance you gave, or provide such reassurance and feedback to your colleagues.
- **A log of repeat correspondence** – your colleagues can refer to this to know what has been said before and by whom.
- **Professional contacts in mental health** – familiarise yourself with the local contacts. Establish contact with your local Community Mental Health Team or Service. They should be available to give information and guidance when you feel a constituent needs more specialist help.

Information about a constituent's mental health is sensitive personal data. A person's consent is needed before an MSP can disclose or pass this information on to anyone else. Sometimes consent is implied when a constituent contacts you and makes it clear that they want you to use information about their mental health to assist them with the issue they are asking you to help with in your casework. Here are some good practice points:

- Always clarify with your constituent what information is to be disclosed and what action you will take on their behalf.
- Always clarify what it is you are being requested to do.
- Only disclose information about mental health to the extent that it is strictly relevant and necessary to deal with the specific issue you are being asked to help with.
- Where possible get written consent for disclosure and for your action plan. If there is no time to get written consent, you should seek verbal consent and make a note of it.

In some circumstances, you can convey information about someone's mental health to a third party; where it relates to the prevention or detection of a crime, the prosecution of an offender or the assessment or collection of taxes. In these circumstances the relevant information should be passed to the police.

A constituent could contact you about someone else's mental health problems, such as a friend or family member. You should try to find out what it is that the third party wants and whether they give consent to you taking up their case.

Establishing good practice can help clarify when you are able to disclose information about someone's mental health. If you are unsure about how to proceed, you should seek legal advice.

**how to help
someone in distress**

Most MSPs and their staff will come into contact with constituents in distress.

Whether this is face-to-face, over the phone, on social media, or via written contact in letters or email, the basic rules for helping someone are the same:

- Offer a menu of potential options rather than a command.
- Avoid focusing on negative options or language.
- Be realistic about what you can do – as set out in the previous chapter.
- Don't be afraid to say no – you can manage people's expectations in an empathetic way which does not involve you taking on their situation.
- Acknowledge a person's anger rather than trying to defend yourself – even if the anger is directed at you or your actions.

Tone and language

How you speak to someone in distress may have an effect on how they feel. You should consider how the other person will interpret the way you interact with them. It may be helpful to use the following techniques to ensure you appear empathetic and interested:

Use a reassuring tone and display responsive body language – retain eye contact, nod and use utterances to show understanding.

Listen sensitively – allow the person to talk freely and don't interrupt. If they cry or break down, let them express their feelings without rushing:

- *"Take your time; it must be difficult for you to cope with everything at the moment."*

Acknowledge how the person is feeling – but use statements that are neutral or supportive:

- *"I am very sorry that you have experienced this..."*
- *"This sounds like an upsetting/a frustrating situation for you..."*
- *"You must be having a difficult time."*

Validate and assure – help the person to feel hope and optimism. You can tell them that many people also have similar experiences. If they have told you about a specific mental health problem you could say:

- *"Lots of people experience mental health problems."*
- *"There are different treatments available which people find helpful."*

Avoid statements that may appear to belittle someone's feelings, like:

- *"You'll feel better tomorrow."*
- *"Don't worry about it."*

Reflect back and introduce signposting – after listening, introduce a positive note:

- *"I appreciate it helps to talk about the situation. I can help you with X, but I am not able to help you with Y. However, I can suggest some options for where you might be able to find further help with Y, if you would like."*

What can i do if someone is experiencing a crisis?

Social media gives people direct access to MSPs in a way they've never had before. Think about how you and your team may respond if someone contacts you in distress via social media, for example:

Q: @MSP I've been feeling awful and the only way I can cope is self harm

A: *@constituent It sounds like you're having a difficult time. If you'd like to talk to someone, the Samaritans on 116 123 is open 24/7. Please take care.*

Q: @MSP I can't cope any more. My life is pointless. When my husband goes to work I am going to end it all

A: *@constituent I'm very worried about you. The Samaritans listen 24/7 on 116 123. For urgent help call 999 or visit A&E. Please take care.*

If you think a constituent you are in contact with, either by telephone or face to face, is experiencing an acute mental health crisis, or expressing suicidal thoughts or feelings, there are several things that you could do:

- Try to appear calm, even though this can be hard to do.
- Ask the person if there is anyone they would like you to contact on their behalf. This could be a carer, friend or family member or their healthcare professional.
- Suggest that the person contacts their GP.
- Suggest the person contacts their local Crisis Team.
- You could suggest the person goes to the local walk-in or crisis centre, or if this is not possible, a nearby Accident and Emergency department. In some areas people can go direct to crisis houses, but it is worth checking beforehand that they accept self-referrals in your area before you send someone there.
- Suggest the person contacts a listening service such as the Samaritans: 116 123

What should i do if there is a risk of harm?

If you are seriously concerned that someone is at risk of harming themselves, you or others, you should contact the emergency services by dialing 999.

You should explain to the operator that you are concerned about someone's mental health and their safety or the safety of others. The 999 operator may request that an ambulance is dispatched. The police may attend.

Sometimes contacting the emergency services can lead to a person being detained under sections of the Mental Health Act. This should not prevent you from taking action, but you may want to read more about what this means for the person involved.

More information can be found in the glossary.

What should i do if the person becomes angry or abusive?

Though it is rare, very occasionally people may become aggressive or threatening. In this case your first concern should always be your personal safety.

- Acknowledge the anger rather than trying to defend yourself, even if the anger is directed at you or your actions.
- If someone becomes offensive or abusive, politely but assertively interrupt them to state that you find the language or tone unacceptable and request that they moderate it.
- Ensure that you give them a chance to stop being abusive or offensive so that the conversation can continue.
- If they are unwilling or unable to stop being offensive or abusive then explain the extent of your ability to help them. Explain that they are welcome to ring/come back with a relevant query as long as they are not offensive.
- State that you are going to terminate the call and hang up, or ask the person to leave the premises.
- If you feel you are in danger, follow your office guidelines and if necessary call the police.

**handling
challenging emails
and phone calls**

Repeat contact from constituents can sometimes be a challenge.

These tips can help you address challenging contact in an assertive manner, with a view to bringing it to a close:

- Remain calm and assertive but not aggressive in your responses
- Recap any previous contact registered in the contact log; what they have needed and what you have helped them with in the past
- Ask if there is anything else you can help them with
- Refer to your job role if you cannot help with something
- Offer other sources of help if appropriate and available
- If necessary, be firm and straightforward and ask them not to send further emails or make phone calls
- If you have made this request you could screen callers' numbers, emails and refrain from answering/responding

We know that choosing the "right" words is at times complex.

There is no consensus on the right words to use.

Yet we must continue to have conversations about it.

Mental illness has a huge impact on each person's life, as well as the lives of family members, clinicians, and others.

Often, personal experience guides how we choose and use our words.

Strive to take into account respect for each person's basic humanity; the views and preferences that people may have; and the role that compassionate, stigma-free, person-centred words can play in helping each person on their road to well-being and recovery.

**an overview of mental
health problems and
mental illnesses**

Anxiety disorders

Anxiety is normal in the face of threatening situations. The term 'anxiety' doesn't convey the intensity of relentless overwhelming fear that blocks everyday activities. Anxiety disorders are often accompanied by depression, and include:

- **Generalised Anxiety Disorder (GAD)** – a persistent and prolonged state of worry or anxiety which can involve racing thoughts, feelings of dread and catastrophising.
- **Panic disorder** – sudden, unpredictable and intense attacks of dread and terror. Such attacks occur in other disorders too
- **Phobias** – overwhelming, persistent, disproportionate fear with a particular focus. Extreme avoidance and checking disrupt the course of daily life.
- **Obsessive-Compulsive Disorder (OCD)** – persistent intrusive unwanted thoughts (obsessions), with powerful urges to perform repetitive behaviours or mental acts (compulsions). The compulsions initially relieve the fear generated by obsession, but in fact perpetuate the cycle. Avoidance is also marked.
- **Post-Traumatic Stress Disorder (PTSD)** – symptoms include constant readiness for danger - 'hypervigilance' - avoidance of triggers, and reliving aspects of the trauma through 'flashbacks', intrusive thoughts and nightmares. People often feel irritable and unable to concentrate on the demands of ordinary life.

Mood disorders

Also called 'affective disorders'. Depressive disorders are the most commonly diagnosed mental illnesses. 1 in 5 people will experience depression in their lives. For most people there is no experience of mania, but some people are vulnerable to swings into elation or irritability. This is known as mania, and is the hallmark of a distinctly different condition, **bipolar disorder**, discussed on page 9.

Major Depressive Disorder – everyone experiences times of low mood in their lives - especially in response to difficult events, but usually people recover within a few days or weeks. Extended periods of low mood, though, are debilitating and likely to co-exist with other mental and physical symptoms that form the picture of 'depressive disorders'.

Psychological symptoms can include extreme pessimism, self blame, hopelessness and suicidal wishes or actions. Sadly, people usually cannot make good decisions in such a frame of mind.

Social withdrawal is common, and anxiety is a common addition to the mix of symptoms.

Biological symptoms can include a loss of daily rhythms and sleep patterns, with particularly low mood on waking, changes to appetite, exhaustion, and sexual problems.

A range of effective medications, psychological therapies and psychosocial interventions can individually or in combination be transformative and even prevent recurrences.

Bipolar disorder

Bipolar disorder is characterised by mood extremes: emotional highs (mania), and lows (depression). These are far beyond the emotional ups and downs most of us experience.

Low or 'depressive' episodes

People feel intensely low, depressed, even despairing - often combined with physical symptoms.

High or 'manic' episodes

People may feel extremely happy, elated, and confident, but also may experience irritability - especially if challenged. Normal inhibitions may be lost so that the person engages in uncharacteristic behaviours. Manic episodes may include psychotic symptoms, such as delusions and hallucinations. These may be strongly influenced by the person's mood, but also may share the 'paranoid' elements of schizophrenic delusions.

Hypomanic episodes

This is the term used when mood is 'high' but not as extremely as with mania, and not to the level of psychotic intensity.

Mixed episodes are also observed - in which low mood occurs alongside the restlessness of mania.

Around 2% of people will be diagnosed with bipolar disorder at some point in their life. It usually starts in teenage years, but often takes years to be diagnosed because of the need to see both manic and depressive episodes.

Psychosis

Psychosis is when thoughts and emotions are so disturbed that a person can lose touch with reality. There are lots of reasons why someone might experience psychosis.

Sometimes, people may only experience a single episode of psychosis in their lifetime. However, for some people, psychosis episodes can be chronic and long-lasting. With the right support in place, it is possible to manage the symptoms of psychosis and recover.

Psychosis can affect people of all ages but it usually begins when someone is in their late teens.

There are lots of reasons why someone might experience psychosis:

- Post-partum psychosis can occur after childbirth, especially in people with a personal or family history of psychosis.
- Certain drugs, such as cannabis, LSD, cocaine, ecstasy, can lead to a psychotic episode, and some prescription drugs have to be monitored in case they do the same.
- Psychosis can happen when someone has a serious mental illness like severe depression, schizophrenia, or bipolar disorder.
- In vulnerable people, psychosis can result from lack of regular sleep patterns and lack of exposure to daylight at appropriate times.

Sometimes it's difficult to know exactly what caused psychosis, and it can be a combination of lots of different things.

Schizophrenia

Schizophrenia is one of several disorders called 'psychoses'.

We call symptoms 'psychotic' when a person experiences an unshakeable belief that is totally out of line with the culture they inhabit and usually a change from their own previous views. This is called a 'delusion': when a person fully trusts in the reality of a hallucination - seeing, hearing or otherwise experiencing things no one else experiences - that is also described as 'psychotic', out of touch with reality.

Common symptoms of schizophrenia include: hallucinations, delusions, and disorganised thinking and speech. There are also the so-called 'negative' symptoms - loss of interest in daily activities, neglecting self-care, social withdrawal, and emotional detachment.

Schizophrenia does not involve having a split personality, nor does it typically lead to violent behaviour. The mental illness - or more likely the group of illnesses - diagnosed as 'schizophrenia' are characterised by persistent psychotic symptoms that affect how people think, feel and behave.

Schizophrenia is treatable and, when well managed, many people can reduce the impact to a point of recovery - although they may have periods when symptoms return (relapses).

The diagnosis 'schizoaffective disorder' may be used when someone has psychotic symptoms similar to those of schizophrenia, but these vary somewhat in the presence of mood symptoms like those seen in bipolar disorder.

Eating disorders

'Eating disorders' are a complex and varied group of disorders which share the hallmarks of disordered eating and exercise behaviours.

Whilst these conditions are often portrayed as affecting young girls, all genders and ages can be affected.

Anorexia nervosa is a mental illness characterised predominantly by undereating and overactivity - but self-induced purging (getting rid of food), body checking and self-harm can also occur. Anorexia nervosa has the highest mortality rate of any mental illness and can have impacts that are lifelong.

Whilst anorexia nervosa is often characterised by very low body weight, you can never tell how unwell someone is based on their body weight.

Anorexia nervosa shares characteristics of OCD - but in addition starvation greatly affects brain function, causing depressed mood, higher obsessiveness, irritability and social withdrawal. Both psychological and nutritional problems must be addressed to bring about recovery.

Bulimia nervosa is a mental illness characterised by a cycle of eating large quantities of food (this is called binge eating) and then trying to get rid of this food (sometimes called purging). People often get rid of food by making themselves sick or by taking laxatives. People with bulimia nervosa are not typically underweight.

Psychological therapies specifically designed to address bulimia nervosa are strikingly effective and certain antidepressant drugs in higher doses can also help recovery.

It's important to note

- the symptoms of anorexia and bulimia are often mixed.
- people may also move from bulimia to anorexia, or you may start with anorexic symptoms, but later develop the symptoms of bulimia.

Binge eating disorder

People with a binge eating disorder eat large quantities of food whilst feeling out of control (this is called bingeing). Many people with binge eating disorders often attempt to restrict their food intake but do not purge or try to get rid of the food. There are lots of reasons that someone may feel the urge to binge eat - for example, when dealing with difficult emotions.

Avoidant restrictive food intake disorder

ARFID is a recently recognised mental health condition whereby people limit the volume or variety of foods they eat - often because of an aversion to certain foods or a fear of choking. This is different from ordinary challenges that children may face when trying new foods, or eating foods they don't like. People with ARFID can be any weight, and ARFID can be diagnosed at any age.

As well as distress and anxiety around eating, ARFID can cause nutritional deficiencies, weight loss, tiredness, and muscle weakness.

ARFID doesn't happen because someone is worried about their weight and body image. It can involve sensory sensitivity to the colour, texture or consistency of food or even to the sound of eating.

ARFID can occur on its own, but is also commonly associated with neurodevelopmental conditions like autism and ADHD.

glossary of mental health terms

Advocate

A person who can make sure someone's voice is heard when they are unable to speak powerfully for themselves. Having an advocate can be helpful in situations where someone is finding it difficult to make their views known, or to make people listen to them and take them into account.

Advocacy

The process of supporting and enabling people to express their views and concerns, access information and services; defend and promote their rights and responsibilities and explore choices and options. People covered by the Mental Health (Care and Treatment) (Scotland) Act 2003 have a legal right to independent advocacy. In most localities, there are also advocacy services specific to children and young people.

Antidepressant medication

A general term for medicines commonly used in the treatment of depression, anxiety, obsessional problems and sometimes pain. They fall into several groups with different chemical actions and are not in fact specific to 'depression'.

Antipsychotics

Again, a general term for medicines commonly used in the treatment of psychosis. Many of them target dopamine pathways in the brain and are used in the treatment of disorders other than psychosis, such as severe anxiety.

Capacity/ mental capacity

The ability to understand information and make decisions and the ability to communicate decisions. If someone does not understand the information and is unable to make a decision about their care, for example, they are said to lack capacity. Having a mental illness does not automatically mean that a person lacks capacity, and it's important to remember that capacity is 'decision specific' - a person may have capacity to decide about one issue but not another. The Adults with Incapacity (Scotland) Act provides a legal framework for decision-making in the best interests of people who lack capacity to make a particular decision at a particular time. This could include managing finances, deciding where to live, or what treatment to receive.

Care plans

In Scotland, care planning for mental health follows a person-centered approach based on the Mental Health (Care and Treatment) (Scotland) Act 2003. However, patients who are not subject to compulsory orders can still benefit from the collaborative production of a care plan. Such plans coordinate the multi-disciplinary work of psychiatrists, nurses, psychological and occupational therapists, social workers, and others. This plan should set clear goals, identify support needs, include a risk management and crisis plan, and should be regularly reviewed.

Child & Adolescent Mental Health Services (CAMHS)

In Scotland, if children and young people under the age of 18 require treatment for mental illness, they are referred to CAMHS services where the responsible consultant psychiatrist is specially trained in the particular social, neurological, physical, emotional and behavioural influences of the developing brain and mind. There are national and regional inpatient units for when hospital admission is needed, and families and schools are closely involved in treatment

Community Mental Health Team (CMHT)

A CMHT supports people with mental health problems whilst they live in the community. People may attend clinics or receive visits at home. CMHTs are led by a Consultant Psychiatrist and usually include community psychiatric nurses (CPNs), psychologists, occupational therapists, social workers and support workers.

Community Psychiatrist Nurse (CPN)

A nurse trained to specialise in mental health, who can assess and treat people with mental health problems under the responsibility of the lead Consultant Psychiatrist.

Clinical psychologist

A psychologist who has undergone specialist training in the assessment and treatment of people with mental health problems. Usually trained to offer CBT (see below) and other talking treatments.

Cognitive Behavioural Therapy (CBT)

A psychological therapy (talking treatment) that emphasises the interactions between our beliefs (thoughts), feelings, and behaviours, and uses these connexions to improve mood and function. A hallmark of CBT is identifying unhelpful thoughts and assumptions, then tackling them.

Crisis services

Mental health crises include: suicidal intention or behaviour, psychotic episodes or other behaviour that seems out of control or irrational and that are likely to endanger oneself or others. Many different agencies may be involved in bringing the person to safety so that further assessment and help can be provided.

General Practitioner (GP)

GPs are our 'family doctors'. They and their Primary Care teams provide both mental and physical health care and are the first point of contact with the NHS for most people. If more specialised treatment is needed, a GP can make a referral to a specialist psychiatrist colleague in secondary mental health services - based in hospitals and out-patient clinics. This usually involves community mental health services, and occasionally involves consideration of admission to an inpatient setting.

Guardianship

A person is placed under guardianship if their capacity makes it difficult for them to avoid danger or being taken advantage of. Dementia and some other mental conditions can affect capacity. The guardian has the legal power to make certain health care and financial decisions, so must be appointed with due legal process. Many people who have lost capacity do not require guardianship because they have appointed a Power of Attorney.

Mental health

See page 3

Mental illness

See page 3

Neurodevelopmental condition

See page 4

Mental Health (Care and Treatment) (Scotland) Act 2003

This extensive law gives Approved Medical Practitioners (specially trained psychiatrists) the responsibility to deliver compulsory treatment (including hospital admission if necessary) if they have a mental illness that causes behaviour that poses a significant risk to themselves or other people and if the mental illness compels them to refuse such treatment. This same law contains details of the rights and protections which must be provided by Mental Health Officers (specially trained social workers).

People sometimes refer to 'being detained' when the compulsory order involves detention in a hospital, and the term 'being sectioned' is also used to refer to the different sections of the Act. These differ in terms of how long the patient may be subject to compulsion and which safeguards are therefore required.

For further information, please see the website of the Mental Welfare Commission.

Psychiatrist

A medically trained doctor who specialises in mental health problems and is trained to deal with the diagnosis, formulation and treatment of mental illness. Psychiatrists are trained in the 'bio-psycho-social' model. They consider what factors predisposed the individual to fall ill, what the triggers were and what may be maintaining the problem. They offer a range of treatment, some of which is delivered by the multidisciplinary team. All psychiatrists have training in prescribing and monitoring of medication and other physical treatments and in delivering psychological and psychotherapeutic interventions.

signposting and information

Getting support

GPs are the first point of contact for getting support and help for mental health problems in the NHS.

If you are seriously concerned that someone is at risk of harming themselves, you or others, you should contact the emergency services by dialing 999.

We provide here a list of helplines and websites that may be of use, including in situations of crisis. It's important to highlight that this list isn't exhaustive; additionally a significant number of local initiatives and groups will provide effective support for a significant number of people.

We would recommend familiarising yourself with what is available in constituencies as well, and having those references and contacts close to hand. Most Health and Social Care Partnerships have a directory of resources available - which provide signposting to local health and social care services on a number of matters, including:

- alcohol and drug recovery services
- children's services
- domestic violence services
- mental health services
- rape crisis services
- social care services

ALISS (A Local Information System for Scotland) also provides information on local services and resources:
www.aliss.org

NHS 24

Dedicated mental health advice service, offering support for all age groups through the established 111 call line.

When you phone 111 and choose the mental health option, you'll be connected to the Mental Health Hub to speak to the team of Psychological Wellbeing Practitioners (PWP's). These are specially trained advisers who work in mental health and are supported by Mental Health Nurses (MHN's).

phone 111

Visit www.nhs24.scot

Breathing Space

A confidential out of office hours telephone line for people over 16 experiencing low mood, anxiety or depression.

phone 0800 83 85 87

Visit www.breathingspace.scot

Samaritans

Offer a 24/7 listening service for anyone who needs to talk.

phone 116 123

visit www.samaritans.org

Mental Welfare Commission

The Mental Welfare Commission is an independent body that protects the rights, dignity, and welfare of people with mental illness, learning disabilities, dementia, or related conditions. It ensures that care services comply with legal and ethical standards, including the Mental Health (Care and Treatment) (Scotland) Act 2003.

MSPs may be contacted by constituents who have concerns about their mental health care, the treatment of a loved one, or issues within mental health services. The Commission can investigate complaints, provide guidance, and intervene where necessary.

The Commission conducts visits to hospitals, care homes, and community settings to monitor how individuals are treated. MSPs and their staff may find these reports useful in assessing whether mental health services in their constituencies are meeting legal and ethical standards.

The Commission provides guidance for professionals, patients, and families on mental health laws and rights. MSPs may use this information to support casework, help constituents access services, and better understand mental health legislation.

MSPs can contact the Commission for briefings, reports, or specific advice on mental health-related issues. They may also refer constituent concerns or request information on mental health service performance in their areas.

The Commission can provide information and advice in relation to rights and good practice to do with:

- Mental health and incapacity law
- Care and treatment

They cannot:

- Give specific legal advice
- Comment on whether diagnosis or medication is correct

Email mwc.enquiries@nhs.scot

Professional advice line [01313138777](tel:01313138777)

mental health guides

We have identified a number of guides that are appropriate to share with constituents who may have queries on the nature or support available for different diagnoses of mental illnesses

Support, care and treatment

- Alzheimers
- Being sectioned
- Benefits
- Caring for someone with a mental illness
- Cognitive behavioural therapy
- Complementary and alternative medicines
- Deprivation of liberty safeguards
- Electroconvulsive therapy (ECT)
- Guide to mental health tribunals
- Hypnosis and hypnotherapy
- Liaison psychiatry services
- Mental health capacity and the law
- Mental health services and teams in the community
- Mental health tribunals
- Neuromodulation
- Psychotherapies
- Social prescribing
- Spirituality and mental health
- What to expect from your psychiatrist

Medication

- Alzheimer's: drug treatments
- Antidepressants
- Antipsychotic medication
- Benzodiazepines
- Depot medication
- Stopping antidepressants

Our mental health information is written by psychiatrists in collaboration with patients and carers.

The information is routinely reviewed and updated.



Problems and disorders

- ADHD
- Alcohol and depression
- Alcohol and older people
- Anxiety and generalised anxiety disorder
- Anxiety, panic and phobias
- Bereavement
- Bipolar disorder
- Cannabis
- Catatonia
- Cocaine dependence
- Coping after a traumatic event
- Debt and mental health
- Delirium
- Dementia and memory problems
- Depression
- Depression in older adults
- Eating disorders | anorexia and bulimia
- Eating disorders | avoidant food intake
- Feeling overwhelmed
- Gambling disorder
- Heroin dependence
- Hoarding
- Medically unexplained symptoms
- Obsessive compulsive disorder (OCD)
- Personality disorder
- Physical illness and mental health
- Post-traumatic stress disorder (PTSD)
- Schizophrenia
- Schizoaffective disorder
- Seasonal affective disorder
- Self harm
- Shyness and social phobia
- Sleeping well and tiredness

Before, during and after pregnancy

- Mental health in pregnancy
- Mother and baby units
- Perinatal OCD
- Perinatal OCD for carers
- Planning a pregnancy
- Postnatal depression
- Postnatal depression for carers
- Postnatal depression: key facts
- Postpartum psychosis
- Postpartum psychosis for carers
- What are perinatal mental health services?

Medication

- Antipsychotic medication in pregnancy
- Lithium in pregnancy and breastfeeding
- Valproate in women and girls who could get pregnant

Young people's mental health

For young people

- 🔗 Anxiety
- 🔗 Bipolar disorder
- 🔗 Cannabis and mental health
- 🔗 Club drugs
- 🔗 Cognitive behavioural therapy (CBT)
- 🔗 Coping with stress
- 🔗 Depression
- 🔗 Drugs and alcohol
- 🔗 Eco distress
- 🔗 Obsessive-compulsive disorder (OCD)
- 🔗 Physical activity, exercise and mental health
- 🔗 Preparing for a blood test or vaccine
- 🔗 Problem gambling
- 🔗 Psychosis
- 🔗 Schizophrenia
- 🔗 Use of digital media
- 🔗 Weight, exercise and eating disorders
- 🔗 When a parent has a mental illness
- 🔗 When bad things happen
- 🔗 Who is who in CAMHS: for parents
- 🔗 How to cope when life is difficult

Translations

We've been working with our partners in Clear Global to ensure that our resources are most accessible.

We are rapidly increasing our library.

- | | |
|-------------------|-------------|
| 🔗 Arabic | 🔗 Polish |
| 🔗 Bengali | 🔗 Punjabi |
| 🔗 Bulgarian | 🔗 Romanian |
| 🔗 Chinese | 🔗 Russian |
| 🔗 French | 🔗 Sindhi |
| 🔗 German | 🔗 Somali |
| 🔗 Greek | 🔗 Spanish |
| 🔗 Gujarati | 🔗 Swahili |
| 🔗 Hindi | 🔗 Tamil |
| 🔗 Italian | 🔗 Turkish |
| 🔗 Japanese | 🔗 Ukrainian |
| 🔗 Kurdish | 🔗 Urdu |
| 🔗 Lithuanian | 🔗 Welsh |
| 🔗 Pashto | |
| 🔗 Persian (Farsi) | |

For parents and carers

- 🔗 ADHD and hyperkinetic disorder
- 🔗 Alcohol and drugs
- 🔗 Autism and ASD
- 🔗 Behavioural problems and conduct disorder
- 🔗 Bipolar affective disorder
- 🔗 Bipolar disorder
- 🔗 Child abuse and neglect
- 🔗 Children who soil or wet themselves
- 🔗 Chronic fatigue syndrome
- 🔗 Chronic physical illnesses
- 🔗 Dealing with tantrums
- 🔗 Death in the family
- 🔗 Depression
- 🔗 Divorce or separation
- 🔗 Domestic violence and abuse
- 🔗 Eating disorders
- 🔗 Eco distress
- 🔗 General learning disability
- 🔗 Good parenting
- 🔗 Moving on from CAMHS
- 🔗 OCD
- 🔗 Parental mental illness
- 🔗 Preparing for a blood test or vaccine
- 🔗 Psychosis
- 🔗 Schizophrenia
- 🔗 Self harm
- 🔗 Sleep problems
- 🔗 Specific learning disabilities
- 🔗 Surviving adolescence
- 🔗 The emotional cost of bullying
- 🔗 Traumatic stress
- 🔗 Who is who in CAMHS
- 🔗 Worries and anxieties



Email

rcpsych