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

Please tick as appropriate ☒ Yes ☐ No

CONSULTATION QUESTIONS

Overall Approach

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

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

Mental health of children is the responsibility of all agencies, and mental health service delivery does not take place in isolation. For instance, in CAMHS delivery we are critically dependent upon the ability of partner organisations, notably education and social work, to play their part. As a result of the financial situation, there has been a downgrading of service availability to clients by such partner organisations, with a knock-on effect of greater pressures on CAMH services – e.g. reduction of availability of respite care for families with severely disabled children, or social work offering parent support work with children with disruptive behaviour. As an example of joint work, I strongly support the universal roll-out of parent group work for high risk children, such as Webster –Stratton and Triple P, but while specialist CAMHS staff can provide training and ensure treatment fidelity, it would place too big a burden on existing CAMHS capacity if all such work were to be undertaken by specialist CAMHS staff. Rather, health visitors and social workers should be expected to run such groups with CAMHS support.

An approach must therefore be found that not only focuses on measures of health service delivery, but integrates this with evaluation and support for partner agencies too in order to give a rounded picture. The recent integrated care pathway only goes some way towards such a perspective, as it only looks at health service measures.

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the

changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

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

Integration of services across organisational boundaries will be critical. E.g. for children with neuro-developmental difficulties, we need to integrate paediatric services, education, social services and CAMHS in order to provide optimal care for the child and his or her family. The development of an integrated care pathway across agencies would be an obvious way forward, allowing for the evaluation of where along a patient's journey improvements need to be made. In essence, we need a further update of the IAF process incorporating the principles contained in the proposed CAMHS integrated care pathway. This will then allow an audit trail to be constructed that will allow one to see where difficulties and blocks occur in the multi-agency landscape that a child and family with difficulties needs to traverse in order to get help.

Improvement Challenge Type 2

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

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

In relation to children with suspected neuro-developmental disorders (i.e. ASD, Communication Disorders, Learning disability, ADHD, Tourette's, Sensory Integration problems and Dyspraxias), very early identification and intervention are of crucial importance to long term outcome. However, it is clear that service availability for assessment and management of children presenting with particularly ASD is highly variable across Scotland, with some Health Boards offering a very good and comprehensive assessment and follow-up service, and others virtually no service at all. A number of things need to happen:

1. an urgent audit of current service provision for particularly ASD across Scotland, which in turn will inform future service developments for this population.

2. Better integration of paediatric services, including health visitors, with locality CAMHS, to provide an early screening and assessment service for children under 5 years old who present with a possible neuro-developmental service. This is currently happening in some areas, but is rudimentary of even absent in others, with consequent poor service delivery.

3. Further development of multi-disciplinary and multi-agency assessment teams, in line with NICE (2011) guidelines for neuro-developmental disorders. As recommended by NICE, such service provision needs to be set up by Health Boards and coordinated across agencies and age ranges, and "A local autism multi-agency strategy group should be set up, with managerial, commissioner and clinical representation from child health and mental health services, education, social care, parent and carer service users, and the voluntary sector" (NICE, 2011, pp. 9).

4. The provision of a child development centre in every Health Board in Scotland (for an example of excellence, see the Kaleidoscope project in Lewisham, London)

5. Close follow-up of every child that requires speech and language therapy intervention before the age of 5, as we know a very high proportion of such children go on to develop a neuro-developmental disorder over time.

The aim should be to identify every child with suspected neuro-developmental disorder as early on in their lives as possible, and to put in place a coordinated support package involving all agencies, under regular review. Specialist support for educational staff, particularly for those children maintained in mainstream education, is a key requirement. Many schools currently do not have the specialist skills and resources to provide optimum support for these children, who often become invisible sufferers of mental health difficulties as a consequence.

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

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

Deliberate Self-harm and suicide are overlapping but distinct conditions. To date there is little convincing evidence of what works, particularly in young people under the age of 18. However, there is now emerging evidence that the approach taken by the Glasgow Adolescent Deliberate Self-Harm Service is more effective in reducing repeat rates of DSH compared to standard 'treatment as usual', with the latter having no or little evidence of effectiveness at all. Further evaluations of interventions are required, ideally in the form of prospective double blind trials with relatively large numbers, in order to work out the best intervention strategies. In particular, we need to be able to identify which groups of young people presenting with DSH will respond to what sorts of interventions – they are not a homogeneous group! (e.g young people with alternative sexual identities, such as gay, lesbian and bi-sexual orientations, are at particular risk and do not engage well with existing service provision).
Promising approaches include the introduction of supportive exercise and music therapy as adjuncts to current treatment models and support to robustly evaluate such new approaches should be made available as a matter of priority.

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

The introduction of mental health as a routine subject in schools, as well as

health promoting schools, has been helpful. The routine provision of high quality premises in the community where people with mental health difficulties are seen would enhance the public image of mental health and reduce perceived stigma (as opposed to the current all too frequent provision of CAMHS in semi-derelict premises in an undesirable part of town).

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

Comments

I have nothing useful to say on this difficult topic

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

Comments

A public health approach is likely to reap most rewards – i.e. a focus on good nutrition for pregnant mothers, prevention of smoking and excessive alcohol consumption, drug – reduction strategies, etc. A minimum price for alcohol is strongly supported. Also promote community support, such as provision of playgrounds, sports facilities, etc. for children and young people in local communities, promote opportunities for social activities for children and young people – e.g. financial support for third sector provision such as e.g. the Scottish Borders project 'stable life ' or Gala Youth Project, etc.

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

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

The focus on early years is very welcome and should be expanded – e.g. universal provision of evidence-based parenting classes for families with high-risk children such as Triple P and Webster Stratton, as well as more intensive intervention for children coming into care, particularly those below the age of 5.

However, CAMHS staffing levels - despite the very welcome increase in staff over the last 3 years from a very low base – remain well below the recommended staffing levels for a comprehensive CAMHS for children up to age 16, as laid out in the documents 'A Mental Health Strategy for Child and Adolescent Mental Health: Promotion, Prevention and Care' and 'Getting the Workforce Right, Getting the Right Workforce'. In particular, Health Boards should be encouraged to ensure that every CAMH service has the full range of assessment and therapeutic skills available for their population, including provision of specialist child psychodynamic psychotherapy – this

essential component of a well-balanced CAMHS – despite the welcome support from the Mental Health Division of SG for training such practitioners – is still not available in every health Board CAMH service in Scotland.

The target of achieving the recommended overall workforce levels by 2015, as signed up to by successive administrations, looks unlikely to be met, and this will have an inevitable impact on service provision and delivery, particularly as increasing demands are placed upon the CAMH service, such as increasing the age range up to 18th birthday across Scotland, as well as developing LD-CAMHS and Forensic CAMHS (not to mention developing services for teenagers with drug and alcohol problems, nor the impact of the reduction of service provision to troubled children by education and social services as a result of their very considerable financial problems) with what would appear to be no increase in resources. The introduction of the Balanced Scorecard is most welcome and we await the impact on service provision that may result from this.

Within the overall envelope of mental health, there should be a re-balancing of resources away from adult mental health towards services for the elderly and towards CAMHS, particularly very early years, but on practice this will be well-nigh impossible to manage.

Access to CAMHS is in part dependent upon knowledge of both what conditions are appropriate for referral and how to best facilitate referral to specialist CAMHS. An education campaign for young people, parents, teachers and GPs about the sorts of symptoms that would merit referral, as well as information about how to best access specialist CAMHS, would facilitate better and more appropriate referrals . The roll-out of primary mental health workers to work at the interface between Tiers I and II and III has been helpful and should be expanded. More of specialist Tier III CAMHS time and resources should be spent on training staff at Tier I and II, but this will be difficult to achieve when specialist CAMHS staff are having to deal with escalating demands upon their clinical time.

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

Comments

1. Note the comment about staffing levels above. The provision of central funds, matched by Boards, has proven to be effective in expanding the CAMHS workforce, notably for clinical psychology staff. Further such initiatives, linked to expansion of under-developed CAMH services such as neuro-developmental assessment and intervention, CAMHS-LD or Forensic CAMHS, should be considered.

2. A Scotland-wide assessment of current service provision for Neuro-developmental conditions in childhood, particularly ASD, is urgently required to inform national planning.

3. The impact of service re-design on the well-being of children with mental health problems is difficult to evaluate without robust outcome tools. The development of robust and valid outcome measures based on the well-being of individual children and their families, sensitive to changes in service provision, is urgently required to guide further service developments. The Balanced Scorecard is an important new development, but is focused on ensuring the development of a balanced and well-rounded service provision based on current models of accepted best practice, not on impact on individual children in need. The Balanced Scorecard therefore needs to be supplemented by a valid and sensitive measure of a child's overall emotional/behavioural wellbeing.

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

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

Comments
Schools are already doing a great deal to improve the mental health of pupils, and such initiatives should be further developed and supported – e.g. anti-bullying strategies, further development of the IAF process and school-based MACs, promoting exercise in children and young people, etc/.

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

Comments

1. Make referral to specialist CAMHS as easy as possible, and to remove any potential barriers – e.g. remove unnecessary bureaucratic processes in referral, such as lengthy referral forms. Promote walk-in clinics and use school-based counseling services as first entry to more specialised services.
2. Provision of a variety of attractive and easily accessible clinics where children and their families can be seen (one size is unlikely to fit all).
3. Pay attention to what children, young people and families say themselves about barriers to accessing specialist services.
4. Better provision of information for children, young people and their families about what services are available, and what sorts of things happen in specialist CAMHS clinics (many of these recommendations are supported by an evidence base – see e.g. van Beinum (2003) 'Young people's perceptions of adolescent psychiatry outpatient services' PhD thesis, Glasgow University)
5. More education for GPs about child and adolescent mental health, and how to seek specialist assessment and intervention

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

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

Comments
In relation to Deliberate Self-harm in young people, I would strongly recommend the adoption of the Glasgow Adolescent DSH service model, which focuses on rapid establishment of clinical contact following an episode of DSH. This has led to high retention rates, compared to 'treatment as normal' models (which consist of an outpatient appointment being sent several weeks after the initial crisis episode), where DNA rates are usually well over 50%.

Better provision of suitable accommodation for specialist CAMHS teams in the community would ensure more rapid provision of clinical services at locations attractive to clients. This is an area of work that could usefully be developed as part of a future Balanced Scorecard indicator.

Raising the awareness of GPs and guidance teaching staff in schools of signs and symptoms of underlying mental health disorders in children and y9oung people would support earlier tier I and II intervention – e.g. by school counsellors – and support better onward referral to specialist CAMHS

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

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

Comments
I have a concern about this theme, in that absence of evidence for a way of working is not the same as saying that that way of working does not work. Most of CAMHS clinical practice has not been properly evaluated or tested, and therefore there is a very real risk of substituting one form of working with another, currently modish, one with no good evidence that this will drive up outcomes. Instead we may merely encourage turf wars between different clinical practitioners, and mangers. We desperately need good outcome measures in CAMHS that would allow us to test whether one way of doing things is 'better' than another. Supporting or encouraging academic centres of excellence to undertake more health technology assessments in the area of CAMHS service delivery should be supported (e.g. by prioritising this area of applied research for CSO grants).

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

Comments
See comments about ASD and recent NICE guidelines (September 2011) above.

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

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

Comments
The voice of the 'user' is of little value unless the 'user' knows what the issues are. As in any other branch of democratic politics, a key driver is education. A much greater focus on educating users on the key challenges and issues is therefore essential if they are to be allowed more than a tokenistic contribution.

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

Comments
Education, education, education.

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

Comments
For children, one needs to think 'family-centred', and not just person-centred. For children the focus should be on promoting resilience and growth, allowing a child to grow up into a healthy and independent adult who can make the most of his/her life. This is different from 'Recovery', although I believe the value base is the same.
Children, as well as their parents and families, need to be listened to and taken seriously.

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

Comments
Recovery as a concept is not appropriate when working in CAMHS, as children and young people do not return to a previous level of functioning, but continue to grow and develop. Improved resilience may be a better concept for CAMHS

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

Comments
See above. The aim in CAMHS should be to support families to help a child to become the best they can be, to allow for a flowering of their capacities

over time so that the developing child (and family) can best engage with the process of growing up in a healthy and well-adjusted way. This is already a key focus of education services and CAMHS staff, and goes well beyond a simple 'clinical outcomes focused' approach as suggested in earlier questions.

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

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

Comments
Family work is a key concept in CAMHS and in all cases seen within CAMHS the family is of central importance.

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

Comments
See above

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

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

Comments
We need much better, robust and valid outcome measures for CAMHS to allow us to better answer this question.
In CAMHS there has already been a marked shift away from inpatient care to community care, so that the vast majority of children and young people

are routinely only seen in community settings. The development of intensive outreach services in CAMHS is a welcome development but needs further robust national evaluation. Further cost-benefit studies are required in this area.

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

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

Comments

1. Within CAMHS community based studies of service utilisation - e.g. the current evaluation of the Glasgow adolescent self harm service – indicate that some minority groups are not well serviced by current service provision, notably people of gay, lesbian or transsexual identity. Seeking the advice of such minority groups in how services could be better configured to meet their needs is required, as well as further studies of current service utilisation by minority groups (note: people of Traveller Families are not routinely involved in such surveys, despite it being recognised that they are often marginalised and discriminated against).

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

Comments
We need to get better at using web-based strategies.

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

Comments
Yes:

1. Specialist services for children and young people with addiction problems, especially alcohol
2. Forensic CAMHS
3. There is a paucity, and often a total absence, of specialist child psychodynamic psychotherapy available in most CAMHS in Scotland (e.g. none in Edinburgh). Support from Scottish Government in developing such service provision within specialist CAMHS is urgently required.

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

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

Comments
See comments above in relation to Autistic Spectrum Disorders and recent NICE guidelines

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

Comments
See comments above on ASD

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

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

Comments
Tier III CAMHS should be encouraged to devote more time and resources to supporting training and development on child and adolescent mental health matters by Tier I and II, as set out in 'Promotion, Prevention and Care'.

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

Comments
Service provision across Scotland for children presenting with a possible Autistic Spectrum Disorder A survey of current provision of child psychodynamic psychotherapy across Scotland.

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

Comments
Health Boards need to employ Child psychodynamic psychotherapists as part of a well-balanced CAMHS provision. The recent support for training for child psychotherapists has been very welcome, but the people that have been trained now need to be employed by Health Boards to ensure equality of access to his therapeutic modality across Scotland.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?
Employ child psychotherapists in CAMHS across Scotland, as these can in turn provide training for the next generation of specialist psychodynamic child psychotherapists.

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

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

Comments

See comments above on the urgent need to develop robust and valid outcome measures for children and young people (and their families) presenting with mental health problems, based on clinical presentation and subsequent clinical course. Once again the Academic centres should be encouraged to take on this task.

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

Comments
Good administrative systems and a simple and robust IT system capable of handling the data! Routine provision of a data manager as part of every CAMHS team (as currently happens in e.g. Cambridge CAMHS) so that we not only collect good data but also USE the data to re-design services.

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

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

Comments
Attention should be paid to identifying and training up the clinical leaders of the future. I have a real concern that there are increasingly less time and resources available for gifted CAMHS staff from all professional groups to devote to National issues, so that there may well come to be a shortage of appropriately gifted and experienced clinicians able and willing to take on the task of providing leadership. We need new, young talent! And will have to devote time and resources to get them trained up to the job.

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

Comments
Good leadership is essential. The development of the Lead CAMHS clinicians group has been helpful here, as had the evolution of the CAMHS Reference Group. Further support for these initiatives would be helpful.

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

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

Comments