

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.

Comments

Over all the broad structure of the strategy is helpful and reasonably easy to follow in relation to providing a response to each of the broad outcomes.

In summary, the gaps/further actions in this response that the Scottish Crisis and Acute Care Network Steering Group has identified could be addressed by the development of a Scottish Mental Health Acute Care and Crisis Strategy/Framework for Action.

This should have comprehensive service user/carer/staff/social care and voluntary organisation involvement at each crucial phase; its inception, development, implementation, monitoring and evidence of improvement.

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.

Comments

1. Re-examine the 'lead in' timeframes for redesign and change programmes. Often not given enough time for preparation, understanding the issues around the programmes that affect the success and sustainability of the desired change. Frequently the pressure and outcome is around making the change itself and not enough investment or acknowledgement in

the value of the change process. The process should be set at the correct pace to enable and empower staff to be involved and allow for the consolidation and sustainability phases of the change programme to have equal weighting/importance as 'making the actual change' in itself. These components have a strong evidence base and are often seen as an added extra as opposed added value.

2. Support the development or exploration of more managed clinical network approaches for mental health.

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.

The area of acute and crisis care requires a focus and ideally the development of a national strategy, including an agreed definition of acute care and its aims, and expected outcomes. This work could be linked to ICP development as well as updated national standards for crisis/ acute care responses.

The area of addiction and substance misuse within general adult acute care/inpatient settings remains problematic for people using services and staff trying to manage increasingly acute and busy wards where potentially the most vulnerable patients are cared for. There is acknowledgement that national work around addictions/substance misuse has, and is, taking place, but this needs to be better joined up in the national strategy document/key statements/outcomes. Mentions 'closing the gap' publication 2007 but needs a stronger steer in national strategy.

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?

The area of most relevance to acute/ crisis service providers is the promotion and implementation of recognised good practice at points of transition in services (admission/ discharge particularly). This may usefully be a focus of a Scottish Patient Safety in Mental Health programme.

An example of work on this focus may be: taking the patient pathway of care

approach to service design, acknowledging risks associated with handover of care between elements of services such as crisis, community and inpatients. Taking a closer look at best or evidence based practice that underpins managing risks at these points, and looking at key investment points in services that could improve or reduce risks associated with self harm and suicide.

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

Need more community resources for people in crisis – need range of provision. Focus on social networks and supporting them to support people in crisis.

Supported networks of people who have experience of mental health problems – e.g. peer support workers. By supporting these networks we can give them a more credible voice – it is important that these networks remain outwith the mainstream so that they can continue to exert political pressure and provide an alternative to mainstream.

Supporting user, survivor and carer led initiatives that challenge stigma and discrimination not just small amounts of money allocated through local anti-stigma grants schemes. Ensuring that funding is allocated to groups that are user led and innovative. We in Scotland could learn from the anti-stigma campaigns in other countries eg NZ 'Like Minds, Like Mine', where people with 'lived experience' continually tell their stories and inform society.

Need to continue to focus on raising awareness of the fact that mental ill health can affect anyone, that the challenges of life mean it is 'normal' for everyone to experience mental health problems. The See Me campaign is nearly 10yrs old, need to consider a new strapline/catchphrase/focus that will have a fresh impact on culture and society. Labels are still with us.

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?

As above- developing a range of services/ resources for individuals in crisis can help reduce stigma. Also continue work with mental health practitioners and senior managers in relation to positive risk and stigma.

Challenging discrimination requires fresh input and the continuing meaningful involvement of people who use/or have used services. In crisis or acute services there is a particular need for peers and advocates to be freely available, independent, and skilled people with experience and expertise. Demonstrating that recovery is possible, giving hope to people in crisis, holding the hope for people who are distressed and powerless.

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

Crisis services in the community and provision of range of services on a continuum which recognises the range of severity of issues that lead to crisis and would enable people to get support earlier rather than only when crisis is severe. One stop shop for help in crisis could be considered – Just to explore that a little more -

Could be a place in the community that might have other services also available eg drop in centre, information library, counselling, alternative therapies. So that when people visited it would not be apparent to others why they were going in. In some health boards there are phone helplines, alternatively people might just like the human face to face contact. A base that was open 'out of hours', evenings and weekends. May need a large team working but might have staff on call who could come in if their area of expertise was needed eg solution focused therapy, person-centred counselling, nurse practitioners, peer support workers.

Also need to re-examine the evidence base for alternative models of service such as Edinburgh Crisis Centre, benefits to individuals and their carers and how this type of community based support could enhance and support statutory services

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?

Need to protect rights of young people and develop range of crisis services available. Need to build greater links between adult and CAMHS services and identify/develop good practice links.

Need to look at patient pathways between early intervention services and CAMHS, Eating Disorder services and CAMHS and Adult acute care and CAMHS and crisis responses.

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

Sharing of good practice between Boards via specific learning events.

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?

Access to information. Discharge planning and relapse management lead to change in focus of activity. Focus on acutely ill and how we help them to manage in conjunction with their carers. There are two ways in which we can influence this from a professional/clinical care perspective, the development of staying well plans/relapse management strategies and plans in place. The other way is through the Peer support model and the development of service user Wellness and Recovery Action Planning processes (WRAP). This would need further exploration and investment if to be considered as an appropriate way to influence this outcome.

An additional consideration is the use of advance statements in Scotland and how this process is being supported to include aspects of wellbeing and health improvement in relation to content and expressed wishes about care.

Involving carers make sense and also consulting with the person when they are well, following an episode of being unwell.

The crisis plan could be included in the advance statement eg preferred medication/drugs which don't suit, other treatments that help. One issue that can be problematic is when people can lose insight and perhaps others don't always pick up on the signs of becoming unwell.

Access to meaningful activities (volunteering rather than going to a day centre). Gaining paid employment is crucial in supporting recovery. The community psychiatric services and relationships with staff who know the individual are helpful. Some service users report experiences/opinions that medication itself can take away motivation and decision making abilities.

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

Improved access to services. Anticipatory care focus. WRAP/care planning – service user focus include all of the above. Participation and leadership of service users.

Services need to be fit for 'expressed' purpose. The expressed purpose needs to be defined more from a service user's perspective and negotiated with service providers in relation to shared vision of what should and can be provided.

Person-centred approaches, listening to the person who is in crisis, even if they are psychotic or in deep distress. An example is "The Leeds Survivor Led Crisis Service" which works out of hours, evening and weekends, with more than half their visitors experiencing/expressing thoughts of suicide. Parents can bring children with them and taxis bring them in to the service. A choice of crisis services could encourage people to seek help, staffed by a mixture of disciplines and expertise. Funding voluntary sector initiatives, user/carer led, different models and settings.

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?

Better detection/identification. Increase access to primary care and mental health early intervention services – early intervention resources can interface with crisis services and be part of the whole pathway of care for patients.

There are some tensions with the identifying 'mental illness and disorder as early as possible'. There is a view from some service users that that psychosis is not a sign of 'mental illness' but is an indicator of distress that need not lead to long term mental health problems. This and other views are more likely to be explored in specific responses to this question from people who have directly had an experience of mental health problems and treatment responses from services.

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?

Need for quality strategy to provide overarching vision for improvement work. Involvement of voluntary sector and users. Patient safety programme may be another vehicle for improvement – acute and crisis care are hugely linked to patient safety issues.

Need to look at the minimal resource put into the MHC programme for MH and the outcomes achieved.

Small targeted resources around improvement work/targets or patient safety priorities could be a successful way to manage a few key desired outcomes.

Make the links at national level between improvement and patient safety.

Real requirement to look at investment in IM&T and information services at a local level. Making information work for you, avoiding duplication of data collection and using data to improve services are crucial outcomes that MH services will need investment and support to achieve.

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

Recognise that ICPs are not separate to the improvement and patient safety agenda.

Map improvement work against process map provided by ICPs.

Recognise ICPs as the process map for MH services; standards and evidence base are already set out. Patient Pathway work has been ongoing across several Board areas for some time now and we need to build on that. Need further look at the Information and IM&T support for patient pathway/ICP work to enable practitioners to concentrate on practice not paperwork.

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:

There is a view that user/survivor/carer involvement in crisis service design and delivery is patchy nationwide. Some areas are robust in their approach, others have very little meaningful involvement reported.

User/survivor/carer participation and leadership in crisis service development must take place within the context that people with lived

experience are equals at the table. Where there is room for challenge and constructive criticism. Where 'professionals' will not take things personally, and there are opportunities for people to make decisions and be accountable.

Users, survivors* and carers should be remunerated for their involvement, as well as receiving expenses. This will help to make a level playing field. For many people they may have put their careers on hold to influence and improve services. Need to have a larger pool of people with lived experience - of using services, of recovery and of the caring role - who can take part in strategic and operational MH groups locally and nationally. A skilled and trained group who could then mentor/give peer support to others.

*The term survivor is often preferred by individuals as it is positive with a sense of having 'overcome', with strength and resilience

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

Comments

Joint training of staff, users and carers would be a useful tool to facilitate good working relationships. A leadership programme for users and carers. Training of staff by service users in involvement techniques. Dedicated staff and resources to support user, survivor and carer involvement. Involvement in quality issues.

An example is "The Mental Health Trialogue Network Ireland" (www.trialogue.co) which is a new community development initiative in Irish mental health. "Triologue stands for the encounter of the three main groups of individuals who deal with mental health and psychiatric problems and with the mental health system - people with experiences of severe mental distress, family members/friends and mental health professionals."

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

Feedback from service users about person-centred and values-based approaches. Sharing good practice examples around the country.

Again it's variable in terms of good practice and unfortunately some areas that have statutory mental health/psychiatric services that do not take account of user carer preference, ideas or recommendations.

Health boards being more accountable regarding their engagement with and involvement of service users and carers in strategic and operational activities. Consultation of users and carers in different geographical areas will determine if there is meaningful involvement, person-centred and values-based approaches.

There are requirements already on the Boards relating to consultation requirements but for people using services it could be an entirely different experience in relation to how they feel consulted on matters that affect them. Levels of complaint in this area should not be a measure of satisfaction with the service. Some people will not complain due to fear of repercussions on care. Also, within mental health services, the service user and their families are vulnerable and at times are too busy trying to cope or to look after their relative to make their concerns or complaint formally.

Service users can feel the acute in-patient setting is the most challenging with increased incidence in alcohol and substance misuse and lack of access to meaningful activities within some areas making the environment feel chaotic and challenging to manage. It is also challenging for staff to evidence person-centred practice and values-based approaches within this context. Staff and service users/families need to be involved and supported to identify solutions to the challenges this environment poses.

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

Comments

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

The SRN should not be seen as the only vehicle to achieve this- rather this work needs to be integral to service improvement work in individual areas.

In some areas recovery approaches have not been embedded yet. There is still a maintenance focus in some mental health services, especially in acute care.

GPs and psychiatrists need to be looked at as these professional groups take the lead in diagnosis, prescribing, and can have the most influence on a person's care, wellbeing and recovery.

The peer support work undertaken across services may need to be revisited. The potential for peer support to be an empowering mechanism whereby people with 'lived experience' would receive recognition, influence services and demonstrate recovery in practice may not have been fully realised.

Need to consider the career paths in peer support work. Need to consider revisiting a plan for peer support that will re-establish its human rights base and renew its potential to embed a recovery approach in services. It's too important a model to be short-changed.

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

Strong evidence base for success factors in early intervention services. Barriers to meaningful involvement in acute care/inpatient settings also well documented. Need to have a defined and targeted approach which is well resourced

Carers and family members need to be at the table as equal partners in the care of their relatives. In some instances people have felt that they are there to pick up the pieces if care is unsuitable, or having to complain about lack of proper care.

Consider setting up an initiative whereby carers and family members have the opportunity to learn more about the area in which they live – how they can have a voice, information about care and treatment in their local area etc. Don't leave it up to local NHS to do this as it can be overlooked, people are too busy. There is an obvious commitment to ensure that carers should be at the heart of mental health improvements. However practical experiences of individuals can differ. Consider supporting the need for a national mental health organisation for carers' and family voices and support. Perhaps equivalent to VOX that will co-ordinate the carer/family voice, give them opportunities to consult on policies, to meet with other carers.

An example of an organisation that does both is ACUMEN, a user carer network in Clyde, promoting involvement and supporting users and carers. Many people are both users, or survivors, and carers so it can be useful to have an organisation that works with both.

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

As above - time to undertake this in partnership with families is a necessary component.

Staff need to have the opportunity to hear from other staff about good practice in working with families and carers. Where this is working well. Carers who have good relationships with staff could speak about this, write it down, do a workshop, deliver training to staff and carers/family members in other areas. Training where staff and carers/family members are at the same session, sitting at the same tables, together. No 'them and us'. If we had a national carers' mental health group then they could lead on training/information sessions, taking it round the country. Promoting the benefits of having carers on board, how it could make everyone's job easier. Better for the service user, more cost effective in the long term, more likely to effect real recovery.

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?

The survey of crisis services across Scotland carried out by this network is currently being further analysed and will help clarify this further. This needs to be examined as part of more detailed research including an assessment of the outcomes of different service models. The Crisis and Acute Care Network see this as a key aspect of their work and would like continued Government support to achieve this clarity and further, to aid dissemination of their findings/ examples of effective service models via the network.

We need to do further work looking at the components of services across the patient pathway of care, their interaction with each other, how this affects the outcome for the patient and how we use this information to improve services and to drive improvements in care.

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?

Improved and simplified data gathering systems including SMR data. A SMR data recording system to capture all acute and crisis care activity is required.

Also need to look at support available from information services to analyse data already available to us that can and will drive improvement in services.

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

Learning events/ network support. Difficult to support without source of funding outwith health board financial structures. Direct financial support would enable growth in this area. Often seen as a luxury or extra that we cannot fund but it is essential and is a resourceful way of adding value to activities.

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

Choice and range of crisis provision. Dual diagnosis services and interface with adult mental health.

Out of hours access, MH and A and E both in ours and of hours, work with acute providers not limited to older people. Linking information systems to improve services internally and externally to MH.

Alternatives to acute inpatient care - peer led initiatives – users, survivors and carers consulted and involved in designing and providing alternatives. Psychological therapies available for people in crisis, in psychoses.

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

Work has been done within some health boards looking at integrated guidance for staff working with substance misuse and adult mental health. Patient pathway work has been completed in some areas such as GG&C.

There must be a more cost effective way of treating people with dual diagnosis other than as part of the acute MH in-patient population.

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?

Taking more of an integrated approach to crisis and the development of a national strategy for acute and crisis care that takes account of the Scottish context of MH services. A strategy that is developed involving users, survivors and carers/family members as equal partners, and will include voluntary sector participation. Offering choices in crisis care and support so that acute inpatient care is not the only option for people with psychoses.

Having a range of psychological therapies available for people in crisis, at their point of need, regardless of setting, so that drugs/medication is not the only treatment on offer

Work with, and across, acute care providers for adults with mental health problems. Particularly work with acute medical/surgical wards and A&E and community mental health teams, liaison and crisis services

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

Further work on competencies/joint training to meet service or patient requirements not a managerial structural focus.

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?

Gather evidence around existing work in relation to competencies for workforce for acute/crisis service and clinical/practice response

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

Comments As above and undertake work in relation to competencies for workforce for acute/crisis service and clinical/practice response. Time, resource, dedicated work programme to support Board Directors to undertake.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

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.

Good at counting activity. What about standardised collection of acute activity. Need to look at interface and relationship across service components and the impact on patient outcomes. Using a patient pathway approach to gathering information, reporting and analysing this, and then looking at individual outcomes and impact on patient care. This approach has been used in some Board areas (GG&C has undertaken a proof of concept phase of this work).

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

National ehealth strategy. Need increased investment and coordinated approach. Investment in information services support staff to support the statement/strategy outcome that using good information drives service improvement and meaningful change.

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?

Development of robust service design process that fully involves the views of service users and carers. Targeted improvement programmes for MH such as the MHC approach. Engaging and joining up activities around Scottish patient safety and MH and these improvement programmes

The Mental Health Collaborative work stressed the importance of patients/service users and carers being at the heart of mental health service improvement. Need to support areas to have, or to re-establish, a user/carer voice. The participation and leadership of users and carers in mental health services will bring about improved productivity and best value.

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

Overarching strategy for quality improvement in mental health – focus on patient safety and also on methodologies. Needs to build on the work of mental health collaborative. Best practice/ICP/Patient safety. Mindfully targeted resource allocation for improvement work – not just to go into an overall board allocation but to come direct for Mental Health in the same way the MHC resource did. Was used effectively and was targeted!

Quality improvement must be about keeping the service user involved. Ongoing evaluation and monitoring to check that improvements are happening on the ground and not just in management meetings. And that these improvements are happening all over, in every locality and health board area, urban and rural. Involve local people in this, users, carers, voluntary sector groups, and the public generally. Ensure that there are a variety of ways for people to feedback on mental health services, to speak up and out about the good and the bad, so that there can be real improvement and accountability. Crisis and acute care services in particular need to have effective and thorough feedback mechanisms so that patients, users and carers/family members can easily have a say. This might happen some time after the event, when the crisis has passed and there is time to reflect. On what could have been better and what did work well.

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?

Need commitment to time for proper implementation of supervision within clinical areas and for managers as well. In-patient areas often are challenged by this staff need protected supervision time.