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
There is nothing in the strategy about valuing each other or spiritual care. How could this be added to the strategy?
The strategy could be structured better for example, with themes such as treatment and improvement.
We would like to see health improvement included in the four priorities in the introduction. Prevention needs a higher degree of visibility within this strategy.
Some gaps identified were in aspergers, autism, treatment, care or support.

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.

Giving local areas access to a strong evidence base and the chance to share learning and best practice. Training in change management would be helpful.
Scottish Government to communicate importance via a requirement to include actions in Single Outcome Agreements.
Difficult to tell as work progresses at different levels in different areas. Given the future challenges people with dementia will have in accessing services, staff in 'all' services need to be dementia 'aware' and services require to provide the appropriate environments in which they are cared for safely and with dignity. Therefore, there might be a need to consider mandatory dementia awareness and values based practice training to ensure people with dementia and their carers have their needs met in a truly person

centred manner.
Establishing a mechanism in primary care where there is an incentive for GPs to follow best practice without having to use a LES.
We are currently going through such a redesign of services. Implementation has been delayed by a change in system of application for funding of major initiatives. It is important to note that reorganisations in central government have a knock on effect on clinical services.
Electronic systems between Health and Social Work need to be compatible and 'talk' to each other.
We also feel frustrated by the apparent differences in mind set with respect to time frames between NHS and Local Authority so clarifying the definitions of 'emergency', 'urgent' etc might be of 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.

Comments
More early intervention provisions would be beneficial.
Given the impact that developmental (including attachment) disorders and life trauma (military, accident, assault, rape, CSA, etc.) has on peoples mental health & wellbeing (and indeed, addiction disorders) there does require enhanced training for staff working with individuals presenting with such issues. In addition, traditional service boundaries will require to be 'challenged' to ensure people have access to 'specialist' treatments that are effective in dealing with such issues. 'Safe to Say' and other similar initiatives could (should?) be made more widely available for people working in services and should make a difference.
Fund good evaluation projects.
Increased awareness.
Research into the benefit of emerging therapies e.g. sensori-motor psychotherapy.
Increased self help and research into Autistic Spectrum Disorders
Information and a reduced expectation that mental health services can 'treat' all conditions especially developmental and personality disorders.

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?

Comments
Community training should be supported, for example courses like Scotland's Mental Health First Aid. Staff in workplaces should have some sort of basic mental health awareness training such as SMHFA.
We need more National Public Awareness campaigns focussing on giving information and supporting anti stigma messages.
More and continued support for the third sector such as ACUMEN.
Suicide actions via the Choose Life Initiative are quite comprehensive and should continue to be delivered. Reduction of Self Harm is not being dealt with particularly well. Staff in A&E/Casualty departments (as do a number in mental health) require improved training in values based practice in dealing with such individuals who present having self harmed. Such individuals should also have the opportunity to be referred on to and assessed by mental health services and appropriate interventions applied as a matter of

routine.
Decrease alcohol use by decreasing availability.
Support employment schemes – not necessarily paid work
Address the benefits trap that sees people lose all benefits on return to substantial part time work.

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

Comments
National media campaigns, public information such as press releases.
Challenge things we don't like.
Challenge attitudes of our own staff through training and other awareness, for example vocabulary around mental illness or health and behaviours such as acute services.
Help to normalise mental ill health.
Recognising now is a snap shot in time and that progress is ongoing.
Build these messages into school curriculum and make them mandatory at school.
Support to challenge inappropriate language within settings such as school, workplace and homes.
Training in attitudes, values and beliefs for all partners e.g. NHS, Local authorities and the third sector.
See Me was a good campaign and helped (anecdotally) in getting the message across. More needs to be done with the media and how they represent mental health/illness in their use of language. It (anti-stigma) should also be considered in primary and secondary education programmes. Challenging language used would go a long way to impact, positively on stigma and reduce discrimination. Training for Health & Social Care staff on such matters should be made mandatory. Equally working with teachers in primary, secondary and tertiary education would have an impact. Specific campaign work nationally with Police to reduce the fear factor from those suffering from psychotic illnesses.

Encourage/support 'famous' people to talk - champions
Support TV companies to include mental health issues in 'soaps', for example giving them a financial incentive provided the storyline is in accordance with best practice.

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
As in comments in Q4, above, but also consider workplace initiatives.
Workplace initiatives to support anti stigma messages.
Would like See Me profile to be raised again – encouraging local areas to sign the see me pledge e.g. positive discrimination
Repeat the "See me" campaign with updated slogans.

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

Comments
As in comments in Q4 & Q5, above.
More high profile (celebrities) talking about their own experiences of mental ill health and giving positive recovery messages.
Stringent media reporting laws introduced to support positive reporting of issue around mental health and wellbeing.
Laws against the medias use of derogatory language in reference to people with mental illness.
Work in schools through Curriculum for Excellence; more positive messages like everyone has mental health...
More general health promotion work around community development e.g. assets approach to health. The healthy living centres were great examples of this but in many areas the legacy has been lost.
Celebrity campaign similar to the likes of Jamie Oliver and school dinners; someone who can be passionate about this.
Support employment schemes – paid or unpaid to give a sense of meaning and purpose.

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?

Comments
School education.
Joint working.
Improved training of School Nursing staff, Education staff, Children's Hearing System, etc.
In matters of Mental Health & Wellbeing and Child Development, CAMHS working closely with schools in early interventions, build and improve linkages with good parenting initiatives, other children's services across the spectrum.
CAMHS Teams that integrate with children's' services.
Development of web based programmes for anxiety management for school

aged children who are already using this technology in school.

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

Comments

Continued financial support to boost staff numbers remembering it can take some time for job descriptions to be agreed and posts confirmed within local organisations.

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
Awareness of local services
Third sector agencies e.g. Acumen
Link Clubs
More people have an awareness of how to recognise illness and know what to do to help.
Invest in healthy communities. Lots of things contribute to mental health such as work, volunteering, social support networks etc. We don't have to badge everything with "mental health".
Need to focus on those individuals who do 'not' have an understanding of their own mental health (of which there are many). Improved emotional intelligence. Further reduction of stigma would assist in this. Better/improved access to screening of individuals in the primary care, secondary care, occupational health setting, etc. Wider access to wider range of psycho-social therapies to be developed.
We need to think of something equivalent to 5-a-day e.g. good night happy thoughts - this is going to sound twee and middle class! But practicsing reflecting on the day and recognising good things however small.
Celebrity campaign similar to the likes of Jamie Oliver and school dinners; someone who can be passionate about this.
Continue awareness of the initiatives mentioned – including 'Living Life'.
Information is only getting out now and many GPs are still not aware of this telephoned based CBT service that should be particularly useful in rural areas.
Promote the production of local directories that could be available in GP surgeries etc containing a list of the resources that are available.
The Local Authority have a directory of services but the Health version of this or Health input to this is lagging behind.
Emphasise the importance of the tiered model of intervention.

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

Comments
Anti stigma work and easy access to services including social prescribing.
Community development – sources of support are prominent in local communities and a wide range of people use them.
As above – don't need to badge everything as "mental health".
Anti-stigma approaches, psycho-education, information availability in community settings, GP Practices, Hospitals, Social Work Departments, Housing Departments etc.
Making access easy: good signposting and self referral options.
Multiple options to suit personalities, for example peer support, encouragement and a service that can respond to requests directing people to the most appropriate avenue for action, even if this means self help.

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
Think this is badly done.
Acute services inclined to refer on to specialist mental health services.
First contact service need to be fully aware of what is available for mental health.
All services need to be supported to take ownership of mental health.
We need to have comprehensive, wide ranging services in place and everyone needs to know about these services.
Patients need to know where to and how to self refer and staff need to know where to refer on to.
National strategy to support drop-in services like having mental health trained staff in A+E all the time.
Drop in services in A+E.
More support for anti stigma messages – See Me more broadly publicised.
Roll out of public education around mental health and wellbeing.
Mandatory training for frontline staff in general mental health and wellbeing and appropriate referral procedures.
Information available about services and support available to refer people on to including social prescribing activities.
Funding for signposting to pay for people and resources.
Better use of resources such as using LEAN in Releasing Time to Care paper.
Building the capacity of NHS 24 and supporting their use locally.
Better promotion of NHS Living Life service.
GP contracts reviewed – more Quality Outcomes Framework targets in mental health.
Community mental health teams should develop walk in (drop in) access services for people presenting in crisis (during normal hours of operation) as many do not. Referring people back to see their GP before they can be seen by the team for assessment can take a few days (at best) and exacerbate the crisis. People who are already highly stressed/distressed feel further alienated and/or excluded. Such 'immediacy' of assessment can minimise distress and prevent crisis from occurring to a harmful level. Mental health crisis is often short-lived and if dealt with at such a 'critical' time, can resolve many issues. All hospitals should have staff trained and competent in dealing with people in crisis, to respond to the crisis appropriately and the ability to get the individual assessed and seen as soon as possible (next working day).
Introduce a target for referral to treatment in general adult psychiatry.
Work in schools and youth groups to increase awareness and decrease stigma.

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
Support for the implementation of LEAN in services.
Support for local services to share information locally for example joint management teams, integrating service and sharing information between teams.
Support to implement Releasing Time to Care in services locally.
This is difficult to answer when there is still a debate about what is evidence based practice in mental health.
We don't know what "non-value adding activities" refers to.
Still needs to be scope for individual care plans, but recognise need for standards such as NICE.
Joint ownership and management of mental health services, with joint accountability and governance structures which can remove unnecessary or bureaucratic processes.
NHS Boards need a more efficient structure to ensure that mental health initiatives such as those described are acknowledged and implemented. The use of technology should reduce time spent travelling between meetings.
Management structure should be as lean and 'vertical' as possible.

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

Comments
IT systems which are compatible.
Make it mandatory for Health boards to have compatible electronic information systems.
Some sort of HEAT target – not sure how this would be measured.
A national computerised system that communicates with existing organisational electronic information systems in health, local authority, general practice, etc.
An electronic information system and admin support to input data that is currently available in paper form.
Training and support for staff in the use of electronic systems.
Perhaps an acknowledgement that they are a useful reference document and audit tool for variance rather than a tool that improves patient care per se.

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
Support for the role out of peer support workers.
Supporting Link clubs, self help groups such as grants towards accommodation, expenses, travel costs (especially important in rural areas) and volunteering.
Services to provide more support and closer working with them.
Supporting training for service user groups in things like person centred planning and WRAP.
Emphasis on the recovery agenda.
Developing service users skills by providing finance. Encouraging health staff to support patient's access to opportunities, for example helping service users to be involved on committees for the Local Authority and Health board.
ACUMEN model has been successful in Argyll and Bute – roll out more models like that.
Make service user feedback and involvement in service development an integral requirement.
By meaningful involvement and supporting organisations representing service users. Regular service audit of such involvement. Supporting service users to work alongside staff in various training initiatives, in particular VBP training and 'Realising Recovery' materials. Development of more Peer Support Worker posts. As posts in service become vacant, they could be set aside to employ Peer Support Workers.
Continue the current approach.
Increased awareness of the role that individual plays in their own care.
Implementation of the Scottish Recovery Indicators.

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

Comments
Emphasis on the principles of empowerment, advocacy, listening and spiritual care as the philosophy rather than a tool.
Implement a HEAT target on the use and implementation of SRI2.
Support the implementation of WRAP.
Support to provide recovery training courses which utilise the experience of service users by encouraging them to co deliver it.
Audit as noted above. Use of the SRI across services with Service Users being engaged with and involved in its completion.
Increase methods of communication by supporting email, web based forums, text messaging – perhaps via social networks like Facebook if carefully monitored.

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
Support the implementation of SRI2.
Staff training delivered with the help of service users and carers.
Highlight the evidence base using narrative research to get staff onboard

with the messages.
Implementation of a performance management framework – success measures.
Continual roll out of VBP training to ensure that all staff groups have undertaken it. Managers should also be well versed in this too?
More use of patients in training.
Continue the focus on person centred care.
Demonstration of outcome would need a large scale outcome study using a standardised evaluation tool.
It would be good to see a patient led qualitative study.

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

Comments
Implementing a HEAT target.
Encourage SRI2 results to be monitored within annual review.
Make it mandatory – low uptake of use surprised the focus group.
Should be built into all service evaluations and/or re-design processes.
Could be considered as part of the annual review of service performance?
More widespread training available.
By supporting the 'Recovery' approach as at present.
Introduce a target that the majority of care plans in mental health settings have to be recovery focussed.

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

Comments
Help local areas to implement recovery approaches locally.
Implement protected learning time for staff especially inpatient staff and provide access to finance to support backfill to allow staff to be released.
SRN need to be more visible – if the above was mandatory SRNs visibility will be improved.
Be involved in supporting the roll out and implementation of the SRI (much as they are now with SRI2). The representatives will be able to take the initiative back to their respective organisations and implement it.
Showcase the results at uni-disciplinary events as well as multidisciplinary and multiagency conferences, journals etc. Provide mentorship to get things into practice after training not just the training itself.
Increased awareness, remember it takes years to change attitudes.

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
This relies on a good relationship between patient and family. In some cases the "family" may be the route cause of the problem.
Access to respite for family/carers and the patient themselves. It needs to be person/family centred and flexible.
Anticipatory care – to prevent people from reaching crisis before providing support.
Making respite a higher priority and providing Carers support groups. This is generally understood and supported by staff. However, many patients do not want involvement from family and or carers (where they have them) and this needs to be recognised and accepted too. However, where it would be welcomed, staff require enhanced training in psychosocial interventions in dealing with issues such as high expressed emotion when working with families as this can reduce relapse rates by 3.7 times.
Make it a pre-requisite that where there is a carer then care/treatment only proceeds where there is agreement or at least discussion with carer. Or would this slow down treatment?
Lessen isolation – development of networks.
Support and information for GPs on what is available for families and carers
Respite for carers and / or patients, regular and dependable.
Information – DVD/TV/podcasts, YouTube etc.
Increased awareness of initiatives to date, especially the Carers Strategy.

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
Staff should listen more to families. They need a clearer understanding of what they (staff) can say to families whilst protecting confidentiality.
Support for staff to facilitate peer support groups and support to allow them to become self sustaining.
Access to and provision of information on local services.
A national directory containing local information. Support requirements for this are funding, support to keep it up-to-date, publicised to staff and the public.
Staff in psychosocial interventions such are the work undertaken in the Thorn initiative in England.
Staff training in family centred approaches.
Networks and support which staff can use.
Enforce sections 24-27 of the Mental Health Act – duty to provide services in the community.
Improved VBP, psychosocial interventions training (e.g. working with High Expressed Emotion, etc), Family Therapy training, etc.
Education of staff and use of approaches like the CPA that 'sanction' information sharing.
Releasing time to give to carers.
Tackling concerns over the sharing of information between patient and family by increasing awareness of the doctor-patient relationship and how this interfaces with the family/carers.

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
There needs to be better ways of sharing good practice.
Learn from best practice in other areas.
A National mechanism to capture evaluation outcomes from local redesign of service which is taking place in A+B.
Share information about what services are using as outcome measures.
Look at outcome measures in use in local area – maybe they should be mandatory.
Agree what outcome measures are best and share this practice with local area. Let the local area decide which of the proposed measures will work best in that area.
Support to get the balance of both quality and quantity in outcomes from services.
Support for community and inpatient staff to work together better and bring them together sometimes conflicting agendas.
There are concerns over the emphasis on a move towards community services in a climate of less money.
We also have an additional challenge to provide comprehensive community services in a rural area.
Remove the barrier or distinction between in-patient beds and the community and focus on the mental health system as a single entity. Direct access to beds from CMHTs would be beneficial, alongside, bed management initiatives.
Be clear what the better outcomes are that we are measuring
someone with a national remit writes up case studies with the relevant services and disseminates.
Disseminate examples of where redesign of service has been positive.

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
SPARRA Data is assisting with this (to a small degree). Need to consider other means of identifying this though. Further development of assertive out-reach, home treatment services and CPA would assist with this and these should be considered as part of the 'single entity' service noted above.
Ask Boards to show they are using information and then improving if and where necessary.
Statistics – ensure better returns on ethnicity etc from out patients

appointments by creating targets for returns.
Be aware of the problems that remote and rural areas have, support technology initiatives and reduce the tax on fuel.

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

Comments
PIRAMHIDS? Role for NHS Healthcare Improvement Scotland to disseminate and promote good practice notes on this. Electronic as well as paper. Ensure that there is adequate representation at Health Board level for mental health initiatives.

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

Comments
Gypsy travellers Some priorities for "Asbergers and Autism". Knowledge Training Support. Personality Disorder

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
Training of staff in all settings in the assessment, planning and delivery of PCC. Development of more generic Community Mental Health Services rather than division into specialist teams, especially for more rural areas.

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
Service Users – ACUMEN involvement
Need also to consider work regarding people who present with general mental health problems, but also, people with BPD who frequently present with self harm behaviours.
Mental health awareness training general hospitals to increase knowledge, decrease stigma, prevent transfers.
A move away from specialisms to more generic 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
Continue to ensure training and awareness is rolled out and measure the impact of this?
Increase awareness of government initiatives amongst healthcare practitioners working in the frontline so that they can use the content to request training, resources etc,
Support for managers in being able to free up staff for training e.g. protected learning time for hospital workers and other non GP staff.

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
The ScotPHO profiles are very helpful but in relation to mental health they only include 3 measures which are indicators of mental ill-health in the population.
What about an annual mental health check for Scotland that could be manipulated for local data?
Impact on training initiatives such as 10 ESCs, Realising Recovery, Mental Health First Aid, ASIST, STORM, etc?
Further refinement of the benchmarking exercise so that Health Boards and CHPs can compare data more effectively.

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

Comments
Primary care, acute and community staff need to take ownership of mental health and not just refer on.
Ensure a flexible and responsive workforce that is able to meet individuals needs in a variety of settings at anytime of the day and/or night where necessary? Especially during times of crisis.
Getting acute and community staff skilled and confident in dealing with mental illness and dementia for their area; recovery focus for mental health staff and mental wellbeing focus for everyone.
Attention to having adequate staff levels at each tier of intervention so that the stepped model of care works efficiently.

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

Continued use of university and college and formal recognition of the courses currently available in West of Scotland university for CBT.

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
Implementation of a national information system.

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

Comments
Electronic information systems linked to ICPs.
Having IT systems that are routinely used by clinicians at the point of care and gives them useful information back.
IT Support.
Targets.
Availability and agreement on measures to be used.

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
To give a clear direction on the integration of NHS and Local Authority mental health services to reduce the costs of duplication of back office costs.
Disseminate learning points from the Mental Health Collaborative and Lean methodology.
Keep up reviews in relation to HEAT targets.

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

Comments
As above.
Ensure VBP training is embedded across all health & social services so that people with mental health problems feel included and their voices are heard when presenting with any particular needs?
Reduce specialty teams, i.e. more integrated teams on the ground.
Reduce duplication.

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
Ensure robust training & educational programmes are in place and that staff have the time to attend them.
Audit impact and outcomes.
Support the Mental Welfare Commission to continue independent inspections on mental health services.
Increase training/awareness of legal provisions under the 2000 and 2003 Acts through refresher training for all staff every five years.