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
2 Gaps:

1. The concept of "evidence based" psychological support often leads to a focus on CBT based psychological methods, to the exclusion of other models. It is quite possible to measure positive outcomes using assessment forms such as CORE forms (as recommended by NICE) and to thus engage with a range of solution focused approaches while permitting person-centred, psycho-analytical, or cognitive behavioural coaching (including social psychology and lifestyle issues). Many clients who use our Integrative service (combining therapy models according to the needs of the individual) approach and use our private service because CBT based therapy provided free in the past has not addressed deeper emotional issues.
2. There is the problem of high functioning patients who have underlying clinical conditions such as anxiety, unipolar or bipolar depression, OCD or self harm who are missed entirely by the system because they are apparently functioning within society. They then only find support when either seeking help privately (such as via our service), or when at a point of crisis (legal or suicide for example). Effective early warning screening combined with effective action to make discussion or such matters socially acceptable is crucial. Education of the realities of such conditions rather than the urban myths associated with mental illness might make major improvements in take up rates of screening and support. The problem is recognised - I was accepted by Edinburgh University to do research in this area from 2011, but sadly no funding was available, even though early intervention would save money and lives.

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
Initiatives such as the "Health in Mind" service giving volunteers to elderly people to enable matched support and social engagement could be enhanced and if appropriate dementia specific training was given, this could lead to more psychological stimulus for sufferers. Studies have clearly shown that although certain facets of neural damage result in inevitable loss of for example areas of memory, in contrast social engagement and activity help to improve other areas of functioning and greatly improves quality of life. Matching volunteers to sufferers also helps to break down some social barriers and the urban myths associated with dementia suffers.

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

The NHS and CMHTs are very poor at recognising and consulting the existing private services in the non NHS sector. Consultation of private and third sector specialists should be a priority, rather than always attempting to reinvent the wheel. I have on a number of occasions spoken to NHS personnel – nurses, GP's, CPN's, NHS trainers, NHS Psychologists, all of whom told me that no specialist self management therapy training was available for Bipolar patients. They were all suprised to discover that I provide such a service, and work alongside and in cooperation with other GP's and specialists in the area.

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

As mentioned in the first section: high functioning people often do not find themselves supported until they hit a point of crisis, having suffered a gradual yet hidden decline for some time. This often has a cross over with dual diagnosis co-morbidity, especially with malformed coping methods such as self medicating with alcohol for depression or anxiety.

Earlier intervention and better education of society would enable people to seek support earlier, before crisis. However there would need to be the provision available for self management training for conditions such as mood disorders and depression, as well as joined up cooperation with GP's for appropriate medication. At the moment the provision is missing, private sector only or fragmented.

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

Crucially encourage well known personalities to come forward and admit their own struggles. People such as footballer and manager Neil Lennon speaking about their battles with depression helps to make the condition seem less fantastic, weird and alien.

Case studies would also help, emphasising how with the right support people with mental illness can be fully or near fully functioning. At the moment there is a belief among many that if you have a mental illness you are socially undesirable and probably not in fruitful employment!

A concept I use with my clients is - if you had migraines you would take pain killers, if you had flu you would take paracetamol.... just because the problem happens to be within your cranium does not prevent you from taking appropriate action and living your life.

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
See me is a good initiative, but needs more visibility throughout society. Having case study posters in schools, colleges, work places, facebook etc would all help to spread the word better. Again celebrity endorsement helps.

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

Comments
It is crucial that people know the role they can play in helping those who suffer from mental illness. Being a friend, a shoulder to lean on, someone to help them get to the GP when they are feeling so low that they are social phobic, being a "buddy" to go to a class or gym session, and maybe just someone to check on them and take them for coffee from time to time. Isolation leads to worsening of symptoms and increased risk, networks of support are crucial. This can be tied into existing initiatives like the WRAP system used in the third sector, which involves responses and "people to call" in the event of relapse or difficulty.

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
Issues like anger management in young people are often not well supported, leading to enquiries in the private sector. The private sector is not well equipped to tackle such issues since they require adherence to strict policy and procedure - such as Childrens Act legislation. Education and clear direction as to where to turn if you have a child or young person with difficulties (or indeed if you yourself are such a young person), and then actually having the RIGHT services available would be an improvement! I wonder how much consultation there has been of kids and parents as to the type of problems THEY would like to see support for - or whether it is the "experts" who have been designing the choice of services? If you only

provide services a,b, and c - you can only measure the outcome for those, meanwhile often ignorant of the demand for z!

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

Comments

When trying to coordinate the different elements of HEAT, there needs to be better networking between the GP, mental health professionals, family, private providers and other services. Where appropriate a key worker, possibly even a lay-key worker (volunteer or family member) should ensure that all parties are working together. Coordinated psychological support, medication reviews, social activity, fitness or gym work, further education or work development for re-engaging with the social environment..... all of these are important but often are fragmented, or incomplete. In each case SOMEONE should take responsibility for coordination and key working. Historically this has always been a professional such as a social worker. However there is no good reason why a competent volunteer or family member could not take on this role, since it merely co-ordinates other people who have specialist expertise, and does not require particular expertise other than common sense and caring. Personally I would like to see third sector trained volunteer mental health support workers taking on this role with training provided in liaison with NES Research within the NHS, and drawing also on private sector expertise.

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
Joined up thinking - and not relying on short term, surface effective CBT. Deeper emotional therapy combined with self management training are required - not banging the poor patient through a bog standard CBT process that often leaves them feeling depersonalised and devoid of respect.

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

Comments
Education Early Screening facilities Positive emphasis on what can be achieved - i.e. continued functioning

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
Early screening for identifying high functioning clients, who are not currently spotted early. Also joined up thinking between Drugs and Alcohol and mental health services so they stop passing clients back and for in cases of co-morbidity. Subject to the successful kite marking regulation of psychotherapists and counsellors by the CHRE in it's new form (estimated for Nov 2012), a limited referral to private registered therapists, perhaps with some funding would massively speed up the process of treatment, especially of low level cases. This would allow the faster provision of services to acute cases via CMHTs,

while ensuring that low level cases are reviewed and supported at an early stage, potentially preventing decline to acute status later.

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

Great care needs to be taken in measuring the "evidence". CORE forms and other before and after consultation processes can easily be used with a wide range of processes and provisions. If you are not careful the surface level "results" associated with behavioural change will over emphasise CBT as a response, which often leads the client only partially helped. Those who can afford it, and who are not then disillusioned with therapy, often seek other methods privately afterwards.

Another problem is the fire and forget nature of services. After assessment and the given period of support, the client is often "let back into the wild" with very little future maintenance, if any at all apart from their GP or private provision. This undermines any progress or success that might have been achieved during the support that was given.

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

Comments

Above all else they need to accept that the medical model is not the end all and be all of therapeutic care! Lifestyle, social environment, networks of support, and deeper psychological understanding are required - not just CBT and pills!

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
More empowering training for self-management, and more respect for the need to process underlying emotional pain, not just banging the poor patient through CBT processes on their own! Compassion combined with

empowerment!

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

Comments

Training packages - WRAP is quite good if a little basic.

Guide sheets - "how to help / respond if....."

Contact sheets - where to get support for patients and carers

Information on putting together the joined up package of care and self management that the NHS probably has not provided!

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

By being very careful not to fall into the trap of a CBT and pills based approach. Compassion and real support, listening to the patient, not assuming that the "expert" knows what the patient wants to achieve, or what is worst about the situation for them.

Consulting the patient about what kind of therapy THEY want as well - perhaps the kite mark regulation will help if it materialises – referral to regulated therapists providing a range of approaches to good standards would enable patient choice.

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

Comments

Care should be taken not to assume that recovery is always possible. Many acute conditions are long term or life long conditions such as bipolar.

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

Comments

More care should be taken to ensure that supposed recovery really has happened, rather than just short term relief through the use of surface CBT techniques, with associated relapse months or years later since underlying issues or environmental or social conditions have not been resolved.

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

By listening, and not judging. I have repeatedly been told of cases where provision has been restricted, or referrals withheld because the GP or specialist perceived the carer, husband, wife or parent to be problematic. The patient and their support network are the real experts on the situation as a whole, not the medical professional who can easily jump to erroneous conclusions or even reject the case as a "heart sick" patient.

It is vital that the expertise of the medical or mental health professional be kept in proportion and no power imbalance be allowed when dealing with family and carers. There may be some unpleasant examples of carers around, but usually any over assertive behaviour is due to frustration with the service, and thus becomes a self fulfilling prophecy of frustration leading to further examples of unhelpfulness.

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 need to be able to access information from outside of the Mental health

and NHS fields, drawing on environmental, social, private and third sector opportunities and knowledge bases. Critically they need to know what additional services are available, such as therapists, trainers, volunteers or resource centres (physical or online).

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

Faster and better referral to appropriate services. Ideally access to CMHTs without the need for referral by their GP. Screening directly by staff within community mental health would present a massive move forward in access times and efficiency. It is soul destroying for a patient who is suffering already due to the symptoms of their mental health issues, to then have to tell the GP, usually explain areas of symptoms little understood by a GENERAL practitioner, then convince them to provide a referral, and then wait for the referral for weeks. Screening by properly trained staff at a CMHT would be quicker, more efficient and more likely to be correctly skilled.

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

The problem here is identifying who is NOT accessing the service - such as high functioning people who often "go private" unless they are at the point of crisis.

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

Comments
By first drawing on all sectors - private, third sector and NHS and having a multi-disciplinary approach to pooling and disseminating knowledge. Having an across the board training provision overseen by someone like NES Research, available to all of the above sectors and carers would improve matters.

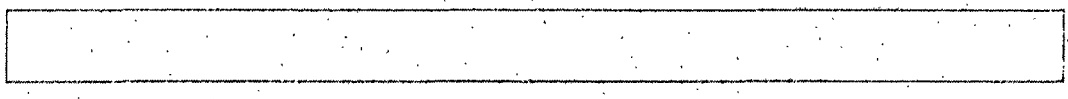
Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments
Early identification of high functioning mentally ill people. Coordinated treatment of cases of co-morbidity long term self management support post crisis intervention Coordination of social, psychological, physical and environmental support.

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
Better awareness of patterns of co-morbidity and moving away from the entrenched stereotypes that exist within service provision- especially the assumption that misuse is always the cause of the mental illness, when actually inappropriate self medication for existing conditions is often present. Clues can be identified from social / criminal or other health needs across service settings. Again someone taking responsibility as a key worker would enable a more joined up approach.



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

- Early screening
- More holistic approaches for self management coordinating a range of social, physical, activity, network and psychological based approaches with a key worker.
- Better understanding of co-morbidity
- More diverse use of different therapy methods, with appropriate measurement of results, not just CBT
- Better follow up after crisis interventions or acute presentations
- easier access to a range of services without GP as first gatekeeper

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

We need a coordinated system of training across the private, third, NHS and carer sectors. This would enable the gaining of qualifications in one sector usable in another, and thus encourage people with long term aspirations and dedication into the different sectors, moving away from the tendency to have under-qualified and underpaid staff in certain disciplines. Also all the sectors have much to learn from the others, and it should not be assumed that the NHS are the "experts", or at least not the overall / only experts!

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 present of key indicators of potential long term mental illness in high functioning people, perhaps via a normal health check at the GP - sent to

an anonymous screening service, who then provide results via an online code numbered entry (code on the screening form pack – with an anon login). This would enable an anonymous screening service without any stigmatisation for all patients, and massive data feedback for analysis of potential undiagnosed conditions and correlations. If combined with an academic piece of research, external funding might be available.

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
People are becoming more knowledgeable, largely thanks to the availability of information online. As this occurs they become more discerning in the kind of response and package of care they feel is appropriate to them, bases on the fact that they are the best expert on themselves (except when perceptually biased). More holistic care, with more acceptance of increased public knowledge, and more effective CPD to stay up to date would all be helpful. It is infuriating for a patient to know more than the GP, because of a hour spent via Google!

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

Comments
Consultation between the sectors, drawing on the wealth of expertise that all the models have to offer. Many people chose to work in the private or third sectors because of the limitations of the NHS. This means that their expertise, knowledge and ideas are lost to the NHS in their planning and provision. There is a huge gap between how "expert" the NHS think they are, and how "expert" the public think the NHS is! Those who can afford to, frequently go private or complementary because of a desire for better quality provision.

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
The legal framework is often a bad joke, because often the patient is in no way emotionally equipped to cope with challenging authority figures, even if

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

Comments
Better understanding outside of limited and blinkered medical models of mental health. Cross training in other sectors would be desirable.

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.

Comments
Being careful not to reduce the diversity of provision. Individuals have diverse presentations. Their symptoms lead to diagnosis through a system of "best match" to existing standards. They are all unique and find different combinations of therapies and activities helpful for them. Outcomes should not be based on the assumption that the patient has all the typical attributes and needs associated with any one diagnostic label.

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

Comments
Better key working. Better interdisciplinary networking Less hierarchical attitude within sectors of the NHS, psychiatrists in particular.

the law is on their side. The hierarchical structure of power still firmly exists with the psychiatrist or psychologist being the "expert" and wielder of treatment options, while the patient pays due respect to them!

Yet another reason why people choose third sector and private sectors!