Mental Health Strategy for Scotland Consultation,

Response from Scottish Old Age Faculty, Royal College of Psychiatry

We welcome the opportunity to be able to respond to this important document. setting out the direction of travel for mental health Services in Scotland for the next 4 years.

We have made comments on the questions asked in the consultation as detailed below. However we also have some general comments which are not addressed in these questions.

1. While we welcome the continued emphasis on the Dementia Strategy, and would agree that it has driven forward positive changes in dementia care and support in Scotland, we are disappointed that no reference at all is made to other mental disorders in older people. The document does refer to CAMHS, in our view it should also do so for older people. Presentation, management and outcomes of mental health problems can be very different from those in younger people. We know that access to Psychological Services, liaison services, crisis services and primary care services is much poorer for older people, as referred to in the Royal College of Psychiatry position statement of 2009, *Age Discrimination in Mental Health Services: Making Equality a Reality*. The Strategy is a major opportunity to address this, and this must not be lost.

2. We are surprised and disappointed that no mention is made of the Equality Act (2010) whose provisions relating to discrimination on access to public services come into effect in April 2012. This is going to lead to changes in how we deliver services to many people, including older people, and must be addressed in the Strategy.

3. A major challenge for Mental Health Services generally is how we deal with the demographic changes relating to age. Our population is ageing. Our view is that the Strategy should address this, by asking how we are going to look at a shift of resources towards older people. Over the next 20 years it is projected that as well as an increase in older people, there is going to be a decrease in the population between the ages of 16 and 65.

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.

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
We commend the work which has already happened through the dementia strategy. The use of the HEAT target in our view had an enormous impact in raising the profile of dementia at least partly by sharing ownership with General Practitioners. While in some quarters the use of such targets is frowned upon, we would encourage the Government to look at the use of further use of targets within 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.

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
As above, the use of well-directed targets has been shown to be very useful in driving improvements.

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
The emphasis on reduction of suicides has largely concentrated on suicide in young people. There is a comparably high rate of suicide amongst older people, we feel there is a need to focus on this group too.

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

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

Comments 4-6

We feel there is a need to further strengthen links with user and carer groups. These are the people who can help answer this question. To use dementia as an example, working with the voluntary sector and with people with dementia has reduced stigma considerably. I think we have all been successful in making dementia everybody's business.

Consideration should be given to encouraging positive portrayal of people who have mental illness in the media, particularly in influential television programmes such as the soaps. I understand River City looks as though it is developing a storyline where a character is developing dementia.

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 & 10: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

Comments

It is important that any systems set up re this look carefully at making access readily available hard to reach groups, particularly older people with social isolation and/or cognitive difficulties.

Continued support of embryonic Mental Health and Wellbeing in Later Life initiatives would be helpful. Reduction in the stigma associated with mental health problems is likely to be of particular value to the current generations of older people. A coherent public health message (e.g. exercise) encompassing mental health (e.g. depression) is non-stigmatising but the clear perception that meaningful care and support exists is possibly even more important

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

Including older people in the current stepped approach (e.g. psychological therapies) to mental health problems in primary care would be a useful start in those health board areas where this does not currently happen

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

Comments 12-13

It is important that ICPs reflect current good practice and that measuring outcomes via ICPs builds on existing systems. Care Pathways in Mental Health services often reflect the complexities of the illnesses, and ICP implementation needs to drive service improvement without leading to cumbersome systems particularly in terms of data collection.

In our view the drive from Government to implement ICPs seems to have stalled and there needs therefore to be more central steer.

Attention requires to be paid as to whether the non – dementia mental health ICPs are "age-proofed" and an overall commitment to no further service developments restricted to working age adults would be welcomed

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

Comments 14-15

There needs to be further development of patient and carer support groups. Alzheimer societies have been very successful at developing these both at national and local levels and similar well resourced support groups for other mental health issues would be just as valuable.

The structure of having an umbrella central organisation with local groups feeding into it needs to be further facilitated.

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

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

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

Comments 16 – 18

A commitment to similar quality of services for older people (e.g. physical environment of inpatient settings) would be a welcome start. Application of recovery-based approaches to older people's services has been patchy at best and simply ensuring that this initiative does not repeat ageist patterns of the past would be an encouraging change

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?
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 19-20

The confidence that even basic (social) care and treatment resources exist in the community for older people with mental illness and their carers can be crucial in avoiding admission, not least to general hospitals. Being able to reassure families and actually having the services about which to inform them would be hugely beneficial as would a practical focus within CPD and protected time for multidisciplinary training (e.g. in AWI legislation)

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?

It is important that this question is dealt with as it is formatted, i.e. building on knowledge *and* experience.

There has been a tendency in recent years to concentrate only on evidence based practices. But often evidence is very weak and is only used because no more robust studies have been done. So it is important to utilise the experience as well as the knowledge of the wealth of experts we have in Scotland.

There is also a danger that relying only on evidence practice stifles innovation. We need to encourage good practice by having an effective way of sharing and evaluating good practice. We have to remember that a lack of evidence fro effectiveness may simply be a result of a lack of proper evaluation. This also applies to areas of poor practice!

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?
Question 23: How do we disseminate learning about what is important to make services accessible?
Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments 22-24

A starting point would be to persuade GPs there actually is something comparable to offer older people with mental health issues in conjunction with setting minimum standards for provision of information from health boards to both those using and those providing services. One volunteer, perhaps a non-executive director, in each area might have this as a personal priority. A willingness to publicly repeat the acknowledgement given here that services to older people are a "significant gap in service provision" until that is no longer the case is to be welcomed.

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?

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 25-26

Depression, or even quality of life, of older people in care homes constitutes an unmet need in terms of patient experience and greater integration of health and social care systems remains an important, indeed necessary, aspiration

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?

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?

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

Comments 27-29

There is in our view a need to coordinate training better. Training is now provided by a myriad of agencies and there is a lack of coordination of this at both local and national level. This is particularly notable in the case of *Promoting Excellence.*

There is a need for ongoing audit of training and perhaps for a national or local register. This would also enable more joint training across health and social services, in keeping with the integration of these services at some levels

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

Ideally by increasing the number of psychologists working in mental health, particularly in dealing with older people as well as in some other shortage areas. However there needs to be a blurring of age boundaries in line with the forthcoming equality act.

While many psychological therapies can be and indeed are delivered by other staff, there is a need for effective supervision and training. The lack of psychologists in many areas is hampering this.

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

Comments 31-32

We have reasonably robust quality data about our inpatient services. However this is not the case for community based services, and we need to look at ways of improving this to ensure we have a consistent approach across services.

Having access to psychological therapies for older people, whose outcomes could then be subjected to standardised measurement, would be welcome progress. Having a full range of care delivery options to offer older people would permit embedding clinical outcomes reporting. Instilling belief that altered patterns of resource allocation would follow demonstration of service improvement is important as is explicitly relating benchmarking outcomes to demographic 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?
Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

Comments 33-34
There is a need for effective national leadership in the field of dementia. The NHS in England has appointed a national "czar" for dementia and we wonder whether a similar approach might be worth consideration for Scotland.

Judicious shifts of resource from relatively over-provided to relatively under-provided patient groups in line with the Pareto Principle of achieving up to 80% of benefit from the first 20% of investment. Clear demonstration of disinvestment in less effective interventions in order to fully apply lessons learned from improvement work in pursuit of

equitable access to limited available resource and proper attention to lessons learned in terms of waste, variation and harm. Prioritising change and visibly challenging age discrimination in the overall provision of mental health services.

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?

Comment

A comparable infrastructure for proper implementation and monitoring of AWI legislation as is seen in respect of Mental Health Act work