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
The Scottish Primary Mental Health Workers Network are encouraged to see the Scottish Government identifying early intervention and improving access to CAMHS as a priority and an outcome of their mental health strategy.

In terms of the overall structure of the Strategy we would like to draw the Scottish Government's attention to the role of the Primary Mental Health Worker as defined within The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care, Scottish Executive, 2005 (FPPC). Primary Mental Health Workers broadly have a role to provide the following:

- To support and strengthen current CAMHS provision through building capacity and capability within community and primary care staff
- To provide advice, liaison, consultation, supervision and training to tier 1 primary care professionals and other agencies who have a role in the emotional wellbeing of children and young people.
- To provide direct treatment of brief evidence based intervention to children and families

Most health board areas within Scotland have Primary Mental Health Workers (PMHWs) in post under various guises. They are all eligible to attend and participate in the Scottish PMHWs Network which exists to share good practice, developments and support as well as provide a link nationally within Scotland but also with the wide Primary Mental Health fora within England and Wales. The Scottish PMHW Network we are aware that currently many PMHW colleagues are being drawn away from task and role into providing support to floundering tier 3 services, and providing waiting list initiatives and triage for tier 3.

A mental health strategy designed to meet the needs of children and young people as one of its aims, has to understand that children are not autonomous, self determining or can take responsibility for themselves therefore thought has to be given to supporting the development of the wider children's workforce whose role, within the multi-agency network, is to respond directly to meet the mental health needs of the wider population of

children and young people. In this regard the role of the PMHW has responsibility to form a bridge between specialist CAMHS and Tier 1 universal services, parents and carers. It is our view that improving access to CAMHS has to include a stepped and matched care approach ie proper match of need to provision at the earliest stage of a child or young person's presentation.

A functioning tier 2 system can successfully combine this stepped and matched care response ensuring that the Specialist CAMH workforce only gets to intervene (to assess and treat) directly at a point when it is their skills and expertise which are required.

The Scottish PMHWs Network have shared practice based evidence indicating that this matched and stepped approach, as well as undertaking the roles and responsibilities of PMHWs has shown efficacy and improvement in access to specialist brief therapies, early intervention and support to tier 1 professionals both in terms of capacity building (thereby further reducing the need for tier 3 services) and wider networking e.g. named mental health linkworker for schools.

In contrast, in areas where the tier 2 Primary Mental Health Worker has been absorbed and pulled into tier 3 specialist CAMHS their roles have become blurred and less distinct. Some health boards have used PMHWs to provide triage/gatekeeping to specialist CAMHS. This task becomes all consuming with little capacity for direct intervention and high demand. In some health boards, PMHWs have also been asked to provide waiting list initiatives for tier 3. However focusing on these areas means that mental health promotion, prevention and early intervention becomes a low priority.

The Scottish PMHWs Network would like to advise the Scottish Government that in areas where the PMHW role has been sustained there is clear evidence of efficacy in terms of meeting many of the outcomes contained within this Strategy document. In short if asking the question what can the Scottish Government prioritise to meet the challenge, our response would be to enforce the recommendations made within the FPPC (2005) that 25% of ALL CAMHS activity has to be primary mental health work. We feel the existence of PMHW posts within CAMHS teams in Scotland and as well as practice based evidence where PMHW work to role provides a compelling argument for the Scottish Government to support the refocus and support the role and responsibilities of Primary Mental Health Workers within CAMHS.

Trauma : Scottish PMHWs are pleased to see that trauma in the lives of children requires some attention. In our experience this often gets confused with challenging or difficult behaviour – but what of the child that becomes withdrawn and quiet e.g. and is not being identified as challenging and difficult. We feel that good support and networking (the type provided by PMHWs) can assist universal services to identify and intervene appropriately with these children. The Scottish PMHWs Network has evidence that PMHWs as suitably qualified clinicians have improved outcomes by delivering EMDR to children affected by trauma – this evidence should be developed and driven nationally.

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
Nationally, we suggest a refocus and return to promoting the benefits of the role of Primary Mental Health Workers within CAMHS and enforcing the priorities of the Mental Health Framework which indicates that 25% of all CAMHS activities should be primary mental health. The PMHW role has the following objectives :

- To support and strengthen current CAMHS provision through building capacity and capability within community and primary care staff
- To provide advice, liaison, consultation, supervision and training to tier 1 primary care professionals and other agencies who have a role in the emotional wellbeing of children and young people.
- To provide direct treatment of brief evidence based intervention to children and families

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 Scottish PMHW Network are pleased to see that trauma and developmental disorders are recognised by the Scottish Government as a priority. In our view all too often trauma can be misunderstood by referrers who tend to refer on the basis of challenging or difficulty behaviour. We believe that any attempt at early intervention has to move away from this and that trauma has to be better understood by professionals working with children. The role of the PMHWs includes providing a bridge from universal services into CAMHS for early years/nurseries/ and primary and secondary schools. Additionally PMHW have responsibility for providing training/ support/liaison and consultation on all aspects of childrens mental health incl developmental disorders. In areas where PMHWs are working to role, there is evidence of improvement in the confidence and capacity of wider childrens services.

The FPPC document also introduced a priority that each school in Scotland have a named mental health link worker. However, the Scottish PMHWs would like to note that the actual activities and role of what constitutes a named mental health link worker requires clarification. Local authorities also have "Emotional Health & Wellbeing" workers and some have School counsellors who have links to CAMHS. We are also aware that the Curriculum for Excellence has been implemented after 2005 therefore childrens emotional wellbeing it is not simply the responsibility of health and CAMHS services. There is a clear role for liaison, joint working between agencies. We feel the named mental health linkworker role should be scoped nationally and the role further clarified e.g. is it a named person that the school can telephone/of someone who works within the school interfacing directly with school personnel.

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 Scottish PMHWs Network is committed to sharing good practice in the delivery of training. PMHWs are already significantly involved in delivering

training to universal services on the mental health of children & young people, self harm and suicide.
We propose that the Scottish Government might approach suicide prevention in children & young people in a similar way to Child Protection, namely make ASSIST (Applied Suicide Intervention Skills Training) training mandatory in the same was as Child Protection Training is mandatory across universal services.

Further, that PMHWs in their role to increase the capacity and confidence of universal services could assist each school in Scotland to have a Self Harm Protocol in place (e.g. Walsh (2006))

Furthermore we believe that with a little investment in increasing capacity for training for trainers, training could be delivered to all S4-S6 pupils in SafeTalk.

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
We suggest that the Scottish Government might continue and build on its investment in parenting strategies for children & young people. We believe that one way to reduce stigma is to have parenting available at tier 1, or universal services within Schools and communities for example. This does not necessaryily need to be the role of CAMHS but part of universal provision. We are aware, for example, that the Curriculum for Excellence promotes a 'holistic' approach to health and well-being across the curriculum.

We feel that PMHWs within CAMHS should continue to be involved and trained in targeted parenting programmes but believe that the Scottish Government could encourage this to be a priority for local authorities to work jointly and that this is also not just a health priority. Often children with mental health difficulties are identified as "bad children" as they often exhibit challenging behaviour, yet those who withdraw are largely ignored as they do not cause any difficulties. As CAMHS referral systems depend largely on teachers noticing behavioural signs of distress in a classroom, we believe this does not allow for the full range of difficulties to be identified including early intervention. Where teachers' perceptions of mental health issues are allowed to dominate the referral process this takes place at the expense of offering support to those whose problems are less evident to teachers, or are not deemed sufficiently serious to warrant additional support. If allowed to develop a reputation as a place where teachers refer problematic pupils, schoolbased or other mental health initiatives can become stigmatised, discouraging children and young people in the wider school from seeking help of their own volition (see Spratt 2009 for further information).
The Scottish PMHW Network believe that further training, capacity building and understanding of the work of child mental health services as well as work across disciplines needs to be further encouraged.

The Scottish PMHWs Network would like to reinforce a children's rights

perspective to the question of stigma and working at the interface between schools and health. The Network would like to remind the Scottish Government that in some areas, PMHWs are based within schools and are attempting to develop less stigmatising services for children and young people. Practice based evidence and experience could be captured and shared.

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
The *See Me* campaign seemed to be directed at adults. The Scottish PMHWs Network are aware that some materials and web resources were developed for children e.g. *Just Like Me.* However this website has been down since Aug 2010.
A dedicated childrens anti stigma campaign linking bullying campaigns/self harm/and also young carers including those caring for a parent with mental health difficulties would be beneficial.
Children and young people who self harm will also tend to tell their friends first therefore there is good evidence that peer support project are advantageous.

The Scottish PMHWs would like to advise the Scottish Government that they liked, used and signposted to the Positive Mental Attitudes Curriculum Pack for Schools available on the *See Me* site. This is a teaching resource with DVD material which provides a structured approach to support teachers and other practitioners to engage with young people about mental health issues. We would like to see this updated and developed further.

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

Comments
Some Local Authorities in Scotland have Emotional Health & Wellbeing workers within Education Departments. We believe that the principles of the Curriculum for Excellence should be encouraged and enforced. To this end we feel that wider mental health and emotional health promotion should be carried out by other agencies allowing CAMHS to prioritise those most in need.

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
1. The Scottish PMHWs Network is aware of the lack of consistency in

terms of CAMHS provision across Scotland. Some do not accept direct referrals for under 5's and in some areas referrals of under 5's are routinely offered consultation with health visitor rather than face to face involvement by CAMHS. Rarely do CAMHS see infants under 2.
As a starting point we suggest that the Scottish Government undertake a scoping exercise on the provision of services to under 5's. We also believe that the needs of infants and under 2's are largely unmet. A true commitment to early years would see a rebranding of CAMHS to be **Infant** Child & Adolescent Mental Health Services.

2. The Scottish PMHWs Network would also like to see the Scottish Government consider access to a wider range of therapeutic interventions including psychotherapy, family therapy, and brief interventions as well as evidence based parenting programmes.

3. A Balanced workforce – We look forward to the introduction and reporting on the CAMHS Balanced Scorecard. However, early intervention is not necessarily cheap nor should be carried out by lower qualified members of staff.

4, As indicated elsewhere in this document, we believe that there is the infrastructure already in place within CAMHS in Scotland to increase access to appropriate treatment for children and young people and that Primary Mental Health Workers, working to role, can provide a bridge to tier 3 but also intervene at an early stage in problem cycle.

5. We believe there should be more joined up working and referral pathways from adult mental health services to child and adolescent mental health services. The mental health of infants, children and young people are often not taken into account when parents are being assessed or treated for mental health problems. The Scottish PMHW Network would like to see this becoming standard practice similar to other countries.

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

Comments

HEAT Targets : The Scottish PMHWs Network would like to suggest that a 26 weeks target for infants, children and young people is simply not good enough. Any service that aims to meet the needs of children needs to take childrens development into account and e.g. 26 weeks (6 months) in the life of a 3 year old is unacceptable in our view. Again, we feel there should be scope to promote the role of the PMHWs to include and prioritise the interface between CAMHS and early years services as well as times of transition including from nursery to primary

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

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

Comments
Parents should be able to access universal parenting programmes delivered in non stigmatising settings e.g. Triple P Parenting Programmes delivered within high schools not necessarily by health services. Health services could be involved in targeted interventions.

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
The Scottish PMHWs network feel that a focus on early years and early intervention has to be a priority but that this may require CAMHS teams to undergo some service redesign. As well as scoping and recording existing services for early years as already suggested, it would be important to note gaps in service provision. PMHWs have a remit for capacity building across agencies, educating other health and social agencies to recognise and manage concerns appropriately. As CAMHS currently do not routinely see those under the age of 5, we believe there is a training need and knowledge and skills gap within the wider CAMHS workforce.

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
The Scottish PMHWs would like some clarity as to what constitutes non-value adding activities. In some areas within Scotland PMHWs are activerly and routinely delivering a rolling programme of training for other professionals as well as teaching. Is this a non-value adding activity? The Scottish PMHWs network have evidence from training delivered to universal services that it can increase capacity and have a direct impact on other agencies confidence and practice when dealing with low level mental health issues (capacity building) however often if liaison is successful this can lead to an increase in referrals, contacts or consultations with other agencies. Therefore we believe there is perhaps an overreliance on quantitative data where indirect activities are unable to be recorded or evaluated.

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

Comments

The Scottish PMHWs believe this is a real challenge for health boards. However there is a lot to be learnt from how child protection protocols and strategies have been implemented within Scotland more wirely-this can also be seen in the way GIRFEC is being promoted and implemented. For example, more getting round the table with partners needed to improve working relationships, knowledge and understanding of each others practice and priorities to enable and nurture joint agendas/ developing pathways and signing up to supporting one and other.
Crucial to this is perhaps someone within each health authority that can take a lead role (similar to the CP Committees in each area). Within Scotland though, some areas have to work across boundaries and some have 2 or 3 local authorities to work alongside-therefore Integrated Care Pathways need to have a clear policy directive from the Government to the Local Authorities.
Integrated care pathways also need to exist between health departments eg: From adult mental health services to child mental health services if parents are being assessed for significant mental illness.
Data collection and information systems that are fit for purpose is also crucial. There is no one standard information system for CAMHS within Scotland, and it is our understanding that the eCare system and protocols are far from ready to be implemented.

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

Service user involvement needs to take a child developmental and children's rights viewpoint. For example, is it appropriate for children to be taken out of class to attend focus groups/user feedback? If held after school, this requires parental approval. CAMHS needs the support of the Scottish Government to put children's rights and needs first in capturing their views perhaps utilising technology and child centred resources.

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

Comments

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

We are encouraged by the Scottish Government's commitment to keep children out of hospital. However this requires access to intensive home treatment teams – again in some areas funding identified for this was not ring fenced.
The Scottish PMHWs Network would like to see more consistent delivery of mental health services even for those most ill, as a "post code lottery" still exists.

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?

Comments
We believe that mental health recovery is a concept and not a model therefore perhaps more training as to how this can relate to children and young people would be beneficial.

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

The Scottish PMHWs Network are aware that there is a clear link between poor recovery and poor socio economic disadvantage. As an example; in one area we have seen an increase in the rate of 15+ year olds referred for anxiety and stress related to exams. Young people disclose they are despairing about their future and feel hopeless and this manifests at a time when they become aware their education is coming to an end and they don't know where they are going. A high proportion of referrals to CAMHS are also related to family breakdown.
As support services are disappearing and refocusing we believe that childrens mental health becomes reductionist in nature/less about treatment and more about support.
We also feel that support needs to be offered for longer periods providing some containment for families-however we do not believe this is a role solely for CAMHS but should fall to wider welfare agencies. We believe CAMHS has a role in assisting those agencies and providing support, training or capacity building to increase confidence. A further example is the high level of children and young people referred for "attachment" related issues. In treating "attachment" the relationship between the child & carer should be considered the "patient" which requires a joined up approach to intervention. Social work departments currently do not see this as their role and that many attachment issues from the more complex to simple are viewed pathologically requiring health intervention and therefore referral to CAMHS. It is also our view that some social workers and social work departments take a case management approach whilst some intervene. If coming from a case management approach, childrens long standing poor family dynamics, lack of resilience and severe neglect is reduced to a referral to CAMHS re bereavement (or attachment).
We believe the Scottish Government need to work with local authorities to be clear about their wider welfare role and responsibilities and the tendency now to open and close cases quickly due to demand. Many families require long term support from welfare agencies.

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

It is our experience that confidentiality around the issue of children is poorly understood by professionals and organisations. GIRFEC can be implemented differently by Local Authorities and in some CAMHS teams, as

they work across boundaries, this can lead to inconsistencies confusion and different systems and procedures even within the same CAMHS team. We believe that COSLA or the Scottish Government might assist LAs to prioritise information sharing systems and clarifying confidentiality to make this universally understood e.g. if professionals do not understand it-how can families.

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
The Scottish PMHWs Network is committed to keeping children and young people out of hospital. We believe better and more consistent access to intensive home treatment teams for those most ill should be a priority

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

At the moment we are not aware of any CAMHS team who is using or gathering this information. Data collection and ifnromation sharing systems are not consistent and many currently being used are not fit for purpose.

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

Comments

The Scottish PMHW Network exists to sharing information, disseminate learning around the primary mental health task and role.

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

Comments

The Scottish PMHWs Network believe that without an understanding of what constitutes the role, function and core business of CAMHS there will always be gaps in service, and in some areas significant gaps. For example in some areas learning disability CAMHS provision is sketchy or non-existent. We also believe there are gaps in provision for post counselling for parents following diagnosis of developmental disorders, and support and joint review when comorbidity exists. Many areas do not undertake direct work with under 5's and many have no access to intensive home treatment teams.

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

The Scottish PMHWs Network believe that this requires more joined up working and thinking. As an example, there is a high prevalence amongst children referred to CAMHS and parental mental illness-yet there is NO protocol in place when an adult who is being assessed for mental illness is identified as a Parent. NHS Boards need to be supported to implement inter professional and intra professional boundaries.
It is also our experience that integrated teams can only be effective if they are integrated within the same geographical location. Many CAMHS teams work across Local Authority boundaries offering a service to 2 or 3 local authorities within the one Health Board.

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

The Scottish PMHWs Network would like to highlight the evidence around parental mental illness (ODPM 2004: one third to two thirds of children whose parents have mental health problems will experience difficulties themselves).

Similarly parental mental health is a significant factor for children entering the care system. We believe that the needs of the looked after population of children, both at home and away from home, needs to be prioritised by CAMHS. However this should not be at the expense of primary mental health working and vice versa. Promotion prevention and early intervention requires to be available in all areas within Scotland. Due to the nature of the post, PMHWs are well placed to work with other agencies and deliver an integrated approach to mental health service delivery. We believe that CAMHS need to be encouraged to allow their tier 2 workers to work to role and return to the priorities within the FPPC document that 25% of all CAMHS activities should be primary mental health. A robust investment in tier 2 will allow the work of tier 3 to become more focused and matched to what referrers are looking for.

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

Better access and investment in training and Continuing Professional Development.

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

We feel that the current RTT data collection serves to mask significant gaps in service provision. For example if CAMHS do not have access to a LAAC team, family therapist, psychotherapist, parenting groups or tier 2 PMHWs – assessments becomes focussed on identifying a mental health disorder and if none exists discharged. Data re the lack of availability and access to appropriate evidence based psychological and other interventions goes unrecorded as does the lack of availability to appropriate evidence based interventions.

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 access to training in wider psychological therapies e.g. EMDR, Baby Observations, Parenting approaches to name but a few.

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

We believe that currently the reporting on ISD is inconsistent and is masking significant gaps in capacity, activity and accessibility. This should be a priority for the CAMHS Stakeholders Group and the CAMHS Lead Clinicians Group.

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

Comments

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

The Scottish Government have given a commitment to reduce senior management posts by ¼.

This means that middle managers within the NHS have inherited these duties some ill prepared or ill trained. We feel there should be increased investment in mentoring, leadership and management training for all managers within NHS.

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

Comments

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
Childrens rights is a contentious issue, as they are different from the rights of adults and require special and separate consideration

Jacqueline Sproule, Chair of Scottish PMHWs Network
ON BEHALF OF SCOTTISH PRIMARY MENTAL HEALTH WORKERS (CAMHS) NETWORK
16.1.12