MHS050

HOPS

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Consultation on Mental Health Strategy for Scotland – Response from Heads of Psychology (Scotland) (HOPS)

The Mental Health Strategy for Scotland has been a key focus of HOPS deliberations in recent months. This culminated in the strategy being discussed in some detail at the HOPS Meeting of 17th & 18th November 2011. Thanks to Penelope Curtis for her useful contribution to part of this process.

HOPS decided to concentrate on a number of key questions posed in the strategy.

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

Given the wealth of high quality psychological research that increases our understanding of what influences behaviour, we are in a good position to integrate these behavioural insights into public health to promote wellbeing. There are many good examples that demonstrate how public health interventions are more effective when behavioural research is used appropriately. For instance, relating to smoking cessation, the evidence shows how combining behavioural and pharmacological support gives smokers a greater impetus to quit. Furthermore, social psychology indicates that using social norms can be an important way to influence behaviour. This understanding could be used with approaches to reduce excessive alcohol use, to increase understanding of actual levels of alcohol intake; some studies have indicated that people overestimate how much others drink and this leads to greater personal use. This understanding is being incorporated into the 'Drinkaware Campaign' in Wales.

In healthcare, behavioural approaches can offer practical approaches to increase quality of service provision as well as being cost effective. Health psychology research has shown how prescription charts are often completed incorrectly and not updated, current work is underway in some pilot sites to simplify and improve the use of such medical records. Routine use of screening tools (such as the distress thermometer) to identify patients' key concerns has led to improved patient wellbeing. Shared decision making is a key tenet of the Quality Strategy; research demonstrates that when patients have a good understanding of the benefits and difficulties of an intervention, they tend to have stronger adherence to the treatment chosen, opt for more conservative approaches as well as have improved outcomes. Studies conducted in Oncology showed that some patients regret the treatment choices taken, if they have not been able to participate in shared decision making. Psychologically informed interventions have demonstrated that the systems of care can be adapted to accommodate greater shared decision making which leads to improved outcomes and patient satisfaction.

1. Support for web based delivery systems for mental health resources. There are many of these in use. Their purpose is to deliver information and resources in relation to mental health. They are designed to provide:

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a. Information on general mental health and well being.
b. Specific information on mild to moderate mental health problems.
c. Self help guides to assist people to deal with common mental health problems
d. Links to CBT online e.g. Living Life to the Full, Mood Gym.
e. Lists of recommended books in relation to common mental health problems.

Scottish examples of these delivery systems are: edspace (www.edspace.org.uk/), Moodjuice (www.moodjuice.scot.nhs.uk/) and Moodcafé (www.moodcafe.co.uk/). These are were developed with a lot of input from psychology services and are maintained by them at Health Board level (Lothian, Forth Valley and Fife respectively).

2. National consistency would be very helpful for the maintenance and continued function of these sites. The Health Boards who have developed good sites might be encouraged to engage in the development of a single web site which could be supported nationally at minimum cost, saving resources at territorial Health Board level.

3. Local integration of web sites into provision of services for mild to moderate mental health problems has been shown to be useful and cost effective, for example,

- Forth Valley uses no self help workers and has assisted GPs use the Moodjuice self help guides as part of their pathway for treatment of the milder MH problems.
- The Glasgow STEPS service uses its site to provide information on additional services at the mild to moderate level, for example, Stress Control or Mindfulness Groups which are delivered on a multi agency basis locally.

If supported at a national level a powerful set of interventions at tiers O (those who are well), 1 (those who are in the process of developing mild to moderate mental health symptoms) and 2 (those who have already developed symptoms and who can be managed through minimum intervention in the community) would be available for those Boards that wished to develop them. This may be in addition to or instead of their existing services at these levels

Question 7 : **What additional actions must we take to meet these challenges and improve access to CAMHS**

- The continued monitoring of workforce data is welcomed.
- There is a need for continued emphasis on upskilling areas of CAMHS workforce to deliver evidence-based treatments
- There is also the need to monitor whether increases in workforce relate to increased delivery of early years agenda
- Psychological therapies heat target monitoring is welcomed in relation to delivery of evidence-based therapies by appropriately trained and supervised staff.

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?**

- Within primary care, designation of a named mental health professional to link with the PCT and advice on case management, referrals and intervention is an effective way of ensuring the right people are referred to the right service at the right time.

Ideally this liaison person is based within the primary care premises some of the time to foster good working relationships with the PCT.

- Within the acute hospital service, mental health liaison is equally important though currently patchy. Its absence leads to inadequate/inappropriate treatment as mental health needs are overlooked/misunderstood; it also leads to unnecessary bed-blocking and poorer outcomes for patients.
- Further development of a skill mix operating within a matched care system of service delivery, with adequate clinical supervision to ensure quality is maintained.

Question 12 : **What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spend on non value adding activities?**

- NHS Boards would be aided by guidance on more targeted implementation of monitoring targets and mandatory training. A number of centralised monitoring exercises appear to make little difference and little feedback is received..
- Ensure clinical staff are not spending time doing their own admin/typing when there are skilled staff who are more efficient at those tasks and who costs less. There are a number of mew electronic systems which both staff and managers have to use which require additional time which may save time for some other part of the NHS system but require more time of clinicians. Admin staff must be retained to support these functions.
- NHS Boards may need support to disinvest decisively and quickly from programmes of activity which clearly do not add value.
- Consideration might be given to ensuring methods of clarifying that interventions delivered from all professions to patients with mental health problems is evidence based and that these staff are competent to deliver it. If this is not the case resources could be transferred or competence and governance increased.

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

With regard to the services highlighted, within older peoples services we believe that non dementia needs of older people should be prioritised alongside the clearly identified dementia needs. Looked after children also appears to require further prioritisation in service delivery..

ISD information clearly indicates service inequalities across Scotland in a number of specialties with regard to psychological services. Significant gaps in NHS Boards within already prioritised services should be addressed.

There are significant gaps in psychological services for physical health, forensic, addictions, brain injury, inpatient major mental illness and in medically unexplained symptoms. HOPS particularly emphasised the link between personality disorder services and medically unexplained symptoms noting that this group provided significant challenges to both primary and secondary care services. HOPS were clear that medically unexplained symptoms should not be equated with the work of the functional neurological symptoms work stream.

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?**

We need to give priority to meeting the psychological/mental health needs of older people with physical health conditions in acute hospitals, day hospitals and other rehabilitation settings. Rates of mental health difficulties are known to be much higher in older people suffering from long term conditions (eg COPD, stroke, Parkinson's disease, and this in turn affects patient outcomes, with an associated increase in costs.

Awareness of the needs of people with dementia in acute hospitals is vitally important, but there is also a requirement for training of all acute staff in basic psychological awareness. This is true across the age range but is particularly true for older people who may have multiple health conditions. The effectiveness of physical health interventions is likely to be compromised if the patient's psychological state is not taken into account when making treatment and discharge plans.

Mental health liaison services to acute hospitals are very patchy and often lacking. Appropriately resourced liaison services would allow not only direct referral of patients but embedding of psychological understanding through consultation and 'hands on' training for acute staff.

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

The Heads of Psychology Services in Scotland would firstly acknowledge the valuable contribution already made by NES, and particularly by the Psychological Interventions Team, in supporting Health Boards in increasing their capacity to deliver psychological therapies. The willingness of NES to consult with Boards and local services on priorities for training in psychological therapies has been welcomed and appreciated. However, to date, many of the training workshops commissioned or delivered by NES have tended to be short (1 to 3 day) events without any formal means of evaluating or measuring knowledge gain or skills acquisition among those who participated in them. Whilst we recognise that many of these workshops were introductory in nature and not intended to provide a formal training in the delivery of any evidence based therapy, we believe that it will be important for NES and Boards to be allowed and encouraged to collaborate in developing a longer term strategic plan for the sustainable delivery of formal training in a range of psychological therapies to established standards. We envisage that this will require more detailed planning by Boards to anticipate and identify their future needs for training in specific psychological therapies which would in turn inform decisions made by NES regarding investment in future training. Since the achievement of the 18 week RTT HEAT target is very probably going to require an increase in practitioners with accredited training in a range of modalities, we believe it will be essential to allow NES the flexibility to commission such training which may extend beyond a single financial year and include a need to fund significant supervision costs as part of supporting staff in training to achieve required standards for accreditation. We also recognise that there will be a continuing need for shorter training modules which are more aimed at increasing the psychological literacy of the NHS workforce but we believe that the use of modern technology such as e-learning might usefully be harnessed to enhance access, maintain standards of training delivery and, in the long-term, prove to be more cost-efficient than repeatedly organising short workshop based events around the country.

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