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.

General

1. We found the consultation paper extremely difficult to read. This was not only because of the number of long words and long sentences with little punctuation, but because it contained a lot of NHS jargon. This was particularly the case in the *What we have Done* sections. As a voluntary sector organisation providing services in the community we had not even heard of many of the initiatives referred to, still less know what they involved. It must have been even more difficult for the general public. It was particularly unfortunate that the "Easy Read" version was not published until nearly 3 months after the original. By this time we had given up looking for it and had consulted our service users on the full version, having to extract some of the questions for our own easy read version when this produced no response.

In order to engage all those who will be involved in implementing the Strategy, it should be written in plain English.

2. The introduction recognises "the importance of partnership working – with service users as well as service providers – and includes local authorities and the third sector too". This is vitally important, but even this wording implies that the NHS is the focus. The remainder of the strategy document makes disappointingly little reference to services outwith the NHS. As recognised in Towards a Mentally Flourishing Scotland, there is more to mental health than absence of mental illness. It derives from a number of factors including having satisfying relationships, a role, feelings of achievement and self worth, hope for the future, feeling recognised and valued as people, feeling a degree of control over our lives and having access to activities we enjoy. Some people face greater challenges than others as a result of any combination of biological, social and psychological factors. The type of support needed to help them overcome their difficulties may range from simple, practical help to highly specialised professional services. People with enduring mental illness, in particular, may move between social services and health services, or receive both at once. Simple, practical help at an early stage may prevent the development of more severe mental health problems at a later stage.

A coherent mental health strategy needs to be wider, covering both health and social services, whether provided by the statutory, the voluntary or private sector, as well as education, employment services and wider society.

3. The number of recent initiatives and reports referred to in the document is a testament to the amount of interest and activity in relation to mental health at Scottish Executive level. We find this very encouraging. There is, however, a risk of this being seen at grass roots level as a scattergun approach, with a host of apparently unrelated initiatives; or of those at national level thinking that the introduction of a new initiative means that the problem has been solved. We believe that mental health services are moving in the right direction, but there needs to be a clear understanding at all levels as to what that direction is. There also needs to be a follow up of initiatives, to evaluate their effectiveness and to ensure they become embedded in standard practice. A Strategy for mental health in Scotland provides an opportunity to help everyone to understand where their own contribution fits in to the overall plan, and how the different initiatives fit together. In the consultation document we were struggling at times to see how the outcomes related to the introduction, and even how some of the questions related to the outcomes under which they were placed.

The introduction needs to include a clear statement of principles or values underlying the whole strategy. These should be simply worded, and preferably memorable. They should be included in the introduction of all new initiatives or policy documents during the life of the Strategy, and it should be clear how any new developments relate to them.

The Outcomes:

These are very general and vaguely worded. They seem to be based on the idea of progression through NHS services from first contact to end. This is too narrow (see above).

This concept also gives inadequate recognition to the cyclical nature of severe and enduring mental health problems or the need in some cases for continuing help and support, which needs to be flexible over time in both level and type.

We are disappointed that the Executive appears to think that *Towards a Mentally Flourishing Scotland* has now been implemented. We are pleased that the specific Government Commitments included in the Action Plan 2009-2011 have been acted on, but these were only first steps towards implementing the full policy. We felt that TMFS was an excellent document, and there might be a case for keeping the same basic structure for perhaps a *"Next Steps Towards a Mentally Flourishing Scotland 2011-2015"*. This would make it much easier for those tasked with implementing the strategy, and enable them to build quickly on what has already been achieved. We are particularly concerned that the *Priority 6: Improving the Quality of Life of those Experiencing Mental Health Problems and Mental Illness* appears to have been dropped. There are a significant number of people with severe and enduring mental illness who are existing in the community with an extremely poor quality of life. Recent cuts in social work budgets have resulted in cuts in services for these people. Some were already receiving a minimal service and others fall through the net entirely.

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

This is a major challenge, especially, as noted, where services cross organisational boundaries. In the current economic situation we believe that cuts in Social Work funded services will put additional burdens on health services and vice versa. We believe that the single most useful change to improve the likelihood of limited resources being used most effectively would be to have **a single budget for mental health services across Health and Social Services.** This is something that has been talked about for many years, but never fully implemented. We were very pleased to hear recently of proposals to implement this for Dementia services, and look forward to learning more details of how this works in practice. We would like to see this for all mental health services. There will need to be clear lines of accountability and responsibility, including an individual with the authority to make decisions.

There also needs to be a shared language between those working in different organisations. Joint training may be one way of helping to achieve this. The Scottish Recovery Network has been particularly effective in this respect.

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

There is a huge amount we do not know about what services would produce the best outcomes, and much more research is needed. At present the majority of research in the mental health field is funded by the pharmaceutical industry, which inevitably produces an imbalance; medication is important for many, but is only one of a range of possible tools in improving mental health. There is scope here for greater partnership working with universities, perhaps in accessing postgraduate students at low cost?

As a first step there is a need to **encourage innovative approaches driven from the bottom up**. Those at grass roots are in the best position to know what is needed. Indeed, two of the most rapidly spreading approaches in recent times have originated from the service users themselves. Beck has said that he is often wrongly credited with inventing cognitive therapy, but that he learned it from his patients and merely wrote it down[1]; and the Recovery movement originated with service users. There must be flexibility for different approaches to be tried with minimal red tape initially, and to discontinue them quickly if they do not seem to be working. Once an approach does appear to have benefits, a more formal evaluation should be carried out.

Financial Issues:
There is a very real problem here. We strongly support early intervention, and agree that it will save money in the medium and long term. The benefits, however, will not come through immediately, as those who have already developed more severe problems will still need to have services provided. There is a need for investment in the short term to provide savings in the longer term.

We recognise the difficulty in this in the current financial climate but believe this short-term investment will be highly cost-effective. We believe there may even be a case for allowing an increase in council tax to achieve it. Alternatively money might be diverted from elsewhere. Time and again over the years, from the money released by hospital closures onwards, we have regularly seen the opposite happening, with money previously earmarked for mental health services being diverted to fund other priorities. Our most recent example of this relates to our counselling services in a regeneration area of Aberdeen. These were funded from the Fairer Scotland Fund, but as soon as this money was devolved the local authority proposed cutting funding by 42%. We recognise that local authorities do not like ring-fenced money, but believe that some ring fencing is necessary to ensure the investment is made.

Another financial challenge will arise if Self Directed Services are introduced as default for

[1] From a lecture given by Aaron Beck to the Mental Health Department at the University of Aberdeen

a wider range of people with mental health problems receiving social support services. We support the principle of greater choice and control, but it must be recognised that if these people are to be given as much support as they need to choose and manage their care, as promised, this will not be cheap. If the funding comes out of the current allocation for mental health services there will inevitably be less available to provide the services.

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

It is good that suicide rates have fallen, but we fear it may be more difficult to reduce them in the immediate future because of the economic situation and the links between unemployment, financial difficulties and suicide. Any initiatives that are successful in encouraging increased employment are likely to help. Other negative factors may include the increasing atmosphere of blame for people on benefits and cuts in services.

There is a need to target at risk groups, e.g. those with a known mental health or drug problem, especially young men, those who have made a prior suicide attempt and returning servicemen. There is a continuing need for awareness raising and multi-agency training.

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

Questions 4 and 5:
People with mental health problems still face enormous stigma, discrimination and bullying. We have been appalled by reports from some of our services users about the ways in which they have been ostracised, made fun of, even threatened, when in normal community facilities. They all face the problem of whether or not to admit to a mental health problem at work or when applying for a job. Those with a mental health problem are more likely to lose their job than those with a physical health problem, and someone with a break in their work history as a result of a mental health problem is less likely to be able to get a job than someone who has had a similar break as a result of being in prison.

These attitudes will not be changed overnight, and there is a need for continuing to plug the anti-stigma message, using the best marketing skills. The message needs to be taken to where people are, e.g. on buses, billboards, TV etc. as widely visible as possible.

There is also a need to move beyond "See Me – I'm a person" to Hear Me, Respect Me, See what I have to offer. The increasing willingness of celebrities to be open about their own mental health problems has been extremely helpful. There needs to be more publicity about the achievements of people with mental health problems. There have increasingly been exhibitions of art works by service users. Perhaps this approach could be broadened to other areas, with national competitions, e.g. for the people with mental health problems who have contributed most to the community?

Employment services have a key role to play in combating discrimination in the workplace. There need to be more mental health specialist teams offering Individual Placement and Support, providing support to both the employer and the employee. Not only will this increase the number in employment, but positive experience of employing people who have, or have had, mental health problems will reduce prejudice both among employers and fellow employees. At present the new Work Capability Assessments may require a person to attend work related activities, but these are not widely available.

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 national campaign must be rolled out more at local levels across all communities in Scotland, in order to take full effect and for communities to take responsibility to carry the agenda forward. Public Health and Community Planning groups could take a more active role with this in joint working with all partners and stakeholders involved.

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

Comments

Whilst good work has been done in response to TMFS in relation to developing models, frameworks and information, there is still a need to follow these through and implement them. The fact that the specific commitments in the 2009-2011 document have been carried out does not mean the job has been finished. The work already done needs to be built on and used. Local authorities and health boards could be asked to report on progress.

There needs to be a lot more publicity and active mental health promotion. This should be noticeable, eye-catching, amusing … anything which works.

Actions to help promote mental wellbeing could include more education on mental health and mental ill health in schools. Good employment practice should be encouraged, both to reduce stress in the workplace and to support those who are suffering from mental health problems. The NHS and Local Authorities should take a lead in this. Other options could include a range of educational groups in Community Centres covering topics such as anger management, stress reduction and stress management.

We strongly support the promotion of mental wellbeing, and fear that this will be seen as low priority locally as cuts in expenditure are being made. Community education sessions have been significantly reduced in Aberdeen, in particular, and some community centres have been closed. With enforced cuts in expenditure the eligibility criteria for people to receive social work services has been raised, so that only those who are rated as at high risk are receiving any services. Those rated as at moderate risk are no longer eligible. It is difficult to see decision makers prioritising mental health promotion in these circumstances. There is a need for ring-fenced monies to ensure this work continues.

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

Questions 7 and 8;
This outcome is very broad, presumably covering a range of ages and a wide range of difficulties, e.g. young children with challenging behaviour, children with autism spectrum disorders, troubled teenagers, young carers, children brought up in a chaotic family environment with drug or alcohol addicted parents, who may have very different needs.

We are pleased that HEAT targets have been introduced, but 6 months is a very long time in the life of a child, and they need to be further reduced as soon as possible. This part of the consultation Strategy is particularly NHS orientated, being almost exclusively about CAMHS. The quickest and most cost effective way to reduce the waiting times may well be to provide a lower tier early intervention. For younger children the problem is often related to parenting difficulties, and more support and advice at an early stage could resolve problems and prevent them from becoming more severe and entrenched. The voluntary sector could have a clear role in this, using trained and supported volunteers, and projects such as Home-start could be expanded. This could reduce the number of problems needing to be referred to CAMHS, who should be dealing only with the most complex and serious problems.

Our own experiences providing counselling for children and young people have taught us that services should not be based in the school. Some children are unwilling to be seen to be attending, some see the school as a hostile environment, and some of those most in need have been excluded.

There is a need for dedicated services for adolescents, not merely specialist inpatient beds.

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

Comments

See above

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

Questions 9 and 10:
This outcome is closely related to outcome 1 in relation to education and stigma.

You report that the Living Better initiative is currently operating in 6 Community Health Partnerships. Has it been evaluated? If it is working well it should be rolled out to other areas.

As noted in our introduction, we have not heard of some of the initiatives mentioned here, so they need to be better publicised. The noted lack of referrals to Living Life, for example, may well be because it is not well enough known. There is a need for wide and continuing advertising. We have found that enquiries to our information service increased significantly when we flooded the local area with our business cards. These were given to all relevant professionals and placed everywhere we could think of where people congregate – doctors' surgeries, community centres, libraries, cafes and shops. Places of worship could also be included.

A similar approach could be taken to providing leaflets on dealing with the commoner mental health problems. There is a need for more active positive mental health promotion at a national level.

There is no mention made in this section about helping people with severe and enduring mental health problems to recognise when they are becoming unwell and take appropriate steps to seek the help they need. We support the approach taken in the WRAP, and would like to see wider use of this tool and the principles behind it.

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

Comments

See above

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

1. In spite of the National Standards for Crisis Services. We have had problems accessing services quickly when people with severe and enduring mental illness have a relapse in their condition, whether this is at crisis level or not. Our service users have also had problems accessing services.

For example, recently a resident in one of our supported group homes became acutely psychotic on a bank holiday weekend. In spite of the fact that all those who had seen him, including the duty doctor at GDocs, were very concerned about him, the duty psychiatrist refused to see him unless he were considered sectionable. Only after the holiday, when his own consultant was back on duty, was he admitted to hospital immediately. Meantime the other residents were subjected to significant stress and we had concerns for their deteriorating mental health. Delayed response to a mental health relapse also generally results in a need for a longer stay in hospital. A reply to our letter to a senior Consultant Psychiatrist expressing our concerns over this incident revealed that there was a system whereby a patient could be placed on an "enhanced access list" which could have enabled immediate assessment by the ward in which he was known. He was not then on this list, and neither we nor other voluntary organisations were aware of the list's existence. More collaboration is required between the statutory and voluntary sectors.

2. We are pleased that HEAT targets have been introduced, but they are still too long. Until they can be further reduced there is a need for some form of support to be available while the person is waiting to be seen by NHS services.

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
We are not sufficiently in touch with the process to advise on what is needed, but we do know that the ICP is not always working as intended. The worst example was when a patient was discharged after a period of several months in hospital, without his family or any of the services which had previously supported him being notified. He was left at a bus stop to catch a bus to Banff (journey of about two hours), then another bus to a rural area, to arrive home to an empty house with no-one to welcome him, no appointment for any contact from previous services, no heating on and no food in. The experience was so stressful he had another breakdown and had to be readmitted to hospital. Another of our service users arrived home to find they had no electricity as it had been cut off while they were in hospital.

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

1. When we asked our service users about this their immediate response was: "*Listen* to us when we give our views". Their impression is that if their views do not fit with current policy they will not be heard.

One example of this relates to day support services in Aberdeen. Until recently there were two day centres in the city, both providing recovery orientated support, with individual Care plans, specific needs-based and recreational groups, and drop-in sessions. The local authority decided to discontinue the contracts for both services and invite a tender for one larger service. The service users were very concerned about what the nature of that service would be. They sought the assistance of the Advocacy Service to help them write a letter to the social work department stressing the importance to them, whatever organisation was running the service, of having a drop in facility, where they knew they could receive support as needed if feeling unwell. A place they could feel was "theirs", where they could feel safe, be accepted for who they are without having to hide their mental health problems, and where they could meet and make friends in a mutually supportive environment. The Social Work department at Robert Gordon's

University carried out research with focus groups from both centres, which came up with similar themes. This is contrary to current thinking which is to move away from so-called "buildings based services". The commissioners awarded the contract to an organisation that did not propose to provide such a facility. Ironically, the invitation to tender stressed the importance of service users being listened to and having a say, but the commissioners did not appear to see that this should also apply at commissioning level.

2. Service users also complained that consultation documents are generally difficult to understand, assuming knowledge they do not have, and worded or structured in ways they find difficult to relate to. We find this too. Rather than having a different easy read version, would it not be good practice to write the original in plain English?

3. Some service users are willing and able to attend focus groups or committees, but many do not feel able to do so. It must be recognised that those who do are not necessarily representative, and the more vulnerable may have different views. They point out a need to avoid excessive consultation, as the feeling of responsibility can increase levels of stress. "I come here because I am feeling fragile and need care and support. I don't want more responsibility." Tapping in to existing meetings in individual projects is likely to provide the widest representation of views.

4. Most find it much easier to give views on their own care than think at national policy level. We are impressed by the Recovery approach and the use of the WRAP. We have also recently been piloting the use of the Mental Health Recovery Star with those attending our day support services. This has been very well received by service users and works well in conjunction with WRAP

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

Comments

We find the emphasis on tools difficult to relate to. What is needed is for people to listen to one another and treat each other with respect. It helps if professionals ensure that participants are fully involved, and avoid talking over their heads or using jargon. There seems to be increasing emphasis on systems, when what is needed is warmth, genuineness and accurate empathy. This may sound old fashioned, but there is continuing evidence that these are more important to therapeutic outcome than the therapeutic framework used.

There is a distinct call from relatives/families of service users for their role to be more valued and recognised by the statutory services. Co-working between

informal and formal services has great potential to assist those recovering from mental health problems, but carers report that they are rarely systematically included by clinical or social services in discussions about recovery. Carers can be a valuable resource both in their in-depth knowledge of the service user and in their role in treatment and recovery. Yet they frequently sense that they are related to in negative terms by clinical or social services, and feel that these services do not assist with the intensive recovery work the carers themselves undertake. They would find it helpful if professionals included them more and removed some of the barriers to working together, often raised under the guise of confidentiality. Carers would find it helpful if they were asked for ideas in the process of problem solving. Most carers are concerned that the person behind the mental health problem should be visible to the formal care providers, as this helps in creating a personalised treatment/recovery plan; carers feel that a more personal approach is needed to learn about the person, not always concentrating on the illness.

Carers tell us they have specific needs that they feel clinical and social services should be meeting to assist them in their role These centre round initial, early and ongoing education, to include:

- Information about specific mental health problems
- What to expect, when to intervene and when to leave alone
- Treatment modes, medication and side effects

Education, information and training should concentrate specifically on directing the efforts of carers to be most effective. Carers' support groups provide an effective forum for such education, which is key to recovery based practice.

Another point raised by carers is that support services for their loved ones should remain consistent, not only when crisis occurs but also when recovery begins. Carers report that often support services seem to retreat at the first signs of recovery, when longer term support is needed to secure prolonged recovery. They also report that often, once a clinical/social support service has been withdrawn, it is difficult to get them to engage again for early intervention in crisis situations or if a breakdown in mental health has recurred.

See also comments on training in question 16 below.

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

It takes time to embed new approaches, and the introduction of too many separate new initiatives in a short time can distract from this. There is a need for ongoing training for staff, and this should be multi-disciplinary and multi-organisational. This would ensure that partners have a shared understanding and vocabulary, and a better understanding of each other's roles. There may also be a case for educating carers and service users. Most of those with severe and enduring mental illness have been exposed only to the medical model, and they and their carers may have

little hope for recovery, and demand little from services other than medication.

The best way to engage others in embracing new approaches is to use those who have enthusiasm and experience in using the new approach, and who can answer questions about details of how they put it into practice. Grass roots staff are often sceptical about dictats coming from above. Where possible service users and carers should be included as trainers, as they can explain the difference it makes to them and guard against the discussion becoming too profession focussed.

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

Comments

Questions 17 and 18:
There needs to be a lot more publicity about it – and not only within the NHS. Training sessions should be multi-disciplinary and multi-organisational (see above), provided within the local area and should be free. This is particularly important for the voluntary sector where budgets for training have often been a casualty of funding cuts, and where it can be difficult to release more than a small number of staff from front line duties at any one time.

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

Comments

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

See answer to question 15

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

See answer to question 15

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

We are somewhat concerned at the apparent assumption that the fewer the acute beds the better. There is still a need for inpatient beds when a person is acutely unwell.

Where there has been a redesign of services there needs to be an evaluation of the effects. This should not only include the success of the new services in helping those in contact with them, but also follow up those who were in regular contact with the old services, or would have been, to ensure they are not falling through the net.

Again the references here are all to the NHS. The local authorities and the voluntary sector play key roles in providing community services. It is vital that those planning mental health services are aware of the need to look at the whole picture. The level of support services provided and/or funded through social work departments, in particular, are key to the success of a community mental health service. This was much more clearly recognised in *Towards a Mentally Flourishing Scotland*, and we are concerned that the proposed Strategy is moving in the wrong direction in this respect.

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
There is a need for information to be collated across organisational boundaries to identify people who are dropping out of services and falling through the net.

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

Comments

There is good work going on, but health professionals and other agencies need to be more alert to cultural issues, for example. There is a need for ongoing awareness training with input from minority groups to highlight areas of concern.

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

Comments

1. There is a huge need for more mental health services in prisons, delivered in a way that will allow a seamless continuation of service in the community after the person's release.

2. There is a need for better services for people with long term mental health problems who are currently just existing in the community in social isolation and with a very poor quality of life. These are some of the most vulnerable members of society, who find it difficult to seek out services but are not actually causing problems to the authorities, so are easily overlooked. They are also the ones most likely to be the victims of abuse or exploitation. They require an assertive outreach approach to engage them in services.

3. We are concerned that some people with a dual diagnosis of Learning Disability and Mental Health problems may not be receiving appropriate services in some places, especially as tightened budgets lead to tightened criteria to access services. In Aberdeen City, for example, a reconfiguration of services has resulted in more stringent criteria for day support services for those with mental health problems, which now exclude those who also have a learning disability. We are concerned about our former service users, but do not have the information to know to what extent this is a problem (see question 22)

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

We are unclear as to whether we, as a voluntary sector provider, are included in your definition of mental health services. The wording of the question and the reference to *NHS Boards* working with their partners implies that you are referring only to NHS mental health services, but we would consider our services, as a voluntary sector provider, to be integral to mental health services locally. We also believe that we are generally recognised as such. This needs to be clearly recognised at all levels.

A single mental health budget to cover services provided by health, local authority and the voluntary sector, as suggested under question 1, should ensure that commissioners look at the whole picture and work together to provide care across organisational boundaries.

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

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

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

Again, we are unclear as to whether the survey is proposed to include only health service staff. It should also include social work, voluntary sector and private services employed in GP surgeries.

For example: We currently provide a range of counselling services carried out by trained and supervised volunteers. We believe this provides excellent value for money.

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

Comments

Training budgets in the voluntary sector tend to be a casualty of reducing funding, in an effort to ensure continuation of front line services. It would be very helpful to smaller organisations, in particular, if they could have access to training being provided in the statutory sector (health and social work). We have made reference in earlier questions to the advantages of multi-disciplinary, multi-agency training. It would cost little (perhaps even nothing) to include one or two staff from voluntary organisations in training sessions already being provided. On the other hand small organisations may have difficulty releasing more than a small number of staff from direct client contact at any one time, which makes organising their own training disproportionately expensive.

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

The collection of information is very important and we welcome the work that is being done. We support especially the inclusion of outcomes, not merely activity, and the indicators to assess the population's mental health. The measurement of outcomes is not easy in person centred services, as the goals for different individuals will be different. Perhaps some combination of monitoring progress towards achievement of goals and a very general measure of mental health would be the best approach, but see question 32 below

We are glad that the benchmarking will be extended to social work services as benchmarking of NHS services provides only half of the jigsaw. The source of funding of services provided by the voluntary sector is often the result of historical factors, including former earmarked funds.
Example 1: We provide 8 counselling services across Aberdeen and Aberdeenshire. Some of these are funded solely by the local authority (from former FSF funding), some are funded jointly by the Health Board and local authority, and one is funded solely by the Health Board.

Example 2: We have made assertions earlier about money originally spent on

mental health being diverted to other areas. Whilst we are convinced from our experience that this is the case, we have not been able to provide evidence because information on the money spent on mental health services by local social work departments has not been available.

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

Comments

It is important that it should not be too time consuming nor too onerous for the service user.

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

A change to more flexible contracts for supporting people in the community might help in this respect. The current norm is to fund support for a set number of hours per week. As noted earlier, severe and enduring mental illness is often cyclical in nature, so that more support is needed at some times than others. This encourages providers to continue to provide the allotted hours at times when they may not be so necessary, for fear that it will be difficult to regain the funding for more hours when it is next needed. The opportunity to provide an average number of hours over a longer period, and/or to vire support between service users when required, would provide more flexibility.

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

Comments

Make it clear how the different programmes link in with the principles and direction of the overall strategy. Ensure that the integrated training and consistent terminology is not only between programmes, but also between organisations.

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