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.

Broad outcomes although resonate with coexisting health care strategy there are some perceived gaps. Physical health needs/ care is considered a major gap throught this strategy despite escalating evidence around morbidity/ mortality in those with severe mental illness and potential service gaps. One example offered by our Area Dental Committee being that dental and oral health needs are ommitted despite the fact that general dental practitioners are treating an increasing number of patients with mental health problems and particularly in the area of dementia. Wider national 'fit' is missing even in summary i.e. current fiscal climate/ workforce demands & 'redesign' so in this sense the content is perceived as somewhat disconnected from the 'real context'.

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

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

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?

The outcome is considered critical yet undermined by the completely dismal social & economic context that history informs us equates to a reversal in social outreach and inclusion with individuals and some social groupings becoming increasingly insular and protective of self rather than other more vulnerable people. Again some reference or accommodation within this strategy recognising today's financial climate would offer some further grounding i.e. recognising challenges & future fears etc and impact on peoples' health & well being. Previous strategy has certainly reversed trends in attitudes and associated stigma compared to a decade or more ago and shifting public opinion/ views must continue/ escalate at earlier stages e.g. late primary school etc. Of note is the increasing negative perception/ 'muted' views of limited and constrained acute beds being taken up by those people with self harming behaviours/ OD/ addictions etc – cross cutting actions apply here inclusive of the Equalities Act (health inequalities) and Human Rights Act.' Effectively resourced community counselling/ support services should be widely and consistently available as well as those services offered by community/ primary care mental health teams.

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

As above.

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?

Sustaining the approach – what we know works well. Publication of evaluation / analysis for all (public/ professionals/ services) to justify and pivot future actions. Use of clear and unambiguous terminology around Equalities and Human Rights Act in terms of reinforcing the implications/ seriousness of discriminatory actions/ behaviours/ decision making etc.

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

Refer to response at Question 3 – context must be recognised/ acknowledged as well as the potential impact on individuals/ families. Publication of 'early warning signs' and appropriate 'sign posting' – only problem with this logical approach is the array and diversity of services and the continuous updating of self help directories or information collation for professionals. Again a drive to support the sustainability of such cannot be overstated.

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?

The focus on access to psychotherapeutic approaches must be increased with specific galvanising of 'medical/ chemical' treatment approaches being reserved only for the most severe cases (not as preventative/ anticipatory measures). The pathway when psychological/ behavioural needs arise must also be consistent across all practices/ services as variances offer significant barriers to 'earlier' access and support. 26 weeks access target for CAMHS is considered too long.

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

Investment in training for all staff involved as part of their non core / profession specific remit e.g. all registered nurses/ AHP offering psychological interventions to patients and being flexible enough to work

across service boundaries.

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?

Linked to response to Question 6 regarding self help directories/ web access but the caveat of the need to continue to focus on multiple 'facilitative' & partnership approaches due to limitations of literacy issues and computer access. Family/ community resilence should be supported with local access points for people who are concerned about a family member/ friend etc. with deteriorating mental health – critical as often people with deteriorating mental health self isolate and do not recognise their need for self or others help/ support – often exhausting those willing to bolster!
Public awareness campains around 'triggers'/ recognising risks/ signs and relevant actions need to continue and receive adequate financial and logistical support.
Consideration also needs to be given to those people with severe mental illness accessing non mental health services and the opportunity available to engage/ proactively link or reengage with mental health services.

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

Breathing space is a particularly well recognised & valued resource and the continued financial support is welcomed. Long term conditions and impact on mental health & well being is also welcomed as an ongoing initiative but needs to be escalated in terms of other LTCs and evidence/ recognition of impact on mental health e.g. rheumatoid arthritis/ respiratory disease etc. Depression, for example, may be screened for as part of any LTC review but this should lead to sustainable and appropriate access to other services at an early juncture. However, this takes time to facilitate, coordinate and evaluate on behalf of the patient from the outset.

Any capacitating physical illness that requires longer term life adjustments/ loss of job/ independence or enforces dependance etc. should be included in their totality and acknowledgement of the need for support to psychologically adjust is as critical as the physical/ illness management 'adjustment' required. Also need to recognise that this may be a fluctuating phenomenon and people should be able to easily access as and when required before 'crisis' develops.

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?

The issue is one of barriers to access – often by those that screen/ gatekeep services with some services deliberating on the negative impact of HEAT target to reduce readmissions as well as the positives – whether service is skewed towards preventing readmission at all costs! This is further complicated by service fragmentation/ multiple services involved (from known significant case reviews/ critical incident reviews) in serious and complex cases where care/ treatment where care/ treatment/ service delivery gaps occur. Thresholds of tolerance to early symptoms can vary between people themselves, their families/ other and importantly between health care professionals and this can contribute to some of the cross communication / care transfer issues that become evident. There is an argument here to simplify and standardise service referral/ access points rather than constrain such by time/ age/ service functionality i.e. only if such and such a symptom is present etc. a situation which is further complicated by other factors such as ethnicity, disability, and communication impairment etc.

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?

The role of physical exercise as an effective treatment modaliy for depression needs to be offered a more 'assertive' and supported role across all services with more focus on supporting individuals to access & sustain increasing commitment to activity programmes. Acknowledged that this is a prominent aspects of the recent HPHS CEL document but again need to cross reference/ contextualise within this overall strategy

The support and facilitation required for those with mental ill health to access/ use psychological and non medical treatments such as physical activities groups must be considered as critical to recovery and invested in from a health, social and third sector perspective to maximise benefits.

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

Integral to ICPs being fully implemented into practice is the articulation with the Scottish Patient Safety Programme as a matter of urgency and identification/ profiling of what must happen at basic practice level in terms of assessment/ treatment/ delivery and evaluation. One of the overall disappointments with this strategy is the lack of focus/ high level priority afforded to the escalating evidence base of mortality/ morbidity for patients with severe mental illness, as stated at the outset.

Whilst it is acknowledged that guidance has been developed in Scotland (reference 22) – it remains an 'opt in or out' approach and does not attach the service/ professional response or responsibilities required. Services and professionals need direction, competence and sustenance to enable this major service shift in accomodating the physical co morbidities of those with serious mental illness as well as a more assertive input to off set future physical health impact.

There is a need to 'nationally' embed systematic approaches and responsibilities associated with physical health needs amid the mentally ill population and investing in competence/ practice development to achieve such. National policy lacks specific/ clear direction around this arena e.g. NICE guideline 50 'Acutely Ill patients in hospital' rightly pivots the need to offer basic vital sign monitoring routinely on all hospital patients to allow early signs of deteriorating physical health to be identified early (Early Warning Scoring system) yet within mental health hospitals this necessity becomes blurred with huge (subjective) variation in drivers to assess patients physically. This should **not be optional** and local services need to be supported across Scotland to develop a consistent approach to such as well as the wider physical health needs of patients. The threshold of catering for physical co morbidities within mental health settings can be, too often, influenced by individual staff, attitudes, opting to leave decision making with patients themselves or GPs etc. The QOF supports GPs to accommodate some mental health conditions/ treatment monitoring but this can become fragmented where patients enter secondary care. This is unacceptable and urgently demands explicit and unambiguous service direction and facilitation.

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?

Unsure of why the Improving Physical Health…' guidance is referred specifically within this section apart from promotion of recovery in an holistic sense??The overall thrust of this cogent issue at the 'lower' end of the critical spectrum rather than pivots the need to respond to escalating evidence.

Recognise the importance and necessary focus of the Recovery Network and ESC's but the success is limited by roll out mostly within MH service areas and not to other areas/ services which are non mental health but deal with patients who may have mental ill health although Person Centred approaches are now beginning to articulate the value of these previous initiatives for all health care services.

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

Feel that the available tools are adequate although some in their infancy. It

may be more about the time required for such approaches to evolve rather than forge ahead with new developments.

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?

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

Additional capacity in terms of time, training and finances should be invested in ensuring basic and additional (responsive) physical care is delivered as safely and effectively as possible.

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?

Communication within a 'professional' (mutually benefical partnership) relationship is essential. Professionals can sometimes become blunted by the right to expedite 'due course' on behalf of the patient and view this as their sole remit potentially to the family/ carers detriment and disempowerment. Again time to interact with family/ carers needs to be acknowledged and 'built in'.

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?

Practically patient centred care is about individuals and the **time** required by staff to assess each individual, involving their family (getting to know them), delivering care and evaluating such – again added time to include family and carers as well as the patient. This time will be variable depending on the individual's capacity, communication abilities and insight (as well as those of family/ carer) and staff must be again empowered to articulate this and recognise that such an holistic and effective approach cannot be contrained by performance targets (time/ numbers/ contacts etc.)

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?

National networks/ exchanges etc? However we are aware that even within the same Board, successful redesign is not shared well across the system – many barriers/ challenges that off set this requirement.

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

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

Comments

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

As stated in response to Question 11 & 13.

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

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?

Leadership across services/ professions is critical to achievement.

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

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

Physical health care – assessment skills and intervention. We know that current curriculum is poor for psychiatrists and psychiatric nurses around these competence sets so critical.

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

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?

Many arenas – most pressing is that of capacity assessment in dementia and other mental illness, the need to ensure that pre registration training in its totality equates to registered nurses being equipped to assess capacity and articulate with AWI.

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?

Simple & regular communication and examples of cases/ situations where HR Act/ conventions can be/ are breached. This was recently highlighted across all nursing services (acute & MH) with the MWC 'Right to Treat' guidance.