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.

This response concerns itself with the implications of some of the key themes and proposals in the strategy for the mental health and well-being of children and young people. Specifically, it proposes more attention be given to the contribution prevention and mental health promoting activities have in relation to this age group.

The strategy helpfully highlights the considerable progress that has already been achieved in terms of increasing investment in CAMHS and in the development of in-patient provision, mental health linkage with schools, integrated care pathways, guidance in relation to psychological therapies and evidence-based parenting initiatives. There is reason for pride to be taken in relation to each of these developments and this is duly acknowledged in the strategy. However, it is important that equal weight is given to the need to continue to support the momentum this has now generated. The differential spending that exists between children and young people's mental health services and adult services remains large and it would be helpful for the strategy to demonstrate a clearer stance on how this can be addressed.

One obvious way for this to be achieved would be for there to be even clearer strategic thinking in the document around prevention, and the particular relevance of this for child and adolescent mental health services. Over the past several decades, a wealth of research has demonstrated how the majority of adult mental health conditions have their origins in childhood. Research has also identified an increasing number of effective interventions that are capable of re-directing the associated maladaptive developmental trajectories, so that many of these adult outcomes can be avoided. We are still far from using the full benefit of this body of knowledge. The strategy would therefore be improved by having a greater focus on this area. While specific mention of the Psychology of Parenting Project, an evidence-based preventive intervention for pre-schoolers, is a very commendable inclusion, it would be helpful for the strategy to outline a fuller framework to guide prevention activity, specifically in relation to child and adolescent mental health. In line with scientific findings in this area, a strategic framework of this nature should be shaped around what is known about the prevalence of key disorders, the costs known to be associated with their continuation and the strength of evidence that the disorder is preventable. Early-onset behaviour problems are a key example but the prevention of substance

abuse and depression also rank highly in this respect.

In recent times, considerable advances have also occurred in our understanding of early brain development and attachment and their joint association with the onset of mental health conditions in childhood. The preventive implications of this deserve recognition in the strategy by more attention being given to infant and early childhood mental health interventions. This needs however to be linked to other mental health and social care inputs such as those addressing maternal depression, ante-natal stress and substance abuse. Once again, scientifically proven interventions should be favoured. For example, learning should be shared from the very effective Family Nurse Partnership home-visiting programme currently being rolled-out in Scotland.

The science of prevention highlights how development is the product of multiple influences, and throws light on the complex ways in which risk and protective factors interact over time to bring about both desirable and undesirable outcomes. Again the strategy would be enhanced by incorporating this knowledge into the direction it provides around prevention. Important as it is to support activities that reduce risks, it is equally important that mental health prevention in early life has a focus on activities that promote psychological health. This will require a paradigm shift for child and adolescent mental health services and require them to engage more fully and in more creative ways with partner agencies, families and communities, so that, in turn, environments conducive to the development of psychological health can flourish around children.

Finally, by adopting more of a risk and resilience, evidence-based approach within child and adolescent mental health services, a more robust prevention focus could (and should) also contribute to increased access to mental health services for particularly vulnerable groups of children, such as those with a learning disability, chronic health conditions, those looked after and accommodated and those who have experienced particularly traumatic events. This is so because this approach strategically identifies key developmental risks and thereby ensures that high-risk populations are identified on the basis of specific needs.

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.

NHS Boards and partners have to respond to a number of policies, strategies and initiatives. National leadership in integrating and connecting these will be crucial. Ongoing support for the CAMHS Lead Clinicans around leadership development and succession planning would be welcomed.

Support from the Mental Health collaborative has been very helpful. This function has now been taken over by MH QuEST and some concerns have been raised about whether or not there is sufficient capacity to support boards with redesign particularly in CAMHS.

We are in broad agreement with the need to offer faster access to Psychological therapies which are evidence based, safe and effective. We are keen to re-inforce the guidance in the text of The Matrix around the need for patient choice. One size does not fit all, and there is not a simplistic relationship between mode of therapy and diagnosis. The Matrix is a useful tool, but it is essential that it is used as it is intended-in an advisory rather than a prescriptive way- to ensure that the needs of the many patients whose problems are not adequately reflected in the research studies are appropriately treated.

We would stress the need to continue to gather evidence on the effectiveness of the provision of low intensity therapy, in reducing the demand for services at higher tiers.

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.

We believe there is a gap in service provision around transitions from Child & Adolescent Mental Health Services to Adult Mental Health Services. Recently, the Mental Health Commission of Canada (MHCC) responded to this growing public health concern by formally identifying young people as a vulnerable group. In an effort to improve prevention rates and maintain the well-being of young people, the MHCC is advocating for dedicated resources to be invested in this population (2009). It would be great if Scotland could be active participants in this the proposed international research initiative to investigate and develop models to improve effectiveness of supporting transition between CAMHS and Adult Mental Health Services. In Canada this piece of work is being led by Simon

Davidson and he and his colleagues write

"Transitions from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) deserve attention because: (1) the greatest financial and institutional weaknesses in the mental health system occur during the transition between CAMHS and AMHS (e.g., Singh et al., 2005; Pottick et al., 2008; McGorry, 2007); (2) a lack of integration between CAMHS and AMHS is believed to "jeopardize the life chances of transition-age youth (ages 16-25 years) who need to be supported to successfully adopt adult roles and responsibilities" (Pottick et al., 2008, p. 374); (3) "a strong focus on young people's mental health has the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the 'best buys' for future reforms" (McGorry, 2007, p. s6) and (4) research has demonstrated that youth between the ages of 17 and 20 are more interested in receiving mental health services than are their younger counterparts (Silver, 1995)

A second gap and in Scotland and in CAMHS particularly, it would be great to develop better models, which support peer to peer support, parent to parent support and carer to carer support . For young people to provide support to one another, this might be facilitated on a National level by working with the Scottish Youth Parliament , Young Scot and others, using social media and IT and also on a more local level to facilitate service users' involvement in service planning and service development.

References

McGorry, P.D. 2007. "The Specialist Youth Mental Health Model: Strengthening the Weakest Link in the Public Mental Health System. *Medical Journal of Australia 187*(7 Suppl): S53-6.

Pottick, K.J., S. Bilder, A. Vander Stoep, L.A. Warner, and M.F. Alvarez. 2008. US Patterns of Mental Health Service Utilization for Transition-Age Youth and Young Adults. *The Journal of Behavioral Health Services and Research 35*(4): 373-389.

Singh, S.P., M. Paul, Z. Islam, T. Weaver, T. Kramer, S. McLaren R. Belling T. Ford, S. White, K. Hovish, K. Harley and TRACK Project Steering Committee members: J. Dale, N. Evans, N. Fung, D. Hayes, B. Jezzard, A. Rourke, M. Zwi. (2010). *Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives Report for the National Institute for Health Research Service Delivery and Organisation Programme.*

Silver, S. K. Unger, B. Friedman. 1995. Transition to adulthood among youth with emotional disturbance. Report 839 Tampa University of South Florida, Mental Health Institute, Research and Training Centre for Children's Mental Health.

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?

Again, a focus on transition from CAMHS Services to Adult would be helpful as we know the years of highest risk of completed suicide in young people happen in the late teens and early twenties. Completed suicide rates for Scotland (2010) show a steep increase in suicide rates of young people aged 18-24, which coincides at a time when young people are often transitioning from one mental health service into another.

It would be good to pilot co-locating services for youth in Scotland, so putting together drop in centres where counselling and advice can be provided alongside advice about Benefits, Work and Housing and also advice around sexual health and health can be provided all in one youth friendly venue, using models developed in other Countries.

A similar model would be to co-locate trauma services so children and parents can access treatment in the same location, both jointly and individually as needed.

Reference

General Register Office for Scotland; 'Deaths for which the underlying cause was classified as intentional self-harm' or 'event of undetermined intent' (2010) Retrieved 16th January 2012 from www.gro-scotland.gov.uk/files2/stats/probable-suicides/suicides-10-table3.pdf

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

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

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

There should be a greater emphasis on infant mental health and awareness of the ongoing impact of adverse childhood events can have on very young babies and children and how early intervention with parents and with babies themselves can help prevent further adverse consequences. The development of the early parent-baby relationship is a key factor in the development of infant mental health and has significant consequences for well-being over the lifespan. Early interactions shape the young infant's brain, stress response system and emotional development affecting positive and negative developmental trajectories. Promotion of a relationship based approach to infant mental health is needed which highlights the role of prevention and early intervention. As mentioned above co-location of trauma services to best meet the needs of parents and children would be helpful as would more education for the children's workforce generally around the impact of adverse events upon child development and behaviour.

Interventions such as the Family Nurse Partnership, which has a well-established evidence base, aims to enhance parenting in order to prevent the associated long-term sequalae of problems in the early mother-infant relationship. Other parenting programmes, such as Triple P and the Incredible Years, both of which have shown to significantly strengthen parent-child relationships from the pre-school period onwards, are now extending their models downwards to the infant age group. Although evidence for the effectiveness of these programmes in this context is limited at present, the early indications are that these approaches will also have much to offer the infant mental health field. I am delighted that the Strategy Consultation supports the roll out Triple P and Incredible Years Parent Interventions for parents and carers of 3-4 year olds with disruptive behaviour disorders. It would be helpful if funding streams, which help to integrate both Local Authority and health intervention is targeted to develop these kinds of programmes capacity and fidelity to model.

Similarly, further evidence for the Mellow Babies intervention is currently in development and interventions such as Video Interactive Guidance, and the Newborn Behavioural Observational system also have an emerging evidence base which promises to enhance the services available to promote positive infant mental health.

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?

We welcome the additional investment in CAMHS workforce and the development of the three regional consortia these investments are facilitating real improvement at a service delivery level. As will the other actions listed.

It would be good if the mental health bundles which come to Health Boards should be more clearly tied as to which is for CAMHS and health Boards should continue to be required to report on how this is being spent. The ongoing expectation of growth in the CAMHS workforce is very helpful.

It would be helpful if there were a requirement that CAMHS along with other Mental Health Services use routine Outcome Measures to ensure that what we are providing is an effective treatment modality for the families that we are serving. Guidance could be developed nationally re Stepped Matched Care Pathways for children and young people. More focus could be given to the further development of low intensity high volume interventions, such as cCBT, healthy reading and supported self help.

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

Additional training is required to ensure that staffhave the required competences to deliver child and adolescent mental health services. Essential CAMHS is a foundation level learning resource that NES has developed, building upon the NES CAMHS competence framework

Additional support for service re-design to local Boards will be helpful.

National support for face to face events to share good practice across Boards will continue to be important alongside e-resources.

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?

Support peer to peer and parent to parent initiatives and awareness raising exercises such as Re-Capture by Young Scot, (the photography exhibition for young people who have recovered from eating disorders.)

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

Developed web-based and social media-based platforms aimed at young people and also aimed at families, in order to help families and young people support one another but also advocate for the help that they need. In addition, youth friendly web-based CBT treatment approaches could be developed, building on information already available from web developments designed for adults and web-based development supported by the Scottish Government, such as www.depressioninteenagers.com and www.stressandanxietyinteenagers.com, which signpost young people and adults working with them to effective help-help and where to get help, but do not provide the first line interactive treatment that is available on other more adult friendly platforms.

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?

We welcome the points raised in the consultation document specifically highlighting the role of Early Intervention Services for Psychosis within NHS Lothian and NHS Greater Glasgow and Clyde. This evidence-based approach has been demonstrated to deliver better outcomes for people in a Scottish context and to be cost effective.

A key facet of these services is their ability to reduce the Duration of Untreated Psychosis (DUP). Longer DUP has been repeatedly associated with poorer long-term outcomes. It is important to note that most untreated psychosis, leading to longer DUP, exists *within* existing mental health services. That is, the individual is in contact with mental health services but psychosis has not been identified.

A definition of Early Intervention Services for Psychosis is provided in the draft SIGN guideline for schizophrenia based on the available evidence base. The following components must be included:

- Ability within the service to tolerate diagnostic uncertainty
- A developmental approach to working with the individuals within the service
- Age and culturally appropriate ways of working
- In-depth multidisciplinary assessment carried out over several weeks leading to multidisciplinary formulation
- Intensive outreach delivered according to a psychosocial paradigm
- Family engagement
- Psychological therapies

- Minimal dosage of medication offered as but one of many aspects of the overall treatment package
- Assessment and follow-up over the critical period (3 years)

Services should be organised around individual needs rather than according to traditional age-defined service organizational structures. For example, the Early Psychosis Support Service in NHS Lothian is a CAMHS based service but accepts referrals up to the 19th birthday and will continue working with the young person for up to three years over the critical period. Other Early Intervention Services for Psychosis accept referrals from 14-16 years up to ages 25-35 years in order to capture the age-range most likely to experience onset of psychosis. However these services are organised they need to hold in mind the developmental stage of the service users alongside the mental health needs.

What changes are needed in NHS Scotland?

Despite the challenges involved in redesigning services across Scotland to adopt the approach outlined above, this new way of working would provide significant benefits to the individuals accessing services in line with the direction of travel outlined in NHS Quality Strategy for Scotland.

As highlighted above, the development of appropriate service structures should not be bound by age defined service organisation but organised according to the developmental needs of those accessing such services. In particular, it is known that particular difficulties arise for individuals at transition points (e.g. from CAMH to adult services). Services should therefore be defined, and be sufficiently flexible, to take account of these individual needs.

Whilst Scotland's geography and varied demographic profile provides a particular challenge for the development of Early Intervention Services for Psychosis, models of service delivery elsewhere, e.g. in England and North America, have demonstrated that such approaches can be delivered even within highly rural settings. In urban and heavily populated areas, dedicated specialist services are justified by the available evidence base.

As the summary of the evidence base in psychological services it is really important that the Matrix is updated regularly. It is important the Government puts in place a robust and sustainable mechanism to oversee the widening and updating of the content of the evidence tables

We are keen to reinforce the competence-based approach to training and supervision laid out in The Matrix,

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?

Continual monitoring and scrutiny of the use of evidence based interventions

Support for managers on 'de-commissioning' activities which do not add value.

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

It would be helpful to have a SIGN Guideline on the treatment of depression in children and young people.

Plans for support for the CAMHS ICP need to be informed by careful analysis of the successes and challenges in implementing ICPs to date.

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?

Employ peer to peer young people to work in CAMHS Services and employ parent workers to work in CAMHS Services and in other mental health services using models developed both in New Zealand, Canada and America. Support Parenting and Family Support Groups.

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

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

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?

As stated before, both in America and New Zealand and Canada, carers, parents and peer workers are employed by services to work alongside service providers and to help with advocacy for families. We need to provide good information on consent for families and carers. We need to provide good information in leaflets about the kind of treatment offered and the things that families should expect from services. It would be good to develop web-based advocacy around the Mental Health Act. This could be led by the Mental Welfare Commission using information from the site already developed in Ireland by the Mental Health Commission there http://www.headspaceireland.ie/downloads.html.
Families need to have access to education and guidance and support

that they need in order to foster recovery and wellbeing and to respond to their own needs. Wherever possible, families should be treated as partners in the delivery of care and should be integrated into decision-making in a way that respects consent and privacy. Roles have been developed in other countries to assist families to navigate both the National Care Systems and the realities associated mental health problems and illness and this is a role which could be developed in Scotland and any programmes support or information which is developed for families should be recognised cultural differences amongst the population.

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?

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?

Build on the experience of the CAMHS regional Tier 4 consortium. This is a piece of work which could be developed further in Tier 4 CAMHS across Scotland using data with a clear expectation that all of the Regional networks around the Regional Inpatient Units should be able to provide information about length of stay, treatment outcomes, pattern of referrals and discharges to the different areas .

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 before, I think there is a gap in infant mental health provision and very early year's provision. At present, infant mental health is directly promoted through the Family Nurse Partnership pilot intervention for young mothers living in difficult circumstances and for infants of mothers with severe mental health difficulties who receive specialist treatment in Mother and Baby Units. Service provision to promote a healthy mother-infant relationship for mothers who are experiencing mild to moderate symptoms of postnatal depression is not routinely available.

In addition there needs to be greater thought about transition and what successful transition means from CAMHS to Adult Mental Health Services.

The mental health needs of at risk groups such as those involved with Youth Justice is also a gap in many areas.

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?

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

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

Comments

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

Continue to support a centralised, strategic and long-term approach to the planning and delivery of psychological therapies training, which takes account of the needs of the NHS Boards in relation to the HEAT Access targets, the evolving evidence base, the skills of the current workforce (as established through structured workforce surveys), and the need for regular supervision as one element of a sustainable educational infrastructure. The opportunity to plan training over the longer term would enable building on current training, with increased focus on establishing quality standards and achieving accreditation where possible. Establishing cohorts of experienced and accredited practitioners will create a pool from which future trainers can be recruited and trained as 'trainers'.

The training strategy should take a broad view, aiming to ensure appropriate levels of psychological literacy at the lower tiers of the system (including establishing the foundations of psychological literacy during undergraduate training programmes), and building skills upon this to populate the low and high intensity levels of delivery. It should recognise the need to 'seed' high-level practitioners and supervisors in key modalities in all areas to cascade training, to support the increase in capacity needed to meet Government targets, and to provide the necessary clinical governance in ongoing practice.

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?

- Good IT and admin support.
- A requirement to use outcome measures and for this to include outcome measures suitable to be used with children and young people. This requirement needs to be set Nationally Services should also be required/ expected to measure patient experience routinely i.e. a questionnaire and focus groups. There needs to be some recognition that this has an impact on both administrative and clinical time.

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

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