[redacted]

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 comments:

Positive:
The broad thrust of the draft Strategy was welcomed by participants in the consultation process in Forth Valley and many felt that it makes sense. Many also felt that they could not argue or disagree with the proposed 14 outcomes but there is a lot to do with regard to each. The clear reference to recovery and a person-centred approach was widely welcomed as was the specific reference to developmental disorders and trauma. Some expressed the view that the Strategy was ambitious but that it makes sense as a consolidation of the current direction (more evolution than revolution) which was seen as positive.

Constructive criticism:
Some fundamental points are that the Strategy does not come across as a document that sufficiently supports and promotes the improvement of mental health / wellbeing / illness within a mental health system based on partnership working. Neither is there a clear indication of who should be taking the lead with each initiative. Issues of social inequality do not have a sufficiently high emphasis throughout the document. The Strategy would also be more appropriately titled the *"Mental Health and Wellbeing Strategy"*.

Some discomfort was expressed with regard to the number of outcomes and resulting work generation, particularly considering current overall workload and capacity. In addition, many expressed the view that the Strategy did not appear to "join up" with other initiatives (see comments below).Clear reference to recovery and a person-centred approach was widely welcomed however, there was a strong view that these should be at the heart of the Strategy as a "Core Principle" that underpins the whole document rather than just an outcome.

The strategy seems to be underpinned by a medical model of health and focuses largely on the role of mental health services. The strategy lacks a public health perspective and there is too little reference to wellbeing and prevention within the strategy. This lack of balance is reflected in the strategy outcomes, which do not constitute a comprehensive vision for mental health in Scotland.

There is little idea from the document about who it is targeting. It would have been useful to have published evidence of need to back up the approaches identified. In particular what we were going to do differently to support people during the current economic crisis - *"Poor women 15 times more prone to suicide than the rich"* Sunday Herald 13.03.2011.

Overall, some were disappointed by the document and came away with the impression of

'more of the same'. This is a document very much looking at mental health services in isolation from the wider world. In addition despite the inclusion of the 'prevention' agenda this is addressed by only 2 out of 14 high level outcomes.

Some specific comments included:

Outcomes need to be linked to the individuals situation and needs. All partnership working needs to be in relation to this.

- Needs to be person centred as a strategy and less service centred and
- it needs to be translated in terms of local outcomes.
- We could evidence delivery of much of this now - it is more of the same.
- There needs to be more emphasis on prioritisation.
- Would theming of the outcomes help? Seems that a few could be pulled together.
- There is a risk of bringing everything under the 1 umbrella with a risk of shifting away from health improvement and community development work.
- A person centred approach to care should be the underpinning philosophy
- Pull together some processes and outcomes but within proposals for more integrated mental health services.
- Some outcomes look more like processes - can they be measured.
- Outcomes should relate to:
    - when person can take responsibility
    - when person cant take responsibility
    - when person won't take responsibility
- Outcomes need to be rewritten as person centred processes and outcomes with clear measures included. There should be examples of how the outcomes might be measured.
- The Strategy needs to be more "joined up" with, for example, GIRFEC and Learning Disabilities initiatives.
- Who identified the proposed outcomes - were service users and carers involved (it appears not) ?
- There should be examples of good practice regarding some of the outcomes to prevent services re-inventing things.
- How will this strategy add value - do we need it given everything else? There might be duplication with other strategies - everything could become confusing rather than clearer.
- The lifespan of the strategy is in question as it may take services 1-2 years to get things in place.
- The outcomes and measures could be clearer if they were categorised (e.g. individual, processes, and service). This would make it easier for services to see their role.
- Some are similar, could they be brought together?

The Strategy is very broad therefore vague in some areas – it needs more definition – there is a concern that the outcomes will be difficult to measure. However, there is also agreement that the outcomes are the right ones but concern that they may not be easily measured. Outcomes should have been identified in partnership between communities, service users, professionals etc. Language of strategy does not reflect this.

- greater emphasis on bottom up approach rather than specified from the top tier down.
- The Strategy needs to engage all sectors and not just Health – delivering outcomes are not just a specialist MH service role. It appears to be very Health focused. Therefore it needs emphasis on partnership working between statutory & third sector agencies as equal partners.
- Partnership working with service users at planning and delivery level is crucial.
- Promoting positive Mental Health is all agencies business - strategy is currently too focussed on health
- Recognise the level of stigma out there
- Recognise what the third sector does
- More inter-agency, joined up working
- Value personal experience as well as professional
- More support and rehabilitation after first experience of illness
- Increase funding - Awareness raising and education about mental health
- More early intervention

- More available for crisis intervention
- Easier access to services (including out of hours)

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.

General comments:
Local Authority funding is no longer ring-fenced for mental health therefore there are challenges in sustaining / increasing resources which compromises medium and long term planning and commissioning of services.

Resources are limited - this often causes conflict in prioritisation (e.g. between Primary Care, anticipatory care, etc). It is therefore difficult to sustain and prioritise many initiatives. How can service providers prioritise when everything is a priority?

The 3rd sector is "bulging at the seams" and is picking up "non-core business" from statutory MH services. While this may not always be inappropriate, there is often no transfer of resources to support it.

Integration of services is a priority and should have a stronger focus in the strategy.
In the current financial climate there is a danger that we can't sufficiently support early interventions, community based support, and preventative practice.

There is little reference to *Equally Well* and the health inequalities agenda which is remarkable given the importance of this for the Scottish Government. Surely this agenda is as pertinent to mental health services as to any other. There is little sense, from this document, that 'mental health' is everyone's business and much more should have been said about partnerships and prevention. However, treatment & recovery should also be a partnership (e.g. social referrals) but even here little is said. Why should patients have to pay for a 'social prescription' when a drug prescription is completely free?

While an integrated strategy is welcome it is also ambitious and the current emphasis on specialist mental services at the expense of prevention and promotion is concerning.
There is a need for further articulation of the "systems" approach that the implementation of an integrated strategy requires and an emphasis on the role of the wider public, voluntary and community sectors. It is not clear form the strategy who is expected to deliver key actions

The relationship between this strategy and the national Self Directed Support Strategy and Bill should be considered in the context of safeguarding/ prevention/dual diagnosis/access to appropriate supports etc.

Integration should be promoted further (health and social work services and the 3rd sector) as there is often duplication of effort and resourcing which can only be inefficient. Also, developing and delivering an integrated model between specialist and general services (e.g. interface between substance misuse and general psychiatry) should be more of a priority.

More should be done to ease the transition of prison healthcare to the NHS as local services cannot just absorb this additional workload, particularly with regard to psychological interventions.

The Strategy will require rigorous implementation - particularly integration activity - and should provide more clarity and drive around partnership structures, organisational integration and infrastructure between all services comprising the mental health system.

Comments from the Forth Valley Psychology Advisory Committee:

- Need for a clear strategy regarding training which is linked to service requirements
- Need for a greater emphasis on quality of service provision (in addition to speed of access)
- Need for a lead psychologist at government level
- Importance of maintaining focus on psychological therapies via HEAT targets
- Need for national direction to guide pooling of resources among health, local authority and voluntary agencies which currently provide accessible low intensity treatments for children and young people in a fragmented manner.
- Promotion of equity of access to range of psychological therapies across Health Board areas

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.

Sharing information and sharing agendas between all mental health agencies needs to be improved. The overall profile of mental health should be raised as a clearer priority as it is relevant to everyone. The crucial role of supporting peoples "psychological assets and capacities" is largely absent from much of the document.

The outcomes themselves are largely not "outcome" statements and there is a resulting difficulty in understanding the way in which the key challenges and proposed actions relate to the achievement of the outcomes. They do not set out the vision or the rationale (theoretical framework) for the integrated approach suggested. The outcomes, as they stand, could not be measured in a meaningful way.

There is a recognition that service provision across mental health services is fragmented & that existing criteria for accessing services can be rigid particularly in relation to transition situations such as moving between child, adult and elderly psychiatric services and dual diagnosis and substance misuse.

If integration and joint working is to be effective robust evaluation and accountability frameworks should be put in place and the learning from best practice (evidence based) shared.

Comment on Gaps in the Strategy:

- There is inequity of resourcing between older people with a functional mental illness and dementia based care. The current focus on dementia, while very welcome, may detract from the former. Discrimination in access to psychological therapies.
- The Strategy should have a greater emphasis on the importance of equity of

access for all age groups to all services. This is often not the case, for example, for older people needing to access a psychological intervention.

- The "dual diagnosis" population falls between services (e.g. a person with a learning disability *and* mental health problem, or a person with a physical illness *and* mental health problem). Again, the Strategy does little to promote improved arrangements in these circumstances.
- Prevention, education, early intervention should link in to all the public services thereby normalising services into Leisure, Education, Social Care etc
- Impact of parents Mental Health problems, social problems on children's wellbeing & Mental Health. Not focussed on this enough. Wellbeing is diluted in the new strategy
- Young people with alcohol problems (including Alcohol Related Brain Damage)
    - This group is not diagnosed well
    - Lack of education regarding risks (in schools / universities)
    - Accessibility to support must be improved further
    - Cultural issues are key with this group
    - The "solution" has to integrate health / awareness / prevention
- Older people (65+) with functional illness
    - The transition from Adult to OAP services (65+) is often problematic meaning a change in care provision.
    - This group needs to be as high a priority as dementia - it appears to be being left behind.
    - Part of the Strategy should target the 50+ age group with mental health problems
- Service users need to be encouraged to reduce their dependency on services by:
    - Promoting self management more
    - More service flexibility in mental health rather than just referring "back to the GP"
    - Keeping people well in their community but not isolated
    - Exploring the full potential of telehealth / telecare thereby reducing isolation and costs
- There should be a greater emphasis on broader Learning Disability needs:
    - The Strategy does not promote an integrated approach
    - All mental health services should be made accessible to people with learning disabilities – the strategy falls short of articulation with "same as you"
    - Learning difficulty/ substance misuse alongside Mental Health issues
    - Carers of people with a learning disability are ageing and may not be coping, may have dementia, may have a mental illness
    - Should "generic" workers (e.g. in education) be skilled up to work more effectively with people with LD?
    - Shared care is the current approach – could there be a better way?
- The 18 weeks referral to treatment target for psychological therapies was considered too long by some participants.
- Reference to the importance of access to good housing and financial inclusion are gaps in the outcomes.
- Rurality brings a range of issues regarding equity, access, etc.
- Forensic provision has an increasing profile and significance but this is not reflected in the document.

Comments from the Forth Valley Psychology Advisory Committee:

- Increase capacity in CAMHS by distinguishing between children/young people who have a developmental disorder along with a mental health problem, from those who have a developmental disorder without complications and who can be supported by Tier 1 and 2 health and local authority services.
- Clarification of most appropriate and effective care pathways for people with specific types of developmental disorder (e.g. Aspergers, ADHD etc.).

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?

Providing financial support to maintain the momentum of Choose Life and associated initiatives, training in suicide assessment and prevention should be a top priority in this as it has proven to be very popular and effective across a wide range of services.

"I have tried (suicide) a lot of times over the years and self harmed. I don't get as many suicidal thoughts as I used to because I get a lot of support through my peer support group" (Female, Stirling)

"I was in that situation once (suicide). I couldn't get anybody to speak to me so I just thought 'right, what is the point?" (Female, Stirling).

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

Employability and training for employment must have a higher profile in the strategy. This links directly to the agendas on stigma and recovery.

The benefits of volunteering should be included alongside employability but as a specific action.

Central to challenging stigma is the inclusion of the perspective of individuals who have experienced mental illness to help inform service design and responsiveness from health and social care services and employers' etc.

"Stigma is still huge, absolutely huge."
(Female service user, Stirling).

"A guy (in my group) got a job. It was a job he could do but when they found out that he had a particular mental health problem they said 'I'm sorry but we can't keep you on'. Then he had a struggle getting back on his benefits. So he had the high of the achievement of getting a job and then he had all the stress of losing it and trying to get back on benefits" (Female, Stirling).

"The media can be useful if it is portrayed accurately. But it is the headlines that tend to lead to perpetuating stigma" (Support Worker, Stirling)

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?

Developing and supporting community based support, including peer support, and recognition of the role of "low intensity" support in preventing problems becoming more serious to the point of requiring specialist input and therefore possibly increased stigma.

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

Towards a Mentally Flourishing Scotland has been met with a very positive response locally and has been supported widely by multi-agency groups resulting in action plans that are delivering improvements. There is a clear view that this type of initiative should be sustained.

Comments from the Forth Valley Psychology Advisory Committee:

- Should be national strategy for well being
- Message should be that mental health is everybody's business
- Should move to national self-help website (rather than proliferation of numerous local ones – e.g. Moodjuice, Mood Café etc.) for staff and public access
- Use of local community facilities for information about local resources and provision of mental health self help materials (e.g. libraries, Citizens Advice, community centres, supermarkets)
- Targeting schools – *teaching psychological resilience*
- Further development of community based courses to promote positive mental health (e.g. Stress Control, Mindfulness)

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?

While this outcome was welcomed, several comments were made to the effect that there is no sense of integration or articulation with, in particular "Get It Right For Every Child" (GIRFEC).

The focus on CAMHS is unhelpful and does not emphasise the importance of early intervention and the wider multi-sector work around early intervention and improving outcomes for children.

Greater support of the links between education and mental health services – to improve understanding what works or is best the approach in Education.

Comments from the Forth Valley Psychology Advisory Committee:

- Ensure that each NHS Board has an Intensive Home Treatment Team for children and adolescents
- Ensure that links between schools and specialist mental health services conform to a national standard
- Ensure that provision for early years is jointly planned and delivered.

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

Comments from the Forth Valley Psychology Advisory Committee:

- Redistribution of resources to reflect the issue that some NHS Boards have more Looked After and Accommodated children (placed from other areas) and young offender institutions than do other Boards, hence the provision for specialist CAMHS should be adjusted accordingly.

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?

This was considered a very important outcome as it is central to recovery and recovery-based practice. Some participants felt strongly enough to suggest that the document should be titled the "MH and Wellbeing Strategy" to reflect this.

With regard to outcomes 3, 6 and 7, many felt that there were a lot of similarities or overlap between them to the extent that they could / should be combined into one.

It might be useful to consider how anticipatory planning can be further embedded in service provision.

The role (and reach) of services in increasing general mental health literacy and improving people's understanding of protective factors should be a key focus

Self-directed support must be included by outlining what support is required and how it will be delivered.

This Outcome recognises the need for a person centred approach which should be at the heart of the Strategy rather than just an outcome.

Steps should be taken to ensure that promoting wellbeing (understanding stress, anxiety, mood) can be delivered (normalised) by non-mental health services (leisure, education, social work, community dev.)

- Embed this into training of the above professionals

"You don't understand what is happening to you. It took a long time before I realised what was wrong with me" (Female, Stirling).

"I spoke to a psychotherapist and just some of the simple coping strategies he gave me were brilliant" (Female, Stirling)

"You have to give people choices. What works for some people does not work for somebody else" (Support Worker, Stirling)

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

Developing and supporting more informal community based support, including peer support, and recognition of the role of "low intensity" support in preventing problems becoming more serious therefore requiring specialist input. This would need to be within the context of a "joined up" local mental health system to make sure people do not fall between gaps.

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?

It would be useful to have a broad definition of first contact services, do they include for example education, housing, voluntary sector? If so, how will we know if they are working well?

Improved awareness of GPs and other services re existing low level support.

Improved access to availability of low level/safe crisis support services.

In the Criminal Justice System there are often problems with maintaining the level of support after release from prison to ensure access to services is taken up.

Many participants were happy with the strategy pulling together currently separate strands but there is a need to recognise that this is a strategy for all involved in the wider system –

Third Sector, Local Authorities and Health. Maybe this needs to be emphasised more?

Closer integration of Health and Social Work Services was a common theme. This was also taken further to suggest that the 3rd sector is included to support the design of clearly defined local Mental Health Systems.

Comments from the Forth Valley Psychology Advisory Committee:

- Ensuring that healthcare workers and community care staff continue to develop skills in identifying, and routinely screening for, early signs and symptoms of mental illness
- Need for clear pathways to signpost the most appropriate referral routes. This could potentially be provided by an efficient electronic pathway.

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?

There is recognition that Integrated Care Pathways will help address some of these challenges.

The focus on Improvement Methodology promoted very successfully via the Mental Health Collaborative must be sustained in the long term, and developed further to meet the current and future major challenges. This is viewed as imperative and should be supported directly by the Government by means of a degree of "arms length" support from national expertise (i.e. Information Statistics Division (ISD), NHS Education Scotland (NES) and Quality and Efficiency Support Team (QuEST) together with ring-fenced funding for Boards to further develop specific specialist roles and expertise. The latter is probably the most efficient way to build long term capacity to bring about the required "culture change" that will deliver on the Quality Strategy.

"You get pushed to different people all the time and you have to start telling them your story over again. That really annoys me. I don't like getting pushed from pillar to post." (Female, Stirling)

Comments from the Forth Valley Psychology Advisory Committee:

- Importance of appropriate levels of administrative support to reduce high cost of clinicians spending time on administration
- Increase use of tele-health and teleconferencing to reduce travel for staff and patients

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

With reference to Question 12 above, Integrated Care Pathways require a similar approach to ensure their full implementation, application and development over the long term. If not supported in the long term there is a significant risk they will fade away as a priority rather than becoming embedded as a cornerstone of services based on good practice.

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?

This outcome regarding care and treatment was considered more of a process than an outcome and many felt that it falls short of what is required. This should not be an outcome but should be what underpins the whole strategy. The Strategy must prioritise recovery (person-centredness) which should improve employability, self-esteem, recovery, etc.

Nationally promoted good practice such as use of the Avon "My View" measure would be very helpful in this respect. This approach would help to change the culture to one of user involvement being the norm rather than an afterthought.

A question arose with regard to how recovery, as an approach, sits with older people with a functional mental illness? Perhaps this needs a clearer emphasis.

By ensuring an "outcomes" approach is embedded at levels across services and used to ensure a robust commissioning approach.

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

Service users and everyone who supports them must know what support is available locally and how to access it. However, despite many agencies' best efforts over the years, it has been an enormous (if not impossible) task to keep any kind of "information database" on mental health services available up to date.

Experience has shown that there is often conflict between the wishes of the patient and needs of families.

Families should be able to access support and information easily.

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?

The launch of the second version of the Scottish recovery Indicator (SRI 2) has been welcomed as it is a more user-friendly (for all) version which does not appear to have lost any of it's relevance. This should therefore remain a cornerstone tool which supports evidence of person-centred practice from all perspectives.

A large part of this can only be achieved through strong, effective leadership which promotes a change in culture from one that "fits the person to the service" to one that "responds to individual needs". Many clinicians and managers have difficulty with this concept. It must be tackled through leadership, new thinking and changes in training.

Training must be delivered in partnership, communicate the experience of service users and have an "outcomes" ethos.

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

The network that has been established is a good support but falls short of what can be achieved by more direct input. The SRI could be used as a measure for Boards (and partners) reporting on performance. Perhaps a clearer, more obviously joined-up, and directly relevant "balanced scorecard" approach is needed with regard to these quality initiatives. Many feel that there are too many things pulling them in apparently different directions - "initiative fatigue" has been mentioned by frontline staff.

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

The Scottish Recovery Indicator should be simpler and more accessible generally. Previous comments above on the potential benefits of greater partnership working within a mental health system would also promote consistent approaches to recovery. Until this is achieved it will always be difficult for the SRN to engage across different agencies.

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?

This outcome was not felt to be robust enough. Carers should have a higher profile in the Strategy generally as they are a key part of care processes at all levels. However, many do not see themselves as carers. This outcome needs to be clearer and better developed.

What measures would be used for this outcome?

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?

Integrated Care Pathways should support clinical staff in this. In addition, Care & Treatment Plans (if not already doing so) should be developed to incorporate carers needs. Should / could there be a nationally developed "carer's pack" which can be added to at a local level?

"Sometimes friends and family are the problem. I find it easier to speak to other service users, people in here (Action in Mind) who know what it is like" (Female, Stirling)

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?

What 'better outcomes' are referred to here? How do you measure the "appropriateness" of the balance between community and in-patient services?

The Joint Improvement Team might be a "platform" from which to share and disseminate good practice.

Good practice examples should be easily available to all from a national database.

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?

The key to this is supporting frontline staff to recognise the importance and benefits of good quality data and to entering data in local systems. Local admin and Information Analyst support to frontline services is patchy.

Data, in the first instance, should be of relevance to local services to inform service review and improvement.

A nationally supported clinical data system used by all Boards would go a long way to improving data consistent capture, would facilitate performance reviews, and would support research / audit / etc. Why do we all appear to be using different systems?

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

A national central website would help with links and references to specific local pieces of work.

Via the Joint Improvement team?

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

Please refer to Improvement Challenge 2 (above) for an overview of service gaps that were identified in this consultation.

The fact that development disorders are referred to is most welcome.

Comments from the Forth Valley Psychology Advisory Committee:

- Prisoner health care
- Personality disordered offenders
- Physical health & medically unexplained symptoms
- Psychosis early intervention
- Learning disability should be considered explicitly
- Aspergers
- Children who are looked after and accommodated
- Children/young people who have lifelong/life limiting illnesses
- Children/young people who offend
- Under 5s, including babies
- Offenders with mild mental health issues
- Neurology & Brain Injury

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?

This Outcome was felt to require further development – services must work in an integrated seamless way if care is to be patient centred

Providing support to offenders post release was viewed as a major challenge and local priority.

Strengthen the profile of Care Programme Approach as a means of ensuring and managing joint working.

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?

Closer integration of Health and Social Work Services was a common theme. This was also taken further to suggest that the 3rd sector is included to support the design of clearly defined local Mental Health Systems.

Comments from the Forth Valley Psychology Advisory Committee:

- Development of psychological thinking and provision in acute settings
- Increasing provision of psychological interventions and support in relation to 'Long term conditions'
- Early intervention with young offenders
- Support the practical implementation of ICPs.

The multi-faceted nature of mental illness and other underlying/associated difficulties such as substance misuse do not necessarily lend themselves easily to a singular or joined-up response by mental health services, particularly if there in no definitive diagnosis of mental illness. Therefore integration should not be driven by services but rather based around outcomes for individuals and tailoring personalised services. Importantly there needs to be fundamental changes to operational practices and information systems in order to promote more effective and joined-up working and communication. Similarly, shared training is essential to change existing cultural and practices.

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?

What is meant by "appropriate attitudes and behaviours"? This could have benefited from clearer definition and / or examples.

Training for staff from all services, users, carers should, wherever possible, be delivered jointly. Also, services should be more proactive in involving service users and carers in the delivery of training.

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?

Further development of the National Mental Health Benchmarking tool would be helpful, particularly if it focused on clinical activity data.

Comments from the Forth Valley Psychology Advisory Committee:

- Survey of range and level of services available in each Board area (which includes consideration of level of service such as number of sessions, range of options available, types of therapy, intensity of therapy, qualifications of therapist)

- National survey of caseloads of mental health workers

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

Developing a clearer understanding of the range of psychological intervention skills at a local level is very important over the next few years. A standardised approach to this would be welcome. The latter would also inform decisions about training needs which might be addressed through collaboration between Boards or through a nationally driven approach.

Training in relation to evaluation and use of evidence.

"The GPs need to get more education about what mental health is" (Female, Stirling).

Comments from the Forth Valley Psychology Advisory Committee:

- Equity of provision of psychological therapists across NHS Boards
- Range of specialists being available
- Ensuring that speed of access is not at cost of quality of therapy for the patient
- Strategic plan for training and capacity in the workforce at both Board and National level which is suitably resourced
- Ensuring appropriate supervision
- Ensuring the well being of the workforce to allow them to function effectively and efficiently
- Continue to train child psychotherapists and make it more attractive for NHS Boards to support them through training and employ them thereafter.

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

Initially, there needs to be a sustained national drive (building on what NES has already supported) to provide training in clinical supervision to those staff who are trained in a psychological therapy at a "specialist" level. This level is probably the priority as it will support and supervise large numbers of staff trained in low intensity interventions. There is recognition that, in the short to medium term, clinicians trained in Highly Specialist and High Intensity interventions may need to devote more of their time to delivering training and supervision to the wider workforce to build capacity. This, in turn, may have an impact on their capacity to deliver interventions consequently waiting times may not reduce at the rate required.

Comments from the Forth Valley Psychology Advisory Committee:

- Ensuring that staff who are trained in the provision of psychological therapies are supported by their services to be able to put these into effective practice with appropriate supervision and governance arrangements
- Ensuring that there are sufficient psychologists and other suitably qualified psychological therapists with time available to provide quality supervision (in line with the 'Tony Wells report'

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

Is this an outcome?

This is a huge challenge with regard to IT systems (a single national system would be ideal but is a long way off), data input by clinicians (do they have time to do it well enough?), data quality and reliability, and actual measurement (what would be the measures).

The National Mental Health Benchmarking initiative has been very time-intensive to get off the ground and would continue to be so to sustain it long term. The data is also very "high level" and currently of limited use. However, it has the potential to be beneficial in many respects but there is a major question regarding the capacity within services to input meaningful comprehensive data.

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

The key to this is supporting frontline staff to recognise the importance and benefits of good quality data and to entering data in local systems. Local admin and Information Analyst support to frontline services is patchy.

Data, in the first instance, should be of relevance to local services to inform service review and improvement.

A nationally supported clinical data system used by all Boards would go a long way to improving data consistent capture, would facilitate performance reviews, and would support research / audit / etc. Why do we all appear to be using different systems?

Comments from the Forth Valley Psychology Advisory Committee:

- Identify common outcome scales to be used nationally
- Important to include qualitative measures in this

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 from the Forth Valley Psychology Advisory Committee:

- Redistribution of resources to allow appropriate levels of staffing for provision of psychological therapies to ensure equity of provision across NHS Scotland
- To promote service redesign to enable staff who have been trained in particular psychological skills to apply these effectively in practice

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

There should be clear Improvement Team structures at Board level which link with national groups such as Healthcare Improvement Scotland and the Information & Statistics Division. There are many variations across Boards and some consistency would be advisable to promote focus and coordination, and match local and national agendas. Clinically appropriate targets are welcome and the concept of a "balanced scorecard" for mental health should be developed which has the capability to promote local priorities as well as national. Each Board should have a *dedicated* lead for this work.

Programme and project management which is robust at national and local level and which is focussed on positive outcomes for people.

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?

This is not an outcome as it is already a legal requirement. There are different perspectives related to this (medical, legal, service user) therefore how do we know when it is working well?

There needs to be flexibility to treat the individual regardless of age. The structure of the strategy does not currently support this - it should be switched to needs-based care rather than service-based delivery as, for example, this would solve "graduate patient" issues (i.e. care transition at age 65). Current legislation (i.e. ASP, AWI) applies to all ages therefore services should respond in this way.