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.

Comments

We appreciate the effort made to tie together two previous strands:

- The overall strategy to improve the mental health of the population and;
- The strategy to improve the delivery of mental health care

A cohesive strategy should build on present strengths and address the gaps and challenges that exist. We have looked at, and tried to answer, the consultation questions. However, we do not see a clear, cohesive strategy emerging from these questions. We have concerns that a new strategy is being devised without a clear understanding of progress on the basis of the previous strategy. It would help greatly if the Scottish Government provided a structured commentary on progress against previous commitments and targets. In our response, we have tried to highlight relevant previous commitments. Where possible, we provide comment on our view on whether or not the commitments have been delivered.

Given new announcements on the integration of health and social care, the strategy should now make some reference to this. We believe there are significant gaps where important issues receive little or no mention. These include:

- The care of people with learning disability who also have mental illness
- The care of people remaining in hospital continuing care wards because of severe and enduring mental illness
- The physical health of people with severe and enduring mental illness (in all care settings)

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

Comments:

The dementia strategy led to the development of standards that apply across all services. These standards are based on a statement of individual rights. This seems an appropriate starting point. The Government should consider the same broad approach. Many of the dementia standard broad statements apply equally to people with other mental disorders. These standards achieved considerable consensus across all stakeholders, which in turn helped to engender a common sense of purpose, shared among service providers of all types, service users and carers.

A rights-based approach to standards for the mental health strategy could be:

1. I have a right to enjoy good mental health
2. I have a right to early intervention if I am concerned about my mental health
3. I have a right to care and treatment that is accessible, evidence-based, effective and lawful
4. I have a right to services that treat me as a whole person, help with all the problems I experience and promote recovery
5. I and my carers have a right to be involved, consulted and to influence delivery of mental health services
6. I have a right to have my care delivered by staff that are well trained and supported

The strategy need not address every facet of every statement. It should take account of evidence that service provision may not be meeting the rights expressed in these statements, and should seek to remedy this.

1. **I have a right to enjoy good mental health**

The strategy seems to be trying to address primary prevention (improving population mental health to reduce the likelihood that people will suffer poor

mental health) and secondary prevention (early detection, intervention and relapse prevention). It would therefore need to address:

- Positive childhood and adolescent experiences;
- Information across the age spectrum on achieving and maintaining good mental health;
- Community cohesiveness and peer/family support;
- Employment, useful activity, leisure activity and fun;
- Avoidance of harm, such as harmful drug/alcohol use, harassment and stigma
- Right to services under S25-31 of the MHC&TSA

This part of the strategy might point to other relevant strategies and initiatives. The last two bullet points need specific action. We have commented below on both these points, especially the lack of attention given to local authority duties under mental health legislation.

2. **I have a right to early intervention if I am concerned about my mental health**

Early detection and intervention are important and should address:

- Quick access to assessment and support during early years;
- Capacity to deal with mental health issues in primary health care;
- Positive views of mental health services;
- Ease of access to specialist services;
- Promotion of mental health services to the whole community, with particular emphasis on people with disabilities or from minority ethnic groups.

We have given specific comments on most of these areas. Often, the person needs help and support in a variety of ways. We have reported on the difficulty in providing acceptable and accessible services for young adults with complex problems stemming from adolescent difficulties, financial problems, harmful drug and alcohol use and mental health difficulties. Suicide is a major risk for these people. A strategic approach needs a wider consideration of their support needs than is contained in the consultation questions.

The consultation makes no mention of mental health in prisons. We have recently reported on this topic to assist the NHS in targeting actions to improve the mental health of prisoners as it takes over delivery of health services in prisons.

3. **I have a right to care and treatment that is accessible, evidence-based, effective and lawful**

The strategic approach should require services to:

- Enhance "releasing time to care" by reducing staff activity that does not add value to health care;
- Use best available evidence to provide people with a range of community and hospital-based services;
- Ensure delivery of the full range of mental health care in modern, fit for purpose, accommodation and facilities;
- Improve the operation of mental health and incapacity law and make sure that service users and carers are well informed about their rights;
- Ensure that, wherever possible, specialist services are provided on a local or regional basis, and reduce reliance on transfer to facilities outside Scotland;
- Ensure that relevant data on investment, performance and outcomes is robust and available to all.
- Avoid discrimination and obey equalities legislation.

We have some specific concerns, not all of which are addressed by the consultation questions. We feel the balance may be weighted too heavily towards mild to moderate mental distress at the expense of people with the highest needs for care and support. Our recent report on visits to people with severe and enduring mental illness in hospital highlighted poor accommodation and inadequate recovery-based individual programmes.

Also we have continued to express concerns about age-appropriate services for young people in hospital and the lack of secure accommodation for young people with mental illness.

In relation to the law, we have identified incomplete compliance with treatment safeguards and specified persons procedures. We will be reporting on compliance with part 5 of the Adults with Incapacity (Scotland) Act 2000 and we will be surprised if our previous concerns about lack of compliance have been addressed.

4. I have a right to services that treat me as a whole person, help with all the problems I experience and promote recovery

We would expect to see:

- A strong focus on individual privacy and dignity;
- Further work to integrate heath and social care;
- A systematic approach to improving joint approaches between mental health services and, for example, drug and alcohol services, learning disability services, autistic spectrum disorder services and

homelessness services;

- Focus on transition between services due, for example, to changing needs or age;
- Further work to use the Scottish Recovery Indicator to ensure best recovery-orientated practice;
- Continued focus on reducing health inequalities by improving the physical health of people with severe and enduring mental illness.

Lack of privacy and dignity, especially in old, dilapidated, continuing care wards remains a major concern for us. We report on this frequently.
We have already mentioned the issue of young adults with multiple and complex problems. Often, they were known to services for young people. Strategic approaches to management of transition would be welcome.
At the other end of the age spectrum, the strategy must address the fact that the "baby boomers" are now starting to enter the 65+ age group, the traditional domain of older people's services. While dementia has received a lot of attention, other mental health problems in older adults have been a neglected area. We have found that older adults are denied access to some services, e.g. psychological therapies.
The strategy makes little reference to the specific needs of people with learning disability. They have a greater likelihood of developing mental illness. We are not convinced that "Same as You" contains adequate strategic approaches for the treatment of people with learning disability and additional mental illness.
In relation to integration of health and social care, several of our investigations have identified failures of communication and joint working between health and social care services (for example, "Not My Problem"). Proposals to integrate NHS and social care have major implications for service delivery, not least legal issues regarding the appointment of mental health officers and the perception of independence of their role.

COMMENT ON PREVIOUS COMMITMENTS

Delivering for Mental Health Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months

"Delivering for Mental Health" attached great importance to the physical health of people with severe and enduring mental illness. Our reports over that time since that document was published have consistently shown that the commitments are not being met. A revised strategy needs to restate the importance of attention to physical health and look at ways to ensure that this is given due attention by NHS Boards.

Delivering for Mental Health Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas, later that year
It would be helpful to have a commentary on this. In particular, it would be helpful to have a strategic view on the value of peer support. Is there a plan

to widen the employment of peer support to other Boards?

5. **I and my carers have a right to be involved, consulted and to influence delivery of mental health services**

The strategy should:

- Extend and promote the principles the principles of mental health legislation to influence the whole of mental health care;
- Make sure that information from carers is an integral part of assessment, care and treatment;
- Enhance user and carer involvement and influence in the design and delivery of mental health services.

Carer involvement is vital. We have produced guidance on "carers and confidentiality". We are likely to look specifically at carers' involvement during our 2012-13 visiting programme. Our investigations, such as "Too Close To See", have highlighted a lack of response to carers' concerns. We think the strategy needs to specifically address the needs of carers.

6. **I have a right to have my care delivered by staff that are well trained and supported**

- Implementation of training based on rights and recovery across the entire workforce providing direct care for people with mental health problems
- Increasing the numbers of practitioners who can deliver psychological therapies
- Ensure that staff have appropriate training, supervision and access to specialist advice on legal and ethical matters

Many of our investigations, including "Best of Intentions" and "Justice Denied", highlighted poor staff knowledge and training in mental health and incapacity legislation. "Not Properly Authorised", our report on compliance with treatment safeguards, showed the benefit of regular staff training on the provision of lawful treatment. A frequent finding on our "focussed visits" is the availability of psychological therapies, many of which can be delivered by a range of staff with supervision.

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

We advise:

1. Proper external evaluation of pilot studies and innovative service developments to ensure that they are deliverable across a range of communities and within existing resources.

2. An acceptance by government and politicians that it is not always desirable for safety as well as economic reasons to have locally based specialist services.

3. A strong regional and national planning group which includes not for profit organisations or businesses with expertise and a presumption against the registration of stand alone national specialist resources outwith regional and national planning.

4. Engagement and involvement of all professionals in health and social care relevant to mental health and learning disability in designing flexible and responsive services.

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments

We would expect specific attention to harmful use of alcohol and drugs as an action within this strategy. A major commitment to helping people whose mental health is known to be adversely affected by drug or alcohol use would be welcome. Also, as a secondary preventive measure, much more attention must be given to the duties of local authorities under S25-31 of the 2003 Act. Employment, community cohesiveness and financial support are important but perhaps need reference to other strategies.

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

We have been impressed with the work of the *See Me* campaign. The Government should continue to fund and strengthen it. The Government should also take this opportunity to remind people in the public domain, especially MSPs, to refrain from using stigmatising language and take care over public statements about mental health issues in the media.

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

We suggest monitoring work place recruitment and employment data to identify specific issues of discrimination against employees with mental health problems. Employers should be able to demonstrate that they make reasonable adjustments to give employees with mental health problems help and support. Also, the Government should take a lead in actively challenging and correcting misleading and incorrect information in media about mental illness.

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

Comments

This is not a key area where we are involved, but our suggestions would be:

- Support early intervention strategies.
- Prioritise resources to vulnerable individuals and communities.
- Again, we draw attention to local authority duties under the 2003 Act and strongly advise a process to identify and report on how these responsibilities are being exercised.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

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

Comments

Delivering for Mental Health Commitment 10: We will improve mental health services being offered to children and young people by ensuring that by 2008:

- ***a named mental health link person is available to every school, fulfilling the functions outlined in the Framework.***
- ***basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people***

There should be some commentary on delivery of this commitment.
As the consultation says there is a need to make sure that there is a continuing growth in the capacity of specialist CAMHS in order to continue to improve access to specialist services.
It has been recognised for a number of years that there are significant shortages of professionals within CAMHS, and that there has been a need to enhance the capacity of CAMHS. This gap has been closing with the investments in the CAMHS workforce, and we welcome the fact that the capacity issue is being addressed.
We think the most significant action which needs to be taken is to maintain the focus on workforce development, on expanding the workforce within CAMHS and on enhancing skills within the wider children's services network. To meet the four main challenges identified in the strategy, and the others which influence outcomes for children and young people who need access to services, there is a need to continue to invest in the workforce. We think it is important therefore to continue to regularly monitor, at a national level, the size and skill mix within CAMHS.
With accurate CAMHS workforce figures now available NHS Boards are well placed to plan future workforce requirements to meet the main challenges listed in the strategy. There are also equity issues with regard to access to CAMHS, and some NHS Boards started at a much lower baseline in terms of their CAMHS workforce. Ongoing monitoring would ensure that NHS Boards keep a focus on the development of CAMH services .and of the CAMHS workforce, in line with local needs.

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

Comments

Delivering for Mental Health Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009.

This was not achieved. There should be a commentary on the reasons

for this.

The consultation document refers to the significant pieces of current work which have either been completed, or are ongoing.
We agree that it is important to capitalise on the development of the CAMHS balanced scorecard and on the publication of standards for ICPs for CAMHS. We think using these tools will be a benefit to services, in terms of monitoring outcomes, and we would support a continuing Scottish Government focus on this.
We think that the role of the CAMHS nurse adviser within the Scottish Government is an important one, providing support to NHS Boards, and we would support the continued funding of this post beyond the end of the current contract.
The development of the three regional consortia to increase the number of inpatient beds also provides an opportunity for NHS Boards to plan together to share some other specific specialist therapeutic services which can realistically only be delivered on a regional basis. We would welcome national support for such developments.
We recognise that the opening of Skye House has increased the number of adolescent in-patient beds in Scotland. We think it is important that the work of the regional consortium developing the plans for a new unit in the north-east of Scotland is driven forward and we feel that ongoing national support for this development is crucial to ensure that the proposed new unit is built sooner rather than later. This expansion in the availability of adolescent in-patient beds would obviously assist in preventing admissions to adult wards, but would also assist in the development of intensive community services in the north east. We know that the work undertaken in relation to planning admissions, in-patient treatment, and discharges in the Edinburgh unit has had an impact on reducing the length of stay in that unit, and we would welcome national support to ensure that access to specialist in-patient services is maximised appropriately, and that there is effective multi-disciplinary planning for discharge.
The strategy mentions four main challenges, and we would agree that the challenges listed there are important ones. We also feel that there are challenges in meeting the needs of looked after and accommodated children. We know that work is ongoing within the Looked After Children Strategic Implementation Group, looking specifically at improving health outcomes. We feel that national support should be given to driving forward any actions relating to mental health which come out of the LACSIG work.
We would also welcome national support to help NHS Boards plan to meet the specific needs of the small group of young people who currently will end up placed in adult IPCU settings, or will be placed out of Scotland in secure intensive treatment facilities.

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

Comments

- Ensuring information on existing supports for both service users and carers through statutory services and voluntary sector is well publicised in local libraries, Health Centres, CABs, Job Centres etc. : Support in Mind; Bipolar Fellowship; SAMH; Alzheimers Scotland; Enable; Mental Health Foundation, etc. Centralised national data base for information and support services available nationally and locally would assist.
- Promote greater response by local authorities – not just social work departments- to statutory duties under relevant legislation, especially sections 25-to 27 of MH Act.
- Review NHS Boards response to responsibilities under section 31 MH Act as part of implementation review
- Promote mental health and well being educational input at primary and secondary levels

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

Comments

- We advise continuing work to lessen stigma and enhancing the accessibility of social services and primary care input.
- Increasing general public awareness of their rights to community care assessments and assessment of the needs of carers and how these can be accessed.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

Delivering for Mental Health Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment

models for those who have depression and anxiety and who have coronary heart disease and/or diabetes who are identified under the new QOF arrangements

There should be some comment on progress in delivering this commitment

Delivering for Mental Health Commitment 7: Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010

There should be some comment on progress in delivering this commitment

Delivering for Mental Health Commitment 8: Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009.

We have anecdotal evidence of people in contact with mental health services who have not been given crisis contact information and have had significant difficulty accessing support when they self-present at mental health hospital departments out-of-hours.

We have two additional broad concerns.

The first is equality of ready access to quick intervention for mental health problems. The Equalities Act requires not just equal access but positive action where it is known that access to services is less because of the characteristics of the person. Therefore, the strategy should address differences in access to services on the basis of:

- Gender – e.g. ensuring that services are promoted for (especially young) men as they have a high risk of suicide and may be less likely to use mental health services,
- Age – e.g. ensuring that services offering quick intervention are available for children and older people as well as the 18-65 age group,
- Ethnicity – research being submitted for publication suggests that people from certain ethnic groups are underrepresented in people who use mental health services but overrepresented among people subject to compulsion,
- Disability – e.g. making sure that deaf people, blind people and people with physical disabilities are positively assisted to engage with mental health services.
- The varied geography of Scotland is also important. More use of tele-mental health care in remote communities must be a strand of the strategy.

The second concern applies to people already known to mental health services (although not necessarily in active contact or in loose contact). It is essential that people can access help quickly to catch and treat early

relapse. People in this situation should have information on how to get help in a crisis and be positively assisted to get help if they present in a way that does not absolutely fit the service model.

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?

Comments

Anything that reduces bureaucracy and unnecessary paperwork will help. We have specific concerns about the relevance of some health imperatives in mental health e.g. the requirements to reduce hospital acquired infection. Inspection agencies should develop a proportionate and relevant approach to the implementation of guidance which is principally aimed at general hospitals.

As a general point, NHS Boards and their partners should have authority to be flexible in implementing policy imperatives based on local need.

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

Comments

Delivering for Mental Health Commitment 6:NHSQIS will develop the standards for ICPs for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.

It would be helpful to have a commentary on the accreditation

We advise attention to a relatively small number of critical generic and condition-specific standards. Attempts to report on all standards, all of the time, is not likely to achieve the aim of reducing bureaucracy and releasing time to care.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

Comments

This should be a reporting requirement at Board annual reviews. We advise dialogue with UK benefits agency to simplify payments to service users and carers to enable them to participate in such activities without financial penalty. This can be a barrier to paid participation.

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

Comments

No specific tool advocated, but mutually beneficial partnerships require good communication, respect and flexibility.

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

This is the type of research that tends not to attract commercial sponsorship, so there is a role for Scottish Government in promoting and supporting qualitative research and small scale local evaluations 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)?

Comments

Delivering for Mental Health Commitment 1: We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010

MWC comment – we are not convinced that the tool is in "general use". We are pleased that the consultation recognises this.

Version two of the SRI should be simpler and easier to complete. In addition, add SRI engagement/completion to annual Board reviews.

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

Comments

Use SRI learning networks to further promote multidisciplinary participation.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Comments

This is primarily a professional practice issue within the context of the organisations in which they practice. Individual practitioners must integrate into their values and practice the need to engage families and carers fully, and the organisations in which they practice must give practitioners the training, supervision and space to make this possible.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

Training needs analysis should cover staff awareness and understanding of key pieces of relevant information as to the rights of carers to assessments of their needs; their potential role as named person; guardian; or attorney. Also need to know available information and support services which may be of value to carers and their families.

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

Comments

This is an area where there are rich sources of information that can be used to inform and influence practice. We provide data on the balance between community and hospital-based compulsory orders, broken down by NHS Board. ISD can provide data on length of stay. NHS

Boards and local authorities should be able to identify relative spending on community, residential and hospital services. There is considerable variation across Scotland. Exchange of ideas, e.g. by seconding managers to other areas to observe different practices, may be a helpful way to exchange ideas and help services to learn and develop.

We have concerns that, in some areas, the laudable drive to invest in community services leaves behind a number of people with severe and enduring mental illness in crumbling buildings with a reduction of services which is not matched by better community engagement. The drive to shift the balance of care cannot be at the expense of people with very high needs who may need ongoing care in a hospital setting. The strategy must not forget this group. We are in the process of launching a report that deals with these concerns.

Delivering for Mental Health Commitment 12: We will implement the new Care Programme Approach for all restricted patients by 2008

A commentary on this commitment probably fits this section better than any other. Our evidence is that this commitment is being met. We have some concerns that other service users may benefit from the Care Programme Approach but are not getting access to it.

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

Under the Equalities Act, NHS Boards and local authorities should be able to demonstrate equality of access across the equality and diversity strands. This can be difficult information to collect when a person is acutely unwell as there may be particular sensitivities around some diversity issues (e.g. religion and sexual orientation) that may form part of the symptomatology of the person's illness. Guidance on the Equalities Act is clear that service providers are not expected to ask the person for this information if it can be obtained elsewhere, e.g. held in primary health care records. The strategy should aim for better exchange of this information to provide better equality data, as long as it is in line with data protection legislation.

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

Comments

Bulletins on innovative projects or approaches may be helpful to share good practice in this area.

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

Comments

We find that people in hospital with severe and enduring mental illness do not have the same access to certain services as people in the community. For example, the drive to provide psychological treatments for people in primary care settings results, in many areas, in a lack of provision of these services for people in hospital, and even leads to services being withdrawn when a person is admitted.

The strategy should also address the issue of people transferred out of Scotland for treatments that are only available elsewhere. A particular concern is young people needing mental health care in a secure setting. Transfer outside Scotland must only be for highly specialist services that, because of economy of scale, can only be provided on a UK-wide basis. Secure mental health services for young people should not fall into this category.

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

Delivering for Mental Health Commitment 13: We will translate the principles of Mind the Gaps and a Fuller Life into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007

We advise some reference to the achievement or otherwise of this commitment. We have highlighted the patchy nature of service provision for people with alcohol-related brain damage

In addition, we advise:

1. Flexibility of services and reduction of strict referral criteria
2. Joint working across agencies and across board areas to maximise access to specialist services and also provision of care and accommodation
3. Reduce the number of local authorities and make them coterminous with health boards
4. Review the affordability of expensive single packages of care and develop sustainable models of care.

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

Our target areas would be:

1. Young people requiring secure mental health care
2. Children and young people with learning disability and additional psychological problems
3. An integrated service model across all agencies and specialties dealing with people with acquired brain injury, including alcohol-related brain damage.
4. Proper inclusion of people with autistic spectrum disorder in services that are appropriate for their needs. They should have support from adult mental health or learning disability services, with attention to staff training and the provision of specialist expertise.

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

We support the implementation of induction standards for health care support workers and the phased introduction of registration in social care settings which should help ensure the skills and knowledge of the public sector workforce; however, to ensure patient safety and promote public confidence in care.

Training and education at all levels must be firmly rooted in a rights-based framework. There is scope for the values and behaviours enshrined in the 'Ten essential shared capabilities for mental health practice' to be adapted for use across all health and social care settings.

We know that service users, carers and families struggle to understand the complexities of care provision across the sectors. We think that joint training at post qualification level could enhance cross sector understanding and help families navigate the care maze.

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

Delivering for Mental Health Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers

MWC comment – we remain concerned that people in some age groups and care settings have limited access to psychological therapies

It would be useful to survey the numbers/percentage of staff trained in psychological therapies who are actively delivering these therapies and take action to optimise .

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

Comments

Investment in training, support and regulation of non-registered health and social care workforce. We believe that people receiving 'care at home' are especially vulnerable and require the protection of compulsory registration of support worker staff. We have concerns that the introduction of compulsory registration of care at home support staff is not planned until 2020. Given the national strategic push to shift the balance of care, we believe there is a strong case for earlier introduction.

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

Continue to widen target market beyond core specialist psychology staff

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

See our responses to outcomes 8 and 9. The variation in geography across Scotland means that direct comparisons across all NHS Board and local authority areas are not easy. Using relevant data to compare areas of similar geography and demographics will help to identify and explain differences and find ways to improve service provision.

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

Comments

It is hard for us to answer this, but a database template might help compare services of similar types.

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

It will be a major challenge to implement new initiatives, especially in the context of existing requirements and a reduction in public sector money available. The effect on morale could be considerable. The Government needs to make its priorities clear. It also must ensure that services are not bombarded with a string of requirements, but have an easily understood set of improvements that are measurable and give services recognition for achievements.

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

Comments

We advise a single set out outcome measures with timescales to demonstrate improvements and "sunset clauses" that make sure that Government, inspection organisations and services are not attempting to pile one initiative on top of others.

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

It is essential that the importance of front line supervision is valued and time protected to ensure it is delivered. Training needs and how they are to be met can be covered here. Professional advice and guidance on implementation of legislation in line with the principles of the legislation and individual professions' standards of practice should be at the heart of the supervisory relationship.
We assist with this by producing good practice guidance, advice bulletins and telephone advice. Managers should ensure these resources are available to front-line staff.