## 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 |
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### 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.

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**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.

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**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 |
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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 |
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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?

Comments

**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 Question 7

Infant mental health is a "Gap" in the mental health strategy document, in particular the need for specialist infant mental health services where the focus is on the infant. CAMHS has historically developed as a service for children and adolescents despite being the service that has a remit to provide mental health services for infants aged 0-2 with virtually a complete absence of specialist list tier 3 services for 0-2's.

Outcome 2 outlines the need for attention to be paid to the early years and childhood to respond quickly and improve short and long term outcomes. However, it does not directly address the issue of what is now generally the accepted view which is that the first year of life is crucial for both emotional and cognitive development. We know what experiences infants need for their development of good mental health and what can happen if there are problems which are not addressed. It is well understood that adverse circumstances can lead to considerable impairment and severe problems even at a very young age. It follows that there is the most to gain from early intervention from birth onwards.

There needs to be a continuum of care and Svanberg and Barlow (2009:186) suggest 3 levels of service for infant mental health including universal programmes that are for the promotion of health development and enable screening for difficulties at an early stage, targeted programmes which are for infants who are at increased risk and indicated programmes which are for infants where serious

problems are already present. This tiered arrangement needs professionals who have appropriate training and supervision to help them be aware of difficulties that are developing and to know when to refer on and when tier 3 services, who are able to provide highly specialist services such as parent infant psychotherapy, are indicated.

The organisational obstacles to this are likely to be a shift to thinking about CAMHS as an Infant, Child and Adolescent Service. A "need for a shift in the philosophy of both service providers and planners to enable the provision of more *infant-centred services"* Svanberg and Barlow (2009: 186) and an increasing lack of universal ante-natal care provision.

Other obstacles to providing a service are due to the lack of infant mental health expertise to be able to recognise mental health difficulties in infants, to provide specialist treatments and to supervise this work. Any suggestion that babies face severe difficulties may raise concerns about stigmatising mothers. Also this is a painful subject to think about and the current view is that support needs to be given to mothers and this will resolve any difficulties that babies might have.

Whilst outcome 2 is welcomed without attention at this very early phase of life and development to outcome is likely to be very much harder to achieve.

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

Comments Improving mental health outcomes. Question 8

The key outcome which I would like to focus on behalf of the association of Child Psychotherapy is the "Improving access to psychological therapies" HEAT target. That Child Psychotherapy is specifically mentioned is welcomed as the current situation is one where there is access to this highly specialist treatment in only 4 of the 14 NHS Health Boards.

There are 12.4 WTE (headcount 14) qualified child psychotherapists employed in the NHS in Scotland. Many NHS Boards are undergoing re-organisation and some retiring child psychotherapists may not be replaced.

SIHR is currently training 6 child psychotherapists whose academic component of the training is funded by NHS Education for Scotland. This is a single cohort in the third year of a four year course with no students following on.

Given the small number of qualified psychotherapists in the NHS, many of whom are due to retire over the next ten years, by the time the six students qualify, in 2020 the number of qualified child psychotherapists is likely to be less than it is at the moment.

This direction of travel is opposite to that recommended in the Strategic Review of the CAMHS Workforce: Getting the Right Workforce, Getting the Workforce Right.

| NHS BOARD | Qualified WTE | Trainee | Population | Recommended Per 100,000 population |
|---|---|---|---|---|
| **Ayrshire** | **3.0** | **0.0** | **366,866** | **3.0** |
| **Borders** | **0.4** | **0.0** | 112,870 | **1.0** |
| **Fife** | **1.5** | **2.0** | 364,945 | **3.5** |
| **Forth valley** | **0.0** | **0.0** | 293,386 | **3.0** |
| **Grampian** | **0.9** | **0.0** | 550,620 | **5.5** |
| **Highland** | **0.0** | **0.0** | 310,830 | **3.0** |
| **Dumfries and Galloway** | **0.0** | **0.0** | 148,190 | **1.5** |
| **Lothian** | **0.0** | **1.0** | 836,711 | **8.0** |
| **Greater Glasgow and Clyde** | **2.0** | **2.0** | 1,203,870 | **12.0** |
| **Tayside** | **0.0** | **0.0** | 402,641 | **4.0** |
| **Orkney,Shetland and Western Isles** | **0.0** | **0.0** | 68,700 | **0.5** |
| **Lanarkshire** | **4.6** | | 562,477 | **5.5** |
| | **Total 12.4** | | | **Total 50** |

2010 mid-year population estimates reference - (http://www/scotpho.org.uk/Populationdynamics/Populati...) downloaded 11.08 2011)

Child Psychotherapy is relatively new core profession in Scotland and until recently Child Psychotherapists have been trained with the support of a charitable fund which was intended to help the profession become established. The current training initiative, with funding for the academic component of the training being made available through NES, for 5 trainees has been very welcome but will only have improved the distribution of Child Psychotherapy in Scotland by one Health Board. This means that children and young people in need of treatment can only receive it in about a third to Scotland's Health Boards and in only two will the level of provision approach the level recommended in the 'workforce' document. Child Psychotherapy is doctoral 6 year training with a 2 year pre-clinical requirement followed by 4 years clinical training. Our view is that the Health Boards will be challenged to fund training places without financial incentives, particularly in the current financial climate.

**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

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

Comments

**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

**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

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

Comments

**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

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?

Comments

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

**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

**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 22

In order to show that the government is committed to providing equity of access across the age range information required from Health Boards as an addition to the 'balanced scorecard' should include what percentage of cases seen by services in a given year are:

(a) 0–2 years old?
(b) 3–4 years old?
(c) 5–11 years old?
(d) 12–16 (or 18) years old?

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

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

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**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 |
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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
In order to develop the capacity of the CAMHS workforce to be able assess provide a service to the 0-2s a priority needs to be the provision of training in the understanding infant of development and mental health across the workforce.

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

**Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.**

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

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

Comments

**Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.**

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

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

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**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 |
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