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

The 14 broad headings are comprehensive and appropriate. It is crucial that development and delivery are evidence based, and that there is capacity to deliver quality services at the right time to patients of all ages and backgrounds, and to support their families and carers.

Children and young peoples' needs are clearly highlighted in Outcome 2. We would stress that all outcomes have relevance across the age range and that children and young people's mental health should be included across all outcomes.

Key challenges include building an evidence base in Child and Adolescent Mental Health. Clear emphasis on the importance of academic/ research infrastructure. Recruitment to psychiatry including child and adolescent psychiatry remains challenging. It will be important to have support to improve undergraduate medical training in all areas of mental health, and support postgraduate training and recruitment.

Links with other areas of health service need to be stressed and the practice of working closely across all disciplines and agencies needs to be maintained and developed.

Key priorities include improving training for all staff but in particular focussing on development of evidence base and clinical leadership. The capacity of the workforce to deliver high quality care and treatment requires support for staff to access training and do research.

Staff need support and recognition. All staff are patients at one time in their lives and many are involved with mental health services as patients or carers. Staff views overlap with users' and carers' views and this can be very valuable in shaping services. Morale in some staff groups has been low and it is important to develop a culture of celebrating success rather than focussing on problem issues.

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

Improve training at undergraduate and postgraduate level for all disciplines, especially in quality improvement methodologies.

We need to get better at understanding the incentives and motivations that drive the behaviours of individual clinicians, teams and services as a whole: inertia or resistance to change should become understandable factors amenable to intervention.

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

Developmental disorders are increasingly being recognised in children, young people and their families. The prevalence is noted to have increased massively over the last decade with in some areas 1 in 5 school-age children noted to have additional needs.

HIS has reviewed services for children and young people with ADHD and SIGN have developed guidelines for ADHD and autistic spectrum disorder. There is a requirement to increase service capacity and training to address the needs of this group. It is also crucial that there are not perverse incentives for diagnosis and that children and young people are not denied appropriate services if their developmental difficulties fall short of diagnosis but still adversely affect health.

So many young people show developmental difficulties that it is important to support them not to see themselves as different or abnormal. Self esteem and confidence are important to this group of patients, this can be addressed through psychological therapies and training and support to families, carers, teachers and other involved professionals.

Transition to adult services needs to be well supported and development of adult services for developmental disorders requires to be highlighted.

In general, the areas mentioned do have an evidence base. The difficulty lies in designing the right components of the complex interventions required to implement those services. The Government should fund carefully-designed pilot programmes to assess possible models for implementation- eg for ASD, borderline personality disorder.

NB We should take care to define "trauma". For some people this refers to PTSD, for others it refers to childhood adversity- these are often different problems requiring different responses.

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
A critical appraisal of social networking would also be useful. Cyber bullying is a growing stress for children and young people and research in this area would provide information.

The debate and discussion around suicide needs to extend far beyond health services, since the determinants of suicide are social and developmental.

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
"Discrimination" is probably a better focus for actions than "stigma".

School education can address issues early. Primary care mental health has a role in working with schools to develop and deliver age appropriate teaching around health improvement.

Improving mental health training for all professionals working across health and social services.

Work could be done to target specific behaviours in specific areas in the health service- eg self-harm presenting to A&E.

People with psychosis or borderline PD or mild depression will experience stigma in different ways because of their different experiences. Better public education about the forms of mental illness- and improved "consumer awareness" about care pathways- should help improve general understanding and hence reduce discrimination.

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

See above...

- A focus on discrimination, not stigma
- Improved awareness of "consumer rights" in health and other services
- Maintain efforts to promote "recovery-based" practice
- Help NHS staff and general public to know what they should do, rather than simply be "aware"... most people don't want to be perceived as stigmatisers, but are not sure what's required.

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

Comments

Better mental health and wellbeing is closely associated with meaningful engagement with others. We organise our communities around local neighbourhood committees and local and national government. Improved democratic engagement at all levels of social organisation represents a "social good" in its own right, and is also one of the ways to improve social cohesion and group wellbeing.

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

Improve capacity of the workforce. CAMHS mapping has shown that overall the workforce has grown and access to CAMHS has improved however there is no clear evidence that outcomes are improving. There are internal and hidden waiting times as patients can wait for long periods to access more skilled members of the team, in particular psychiatry. Psychiatrists are increasingly working with children and young people in brief focussed episodes around medication, complex needs and clarifying diagnosis. There are bottlenecks in the CAMHS pathway which delay timely throughput and impinge on patient care. Getting the right balance of skills across the

workforce not concentrating only on generic staff numbers is vital to improve outcomes.

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

Comments
More skilled staff in teams in particular psychiatrists who are trained broadly to assess a full range of serious presentations. This would allow patients to have high quality timely assessments and management and reduce hidden waiting times. Encourage Boards to use the broad skills of psychiatrists in leadership and development of CAMHS.

Multidisciplinary staff need to be involved in continual professional development. We welcome the NES Competency Framework which provides a structure for CAMHS staff training. Development of nurse prescribing in eg ADHD would help to spread the growing task of supporting this patient group. Improving skills of the workforce will help patients to access high quality care.

National ICP development in CAMHS has provided a quality framework for Boards to look at pathways and improve the patient journey. This work needs to be promoted and supported centrally so that ICPs are taken seriously and used to benefit patients locally.

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
Public health promotion needs to continue to include mental health in a non stigmatising way.

Try to limit our discussion of "mental health" as a vague, generic concept- and instead talk about "low mood", "psychosis", "memory problems", "eating problems" etc etc.

Recognise- through Keep Well and other programmes- that the actions we take to promote physical health are often the same as those needed to improve mental health.

Develop a national awareness of health improvement measures designed to prevent dementia (largely the same as those to promote CV health).

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

Comments

Reduce stigma and improve public health.

Care pathways- for dementia, borderline, depression etc- should be promoted as "public documents" for discussion, debate and implementation by patients as consumers.

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

If there is improved identification there needs to be a parallel improvement in capacity of specialist CAMHS and other mental health services when dealing with children and young people.

The problem is that "mental illness and disorder" is often a complex mesh of personal, developmental and situational difficulties. We need clinicians who

can "formulate" this complexity and propose meaningful responses- rather than staff who seek to compartmentalise problems into over-simplistic categories.

We should try to use "stepped care" models, based on routine outcome monitoring, to deliver programmes of care.

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
More education in these improvement methods should become a standard part of CPD for all disciplines, including managers.

Most of all: a long-unmet need for an electronic patient record, capable of recording and reporting service use and clinical outcome measures.

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

Comments

1. Information: current data systems are wholly inadequate to the task. While it is possible to extract some relevant information from current paper and electronic systems, it is incomplete and resource-intensive.

2. Service user involvement- so that patients and staff work to the same objectives.

3. Clinical leadership needs to be supported to link this work with current activity around access to CAMHS and development of local pathways. All areas of mental health could work together to share learning rather than a separate approach across different age ranges.

4. Within CAMHS development of condition specific ICPs would be helpful to allow for review of best practice and equity of care, eg developmental disorders. Existing adult ICP work could be expanded to adopt a lifespan approach.

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
There is a need to collect PROMS and other data for every clinical interaction or illness episode- this provides continuous feedback that is otherwise still lacking.

We need to make use of the potential for the new PMS to include information delivered by patients into their own care record. Some patients

would benefit from a move away from dependence on infrequent face-to-face consultations towards a more "user-led" form of contact using email and other media to ask questions and seek advice when it's needed.

The potential for peer support using social media is still under-developed. We could make more use of social media to collaborate with patients to share information, discuss problems and develop services.

Within CAMHS there have been many initiatives to involve users and carers. A locality based approach has advantages as users and carers are generally engaged across a range of local services working together.

Existing initiatives, eg locality users groups (often in health linked to specific conditions-ASD group in Inverclyde) are very helpful. Clinicians can attend and discuss informally any issues. Inviting users to professional groups can also be helpful.

It would also be useful to engage with staff as users and carers as with high prevalence of MH difficulties many staff have first hand knowledge and may be interested in contributing their views.

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

Comments
Training in psychological therapy esp family therapy particularly in CAMHS but important across the age range.

See also comments above.

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

We need to treat staff as we expect them to behave with service users and carers. We should articulate the values of our NHS (eg respect, confidence, self-reflection, evidence & critical enquiry) and seek to live by those values both amongst colleagues and with patients.

In CAMHS GIRFEC underpins the service.

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

Comments

If services are not implementing it as intended, we should begin by asking them why not.

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

Comments

see above

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

In CAMHS families/carers are involved in every case. Training for all professionals in working with families needs to continue. CAP higher training curricula include competencies in this area as does the newly developed NES CAMHS Competencies Framework for MDT staff. Backfill and funding needs to be provided to allow staff to access ongoing training.

Within core psychiatric training it would be useful for all trainees to have experience in CAMHS to allow for learning around family involvement.

Public education about families roles, school based initiatives in training can provide information to users and carers about the importance of family involvement.

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 as noted in Q19. backfill and funding and time in job plans. Availability of administrative support, information about community supports and other services. Equalities training.

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

Increased academic capacity in NHS CAMHS is needed to provide more outcome based research. There has been a reduction in academic posts in recent years in Scotland and NHS consultants contracts have been changed reducing SPA time. Research should be encouraged and supported in all areas of mental health so that services can deliver evidence based practice. National Boards , HIS and NES, have an ongoing role in national review and guidelines on best practice.

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

Will probably require a range of methods, including patient surveys, focus groups, "consumer panels" from the relevant groups etc.

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

Comments

Usual channels- but consider more use of social media in future.

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

Comments

In CAMHS there is no Scottish Adolescent IPCU. Young people have had to access adult IPCU when needed to manage risk. This is not ideal and carries additional risks.
Forensic CAMHS has only one consultant and small team in GGC. There are no inpatient beds in Scotland.

The prevalence of developmental disorders notably ADHD, ASD and Tourettes, is increasing across all ages starting in CAMHS. Capacity and training issues need to be addressed. Transitions between services need careful management. A pathways approach to transitions may be helpful.

A large gap for people with borderline personality disorder.

NB "trauma" is a term that may refer both to people who have experienced PTSD and those who experienced childhood abuse; there is some overlap between these groups, but not always. Suggest avoid this term.

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

There need to be clear lines of governance and supervision when clinicians are based out with mainstream services separate from clinical workers. Confidentiality, record keeping and staff support need to be considered

also.

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
Continue work in CAMHS across agencies at all levels.

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

Implement and support ongoing training as noted above through existing undergraduate and postgraduate curricula and the new NES CAMHS Competency Framework.
Reward good practice. Disseminate learning points from good practice examples, eg PYRAMIDS.
Development of clinical forums and MCNs,eg Regional CAMHS Networks for Tier4.

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

The view from CAMHS is to increase higher training numbers in Child and Adolescent psychiatry and consultant psychiatrists in CAMHS. This would help provide quality CAMHS clinical care and leadership. It would also support patients to access high quality appropriate care when needed rather than have patients face hidden internal waiting times for consultant input. Recruitment to consultant posts outwith the central belt of Scotland is problematic and this may reflect the female demographics of the workforce. Regional planning and networks may help address this issue.

From a more general perspective, workforce planning is complex, since many tasks and functions are not discipline-specific, and cost-effectiveness is hard to define. For example, many/most junior doctor tasks can be carried out by other staff and teams. Although consultant psychiatrists have a high "unit cost", the cost per "treated episode" is probably the lowest of all staff groups, because patient contact time is typically low, and caseloads typically high.

It is therefore difficult to know how workload should be shared between doctors and other staff groups, yet without this knowledge a clear workforce development plan is hard to achieve. There are concerns that cost pressures will produce a recruitment freeze, limiting training opportunities, and storing up staffing problems in future.

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

Up-to-date information on DCAQ for all services should be the gold standard- we are some way from being able to achieve this.

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

Comments

Encourage use of outcome measures. Local flexibility about this using evidence based measures. CORC for CAMHS has been suggested but there are capacity and training issues for this to be meaningfully implemented.

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?

Quality improvement approaches should become a standard part of CPD until all staff have a basic knowledge of process mapping, wait list management, DCAQ etc. Unless these approaches are widely understood, it will be difficult to make widespread change in the way we need to.

Consider making this mandatory (as we do for child protection, infection control, life support)- at least for a limited period.

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

Comments

Engage clinicians at coalface and ensure that management support evidence based approaches. Continue to to invest in and develop clinical leadership. Invest in quality training of all staff. Engage users and carers in service planning.

One powerful motivator would be to use peer support and peer comparisons to highlight commonalities and differences. Reliable, continuous data collection and analysis.

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
Training and capacity.