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.

Overall, it was welcomed that this strategy seeks to use the NHS quality improvement framework and also to integrate a broad spectrum of mental health concern, from health improvement at a population level to service provision at the individual level. There also seemed to be a way of analysing services for those with mental health difficulties and distress and those with mental illness.

The broad scope did bring together individuals within the CHCP to discuss their response to the questions posed and it became clear that often people working on this spectrum have passionately held views about service direction based upon their sphere of influence and the primary population their serve. This led to interesting and at times heated discussion where often people where not thinking of the same service group, using the same theoretical orientation or using the same language. This typifies the challenge of integrating services and integrating strategy and an attempt to do this is welcomed, but possibly the differences need clear articulation for any common ground to be mapped – those who talk about 'up-streaming' and the primacy of early intervention and prevention may not be understood by those who are drowning in an excess of demand for service today. Like wise those who concentrate on today's work may be challenged to broaden their scope to encompass earlier interventions. The development of a more robust and shared evidence base will help these discussions – integrating the spectrum of interventions in this strategy is a positive step.

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.

A National analysis of spend on these services and the relative cost of austerity – it may be that a national growth in service spend is needed at such times rather than service savings when compared to other areas of health. A robust examination of the evidence would be helpful.

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
There is a need to develop support for governance arrangements in care homes, what ever the ownership

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?

The consultation acknowledged the fact that both completed suicide and self-harm are behaviourally defined groups with a varied composition including illness, addiction, personality difficulties and psychosocial difficulties. There was also reflection upon the fact that those who were consulted come from rich and varied backgrounds and experience such that view points were at times difficult to reconcile.

Views included:

- Greater work on alcohol and addictions both from a service and a public health perspective given the links made to suicide (and homicide) in the national confidential inquiry. Suggestions that this should include the re-examination of pricing structure for alcohol and acute alcohol in-reach resources for the general hospital.
- Continued work on the culture change of suicide awareness and training of the wider public and non-mental health staff.
- Continued work in health improvement to build capacity within and for resilient communities.
- More robust analysis of the work done in public health prevention such that the balance of prevention and treatment can be better understood
- Support for therapeutic approaches within talking therapies for approaches such as DBT (Dialectic Behavioural Therapy) to support individuals to change long term self-harm patterns
- Integration and constancy in the support and methodology of suicide

reviews – supporting local skills and local learning, national lessons shared in a way that facilitates local learning and professional growth.

- Access to a range of therapeutic options and work to ensure an inclusive approach to accessing these
- Appreciation in suicide reviews of the balance clinically of coercion and therapeutic risk taking – awareness of the need for staff psychological safety and learning organization frameworks in situations where staff can feel under attack for work undertaken in the spirit of recovery frameworks that is analysed without this understanding.

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

Again the issue of long term culture change was raised and the need for effort to continue long term, and that the efforts need to be on a number of fronts including early intervention for example in schools.

More work to increase awareness in schools

There is also a need to work with mental health in the workplace – although some valuable wok has been done by The Scottish Centre for Health Working Lives lived experience of this in the work place – including public service – is patchy. There needs to be a better developed sense of managing common mental health issues such as stress, but also mental illness such as depression and the need for a balanced approach to work support and reasonable accommodations. In part, training for managers can help with this. There also needs to be a well-developed occupational health service, particularly given the fall in employment chances for those with mental illness during times of economic hardship.

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?

We need to ensure that all processes of redesign and demand management currently being used to make services more efficient give sufficient weight to the other quality improvement imperative of being person centred and responsive and flexible at an individual level. The key is an attitude of humanity. This aim could also be supported by keeping a human rights approach in mental health, as exemplified by the publication 'Care about Rights?' by the Scottish Human Rights Commission

In management and leadership terms the essence of this is staff training and empowerment to allow the best for each individual service user and their family. Essentially this requires government to support diversity and localism in service development.

It is also important that mental health problems are described in accessible language and normalised in this way.

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

Strategies to tackle vulnerability factors – social isolation, poverty, deprivation for example. Point made included:

- That this is particularly marked for those with long term mental illness, and many services provided by health for this group in these areas have been scaled back before there have been concerted efforts to build capacity with other agencies as health priorities have been stretched.
- That there is an evidence base that tells us what the risk factors are, we should focus on reducing these risk factors and put more resources into enhancing protective factors similar to an 'asset based' approach in communities where there is a a focus on the positive aspects of communities and celebrates their strengths rather than the usual focus on the negative and what's wrong with them. Community development plays a crucial role in promoting community resilience and bringing people together and should be promoted as a way of working with local people.
- That there should be more access to supported help such as stress control, living life to the full, Wellness Recovery Action Planning and all these evidence based programmes that are working well.

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?

Again the consultation looked at mental health broadly – welcoming the evidence based early years programs (such as the 'incredible years') with a recommendation that these approaches be universally available.

There was an acknowledgement that there is a need for capacity development in schools, so that those with *mental health* issues be appropriately supported and that capacity and resilience be developed within individuals where possible.

In parallel, there should be emphasis within the government's Early Years/Early Intervention programme on mental wellbeing of parents/carers. There remains a need for specific workforce development on what constitutes upstream enablers of mental health and wellbeing.

There were also comments on the need for specialist referrals and link workers so that where more is needed there are rapid referral routes.

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

Mental health link workers in adequate numbers per head of population with

a focus on working with parents and teachers as well as children

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?

Access to a range of choices to therapeutic interventions outside services as well as within (phone, IT based and also face to face). These interventions should be holistic, including evidence based interventions such as exercise for low mood, delivered in main stream services. There is a need for capacity building and good level of information / support to underpin such a change

We need to be careful about the labelling of *distress* as illness – and where there is an aspiration for this to be labelled as distress (and for the solution to be support and empower individuals to take ownership through short term intervention rather than to become long term users of direct service) this needs to be supported at every level of national and local government if this culture change is to be effected. Expectations need to be consistently shifted at all levels if this is to be achieved.

Moving to mental illness, there is a need for services to be aware of their ability to disempower their users and for care plans for those with longer term illnesses to focus each person's recovery, relapse prevention, and anticipatory care to facilitate illness self-management. Again, this is a culture that has begun to change and supported by the work on recovery and self-determination.

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

The range of choices need to be understood in a wide range of places – from primary care and A&E in health to a wide range of social policy service provision, the third sector and the police. The culture shift of mental health being everybody's business rather than just specialist services needs to be built upon, and training and expectations places upon these service areas to ensure effective level of professional assessment and signposting.

Capacity building in these areas should reduce the need for secondary care systems to manage excess demand, and in this way services should be able to reduce any barriers that presently delay treatment for those with illness. Where there is a possibility of a relapsing course to an illness, anticipatory care plans are required and more staff awareness and training to support this should be available.

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?

For mental illness presenting in childhood attention to schools education and link workers to build capacity should be pursued, particularly for those at higher risk such as those who are looked after and accommodated children. Also a need to look at service for children who are the carer of adults with mental health problems and to ensure the needs of this high risk group are met.

Concern was expressed during the consultation about the ability of some early intervention service models to deliver accurate assessments and cost effective interventions and the ability of these services to reduce resources from services for those with demonstrable illness at a time of austerity. There needs to be practice based evidence – separated from rhetorical arguments for service funding – for service providers to be sure that some of these approaches add the value hoped for when they were argued for.

One suggestion in this area in term of early intervention and self care is that there be a national program looking at psychosis – raising awareness of the public to seek help, understanding the links with street drugs, primary care awareness of the effect of untreated psychosis and an integrated approach in secondary care rather than stand alone services.

We need to ensure that primary care workers have the skills and supports to identify (where possible) the difference between mental health problems needing signposting and emerging mental illness requiring access to specialist services

Work to ensure that the popular 'step care' models are actually about matching care rather than a series of filters with increasing difficulty to access a god enough assessment

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?

This question prompted a discussion of practice based evidence – and the sense that more efforts are being made to look at evidence for complex population groups with multiple problems but that still too many assumptions are made about the ability of a simplified and incomplete evidence base with large gaps – especially in those areas not easily quantified- overall the links between frontline staff and academics need to be continually strengthened to ensure that the experience gained by each can be combined to produce the best guiding evidence.

There were a number of specific points:

- For some interventions there has not been the work to demonstrate an evidence base – we need to take care that these are not labelled 'non-value adding' without a robust evaluation to determine the value. There may be a need to respect evidence for a variety of models, especially for complex psychosocial constructs that defy positivistic methodology
- Success with the support of clinical staff by admin and housekeeping staff – releasing time to care, lean approaches to support clinicians having the time to do clinical work (i.e. using evidence based methods outside the clinical arena to release clinicians time for clinical work).
- There needs to be work on integrating initiates between health and social policy at governmental level – often it can be difficult at the grass roots level without this and this will lead to duplication of effort
- There is a huge problem of IT systems, how they record, how they are compatible, how they stand in the way of partnership working and how staff end up working to the IT system rather than IT supporting clinical or evidence based endeavour.
- Where there are national initiatives – such as ICPs –with large cost and opportunity cost these must be rigorously analysed to ensure benefit and that the staff involved are made aware of the balance of these.

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

The key challenge has been the number of element and the ambition of the

ICP project – if staff are to continue to be engaged with this alongside competing priorities there needs to be some feedback about the level of value added for the work and expense so far.

The largest pitfall here is the lack of IT, and that IT designed around ICPs will not necessarily meet the demands of CPA, ASPA or even single shared assessment all of which are competing for implementation (despite the complimentary nature)

Other feedback included a focus on the work to integrate recovery programs for looked after children in a similar way (i.e. via a pathway) of joint health and social policy.

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?

- Inclusion of service users in the interviewing of ALL mental health staff irrespective of professional background or seniority
- Continue to ensure good advocacy is in place and is funded – both for individuals and collectively
- Build policy around a presumption that all organizations and agencies need to integrate care and support around the individual- 'one person – 'one care plan' rather than developing organizationally centred care planning resulting in the individual having multiple care plans that they need to integrate

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

- Alongside metrics of waiting times / numbers seen to ensure that there are measurements of partnership – for example use of the CARE as discussed in the Quality Strategy (2010),
- Locally in West Lothian Rehabilitation Services a measure of relationships between staff across health, social policy and the third sector are being developed within a social capital paradigm. The model chosen, relational coordination, is evidence based and links to reduced medical errors, staff satisfaction, team resilience as well as clinically important outcomes in other medical setting where it has been used (orthopaedic surgery – showing a correlation between high team relational coordination and reduced length of stay and quality of pain relief). Within this work there has been an emphasis on staff inclusion in the process and the development of distributed leadership with staff being involved in the action research project, not its subjects. The next step in development will be to explore the use of this methodology with service users and carers. More information available if helpful
- Talking Points could be more broadly piloted

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?

- Consideration given to a Human Rights focus within services
- Balanced measures as above alongside process measures (recognition of the fact that what you choose to measure has consequences for service culture)
- Evaluation of each initiative nationally at a service user perspective – for example consideration that initiatives such as new paperwork and IT systems may become the focus rather than the individual relationship with the service user and mitigation of this if approaches are to be adopted.

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

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

- Holistic engagement of the multidisciplinary team rather than single professions when developing practice
- Greater articulation of regulatory models and their relationship to recovery models – and the ways in which recovery can be supported even within a regulatory frame

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?

- Inclusive reviews – careful evaluation of feedback
- Supporting continued value for listening and inclusion of views – plus good quality routine and specific information
- Continued financial support for advocacy and carers advocacy / support
- Carers assessments consistently carried through

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?

- A mental Welfare Commission Review of the legal and confidential issues around balancing the needs of the service user and carer where there is conflict would empower staff in these very difficult situations
- Availability of good quality information for carers in multiple formats
- Ring fenced resources for carer advocacy

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?

- Invitation for teams themselves to present redesign work rather than a central interpretation of value
- For the promise of quality in terms of effect and person centred care to read through to redesign which is often valued for budgetary savings alone
- Better dissemination of this information

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?

- Pursuit of the public health agenda re suicide reviews – the population not in touch with services – to identify high risk groups that may not have had access to services
- Analysis by the mental welfare commission of first presentation via the Mental Health (Care and Treatment) (Scotland) Act to see if there have been delays or missed opportunities form which services could learn
- Culture in A&E of analysis / link with primary care for analysis for those who attend and do not stay for assessment
- Communication of inclusion strategies and their evaluation
- Survey of minority or excluded groups to gather helpful service user information

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

Above information collected and disseminated – it may be helpful to have a monthly email with links to this and other information – training, legislative changes etc. Busy frontline staff do not always have the time to keep up with all that would help in their role and this could be a relatively efficient way for them and a cost effective way for the Scottish Government

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

Services for alcohol related brain disorder
Service for dementia in general in the younger age catagories

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?

Easier access to up to date information shared across services

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?

- Increasingly the police play a role in identifying those with mental health problems in the community and this is one area where partnership working will be pivotal. In West Lothian we have a standard operating procedure that gives these individuals the opportunity for assessment where the police consider there is a risk. The partnership working continues to be developed, but this does give a better and more flexible response (and access for disenfranchised populations) than used to be the case.
- Another population that requires core service is male prisoners

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?

- Better awareness of this document across all staff groups
- Explicit linkage to current training and governance

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?

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

- Many services have seen a reduction in RMNs and the skill mix review need to be considered – where services have done this there will need to be thought and care to maintain service quality with this skill mix, and training developed for non-registered staff and support staff. There also needs to be acknowledged that these changes will not be suitable for every service setting and that where such changes in skill mix have been undertaken audit of impact on quality need to be carried out

- There are likely to be a high number of retrials with the pension changes – this will face a challenge to services with cohorts of staff at this age such as West Lothian.

- Continue the choose life training for those staff working with children and young people. Staff in schools need to be supported to meet the curriculum for excellence outcomes and those services that that work with young people at risk such as LAC. More choices, more chances etc need to be aware of how to promote mental wellbeing.

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

Training must be targeted and take into account the service costs of staff time.

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.

Access to research findings for those doing early intervention / early years work to provide evidence of what works and how to evaluate best practice in other areas

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

- As part of leading better care 3 clinical quality indicators have been set (food/ fluid, pressure areas and falls) these are all relevant to inpatient mental health units but it would be good to see a fourth debated that is specific to mental health and wellbeing
- There may be tension between local and national outcomes priorities, especially those agreed in collaboration with service users. Local services need to have input on what clinical outcomes are used and what other measures should be reported on.

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?

- Better dissemination of the work of the mental health collaborative and sharing of practice
- An appreciation of the *leaderships* required rather than a monolithic definition of leadership which can conversely disempower the distributed element of leadership and ownership for progress to be made at the service level.

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

- Better availability of information set in clinical narrative terms.
- Evaluation of the upstream work and capacity building, with the resource to double run services whilst these changes are taking place
- Training and capacity building for public access to non-clinical supports such as living life to the full, stress control, exercise etc

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?

Greater availability of training – including training by expert practitioners – in a range of accessible formats but including face to face training in the application of legal principles