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

Lanarkshire Partnership Response: Methods

The Lanarkshire partnerships (NHS Lanarkshire, North Lanarkshire Council (NLC), South Lanarkshire Council (SLC), Voluntary Sector and Service Users and Carers) have come together to review the strategy and to prepare a joint response which reflects the partnership approach to mental health and well-being across the NHS Board area. Within this approach any unique views of partners are also shared. A number of methods were used to gather specific views.

There is "no health without mental health" and therefore this draft strategy is of interest beyond just mental health services and views were proactively gathered from a wider audience including, Lanarkshire Alcohol and Drug Partnership, Public Health, Early Years forums, Healthy Working Lives, Local Area Teams and Education etc. A standard partnership e-mail was agreed and widely distributed. This was also targeted at key individuals and groups who were asked to give views on specific points relating to their areas of interest across life span, settings and high risk groups cutting across the prevention, promotion and care and treatment agenda. A single point of communication was created for all responses.

Rather than having a single consultation event the draft strategy has been included on multiple agenda's with focused discussion and specific comments gathered. Representatives from the partnerships were also in attendance at the national consultation event on the 7th December.

Service user views were gathered through a number of channels, but also, and specifically through working with Lanarkshire Links (Service User and Carer Involvement), with the Strategy being consulted on at the members meeting (over 120 members attended) on the 14th December.

Key Points

This comprehensive Lanarkshire partnership response is detailed, respecting the 35 questions that were set and the need for all partners to have their view represented. A number of key themes emerged from the consultation process, which require a national focus to support local service improvement:

- **Style**: The mental health strategy as it stands has fourteen broad statements, which are described as outcomes. These outcomes require much clearer definition in terms of objectives which lead to outputs and outcomes, which will then aid local implementation.

- **Integrating the prevention, promotion care and treatment agenda** is largely welcome and replicates the approach being taken in Lanarkshire. However, the overwhelming initial feedback is that the strategy needs to give greater focus to the prevention and promotion agenda, recognising that the infrastructure created through Towards a Mentally Flourishing Scotland has laid the foundation and given the strategic focus required to support local direction and good progress has been made. It is recommended that the 6 high level priorities, children and young people, later life, communities, work place, preventing common mental health problems including suicide and self-harm and improving the quality of life for people with mental health problems, which were contained within TAMFS remain with a view to building on these previous commitments by introducing one or two more actions under those commitments. Greater focus needs to be given to promoting mentally healthy communities with community asset building underpinning the approach.
- **Embedding the strategy within the tiered model 0 (wider community prevention) to tier 4 (specialist services)** will help demonstrate how the integrated strategy comes together. This promotes a whole systems approach to mental health improvement - prevention, promotion, care and treatment.
- **Shifting the balance of care:** A Mental Health Strategy for 2012-15 needs to set the tone and direction for services. The outcomes, as stated are reasonable but the strategy fails to acknowledge the desirability of a shift in the balance of care from institutionally based models towards those in the community. We propose changing to an outcome that over the period of the strategy there is an expectation that the proportion of care delivered in community settings as opposed to hospitals will increase and that resources currently tied up in hospital care should be released to support improved community support and treatment. We should indeed capitalise on the knowledge and experience of systems that have successfully rebalanced services through redesign. It is strongly recommended that the strategy needs to set a direction to support further movement away from institutional care towards more person-centred community services. The question for services should be how far and how quickly can they achieve a further shift in the balance of care, not how we (or whether we can) determine the correct balance
- **Set the context for local delivery of the new strategy within partnership and integrated structures,** building on TAMFS, which did this very well in the first few pages within the 2009 document and therefore we have a very useful blue print. These principles apply to both prevention and promotion, and care and treatment.
- **Local Authority and Voluntary Sector** contribution requires greater recognition within the document. The role of Social Work Advisor within the Mental Health Division at the Scottish Government is seen as very important. It may be that an increased involvement of Mental Health Officers (MHO) and COSLA could be beneficial to the framing of government policy. Examples of good local practice such as the challenges and positive outcomes from integrating services such as addictions may help other local authorities and health boards. The Christie report highlights how important collaboration and integrated response is for improved service provision.
- **Economic down-turn:** National and local data consistently shows that financial insecurity is one of the greatest risks to mental health and well-being. We are in the midst of an economic down-turn and significant welfare reforms, which will impact on individuals, communities and services. This requires priority focus within the strategy making recommendations that national support are in place to ensure agencies understand their duties, impact on communities and services are monitored and service make every effort to identify financial insecurity, provide supportive information and support people to access benefit, welfare, debt and employment advice. See the Director of Public Health Annual Report (Published 2010) for further information

http://www.nhslanarkshire.org.uk/Services/PublicHealth/directors-annual-report-2009-10/Documents/Public%20Health%202009-10.pdf

- **Promoting well-being, preventing mental health problems and increasing access to services,** requires action across the tiers and this would benefit from greater focus within the strategy, with the Christie Commission[1] report referenced as a key driver.
- **Suicide[2] and self-harm:** The continued focus on this area is welcome. A national action plan to support the implementation of *Responding to Self-harm*[3] would be most welcome and would assist local areas to develop improved local responses, with a particular focus on A&E and primary care. Continued national support of ChooseLife beyond 2013.
- **Gaps in existing services**: A focus on the relationship between mental health and trauma, substance misuse and development disorders is welcome. It is suggested that while some specialist services are required much of the solution requires a generic approach to addressing these issues such is the prevalence. There are a number of existing strategies and reports such as *Mind the Gap: Meeting the needs of people with co-occurring substance misuse and mental health problems*[4] *which set out a framework for service improvement* (2003). Through the duration of the next strategy we would like to see these implemented through national support embedded with the performance review framework such as Commitment 13.. Ensuring an appropriate response to gender based violence within mental health services was also highlighted.
- **Older people**: TAMFS 2009 committed to the production of an action plan relating specifically to improving the mental health of older people. An action plan was developed by a national reference group and approved by the Scottish Government, but not included in any national strategy. This new strategy would provide an opportunity to include the specific recommendation within a national framework.
- **Stigma**[5]: A continued focus on reducing stigma is welcome and continued support of See Me... However, there is gap in the current national programmes in relation to dementia. The National Dementia Strategy identified the taboo of dementia as one of the five key challenges. A national programme to support addressing this would be welcome.
- **Children and young people:** While the draft strategy highlights improving mental health in early years and young people as a priority it then goes on to focus on CAMHS specifically. The focus on CAMHS is welcome but this needs to be balanced with a focus on peri-natal, early year and school age public health intervention. A particular focus on improving the service response for young people aged 16-25 would also be welcome. A re-energised national focus on implementing the Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care and Treatment (2005)[6] would be welcome. The links collaboratively with CAMHS Children and Families as well as Educational Psychology.
- **Primary care:** A focus on improving first response and self-management is welcome. If 90% of all mental health problems are managed at primary care level then the strategy should reflect this, with specific commitments related to improving the primary care response. The GMS contract (QOF and Enhanced

[1] *Christie C. Commission on the Future Delivery of Public Services.* Edinburgh: Scottish Government; 2011. http://www.scotland.gov.uk/Publications/2011/06/27154527/0

[2] http://www.chooselife.net/

[3] http://www.scotland.gov.uk/Publications/2011/03/17153551/1

[4] http://www.scotland.gov.uk/Publications/2003/11/18567/29477

[5] http://seemescotland.org.uk/

[6] http://www.scotland.gov.uk/Publications/2005/10/2191333/13337

Services) may provide a useful framework to progress specific actions which improve access to high demand but low complexity interventions at tiers 0-1, such as social prescribing, stress control, living life and self-help, which also provide alternatives to secondary care services.

- **Integrated Care Pathways (ICP's)/ Psychological Therapies:** Much work has been undertaking through the duration of Delivering for Mental Health to develop ICP's and improve access to psychological therapies. It is recommended that the next strategy should focus on further implementation, with measuring outcomes as a priority, supported via improved data-sets and information technology.
- **Information Management: Effectively monitoring performance will be critical to successful implementation. For this reason accurate, timely and reliable data capture linked to all of the actions will be essential.** Reinforcing the need for mental health data to be seen as important as other care groups would be welcome. A specific recommendation was made by a number of partners to introduce a national A&E data-set which accurately records when people attend with self-harm, which would be helpful in supporting a local response i.e. could A&E data be used in the same way as SPARRA data to identify people who repeatedly attend A&E with mental health problems with a view to providing a more proactive response. This would also be likely to improve the response for people with more complex and co-morbid presentations.
- **High risk groups:** It is important that the strategy recognises that some individuals and groups are at significantly greater risk of experiencing mental health problems than others and therefore action is required to address those wider socio-economic risk factors and build individual and community resilience. Equally Well[7] requires NHS Boards to demonstrate that psychological therapies are accessible and appropriate to our most deprived communities. Through national support and performance measures, postcode should be gathered as standard in all service contact data and analysed using Scottish Index of Multiple Deprivation to demonstrate that we are reaching our most deprived communities via deprivation quintiles. Ethnicity data should also be gathered.
- **Recovery:** The continued support of the Scottish Recovery Network[8] is very welcome. Creating the expectation and possible trajectory, that the Scottish Recovery Indicator should be completed by local inpatient and community mental health services would support translation of information, training and policy into direct client experience. At every stage we should look to effect **first level change** that benefits individuals, through accessible services and opportunities which facilitate recovery (SRN). But also effect **second level change** aimed at creating the conditions within community that maintains recovery including improving public attitudes (see me), increasing access, reducing barriers and supporting connections.
- **Co-morbidity (substance misuse and mental health problems):** People presenting with both substance misuse and mental health problems remain a challenge across the system despite some of the progress made via commitment 13 and the continued national drive on this commitment. This includes Alcohol Related Brain Damage. It is suggested that this remains a priority for the duration of the next strategy with stronger links both nationally and locally between departments.
- **A strong service user voice** can add to the quality of care experience however this must be a real voice not a tokenistic effort. A dialogue with

[7] Scottish Government. *Equally Well: Report of the Ministerial Task Force on Health Inequalities*. Edinburgh: Scottish Government, 2009. http://www.scotland.gov.uk/Publications/2008/06/25104032/0

[8] http://www.scottishrecovery.net/

service providers can assist in improving care and the mental health of our communities yet these must be also informed by those who have experience of the services themselves.

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

1.1 **Integrating the prevention, promotion care and treatment agenda** is largely welcome and replicates what the approach has been in Lanarkshire. However, the overwhelming initial feedback is that the strategy needs to give greater focus to the prevention and promotion agenda, recognising that the infrastructure created through TAMFS has laid the foundation and given the strategic focus required to support local direction and great progress has been made.

1.2 It would be helpful to **set the context for local delivery of the new strategy**. Towards a Mentally Flourishing Scotland did this very well in the first few pages within the 2009 document and therefore you have a very useful blue print? The principles apply to both prevention and promotion and care and treatment. The key points where:

1.3 **NLC** made the specific point that **Single Outcome Agreements** are already in place. Is there a national overview of these being used to support mental health improvements, targets sets, commitments made, outcomes measured and what are the reporting arrangements for the partners- perhaps joined with HEAT.

1.4 **SLC** suggested a more **joined up assertive approach to the legal issues** early signposting and referral for assessment of capacity and general cognitive functioning would facilitate more appropriate community based supports, the promotion of Powers of Attorney, Advance Statements and Advance Directives reducing significantly later hospital admission and subsequent delayed discharged resulting from late assessment of capacity and the need to progress applications for welfare and financial guardianship which in itself is a lengthy process. The role and responsibilities of General Practitioners in this area cannot be underestimated.

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

2.1 Continue to involve **service users and carers** in planning, development and evaluation of services. This needs to be increased for young people and older people.

2.2 The **strategy strands on gender-based violence/violence against women and the Survivor Scotland (SS) childhood sexual abuse strategy** would benefit from tie up as the SS strand does not apply a gendered analysis. This leads to a lack of synergy. In particular, prevalence evidence shows that mental health services rates are so high that all staff should be given basic awareness of the gendered analysis of abuse as identified in Safer Lives Changed Lives and CEL41 (2008), including a gendered understanding of trauma-focussed service, be expected to operate with that 'lens' and services assessed to ensure they are sensitive and consistent to gender-specific and GBV-specific elements of delivery requirements.

2.3 **Older people**: Using a combination of the data available from Health Boards, evidence from the literature base, information about what has worked in other areas (including England) and talking to service users and carers, would assist in meeting this challenge. Some areas in old age services where better outcomes are needed are:

- Young onset dementia services
- Support for carers of people with dementia
- Community support for older people aimed at e.g. reducing social isolation
- Availability of psychological interventions, of low and high intensity

2.4 There is a need to **invest in lower tiers of the stepped care model** – looking at general/ overall improvement in population approaches – supporting communities to support themselves. In all tiers consistency of service provision is key; need more research through new clinical leadership structures.

2.5 Greater focus on the needs of **people experiencing the greatest inequalities** with systems to record and demonstrate that people in our most deprived communities are accessing the range of interventions that are available, this is in line with Equally Well i.e. by recording postcode as standard services could be asked to demonstrate service usage by Scottish Index of Multiple Deprivation quintiles. Groups that seem to require a particular focus are:

- **People who are homeless**
- **Veterans**
- **Looked after and accommodated young people**
- **People who are unemployed or living with financial insecurity**
- **People living with long-term conditions**
- **People in prison**
- **Black and minority ethnic communities**
- **Keep Well (high risk populations)**

2.7 Continuing putting emphasis on **self help and community** wide improvement Individual plans and personalisation should be the way forward rather than setting up specialist services.

2.8 **SLC** highlights that: an **increased focus on the needs of people with development disorders is welcome**. Could targeted screening be carried out in high risk groups?

2.9 **NLC** highlight the need for the strategy to reflect and link with the future self directed and integrated services strategic direction. Examples in North Lanarkshire include Self Directed Support and the North Lanarkshire Integrated Addictions Service.

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

3.1 Continue to co-ordinate activity via **local Choose Life Implementation Groups**, supported by Choose Life nationally at NHS Health Scotland after 2013.

3.2 Better provision on for **16-18 year olds**.

3.3 **Trauma** – those who attempt suicide or self-harm who have a history of abuse should receive appropriate support, or their distress will remain unresolved.

3.4 Greater focus on **older people** in health promotion campaigns around suicide and self-harm. To date this has not been a focus.

3.5 **Lanarkshire Links** suggested: Greater focus on **acute sector and GP's** and a visiting/scrutiny programme (possibly peer review) to measure quality and consistency of response for people who attempt suicide or self-harm. We know that the majority of GP's and A&E staff have not received formal training. Do we need a particular target around this?

3.6 During the **current economic climate**, financial insecurities will surely influence suicide rates. Could the link be highlighted and more emphasis put on national financial supports such as the National Debt line.

3.7 **National influence** is required to embed suicide prevention training as standard for certain new recruits such as police, fire service, doctors and nurse curriculum.

3.8 **Delivering suicide and self-harm prevention intervention training** to the wider community not only to social work, health or voluntary organisations. Training has included taxi drivers and call takers, reception staff, fire and rescue, police, students, and pupils at secondary school. The Christie report emphasises integrated training this is another important part for any approach for a mental health strategy.

Training in suicide intervention skills should be a prerequisite for qualification in such fields as social work, housing staff, nursing (mental health, addictions and general), midwifery, General Practice doctors, ambulance service personnel, police, psychology and psychiatry.

Suicide prevention should be delivered and should be embedded in all public

services as well as all health settings, school, colleges and local amenities. Particular emphasis on civil service, DWP.

3.9 **Co-morbidity:** Key risk factors for suicide are alcohol and drugs. With Scotland's national Drug Related Death Review report highlighting the mental health histories of those who have died it would be pertinent to use Commitment 13 and adult protection guidance. By involving addictions and mental health services – especially if integrated with social work - supports for those with co-morbidity issues would be increased. With suicide and addictions being reported by emergency services as a common issue an integrated approach may help other services and help find the person the most appropriate support.

3.10 **Place of safety:** Greater focus nationally on supporting understanding and generating local solutions to 'place of safety' particularly when someone presents under the influence of alcohol.

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

4.1 Have **improving the quality of life of those experiencing mental health problems and mental illness** as the overarching objective which recognises stigma reduction as a key part of a wider strategy. In Lanarkshire we have combined our 'see me' and 'recovery' agenda into an overarching plan while still respecting and benefiting significantly from the unique national branding and supports the four key aims are:

1. Raise awareness of recovery and the things that help and hinder
2. Develop a better understanding of recovery
3. Support and encourage local action towards recovery
4. Reduce the stigma and discrimination of mental ill-health

4.2 At every stage we should look to effect **first level change** that benefits individuals, through accessible services and opportunities which facilitate recovery (SRN). But also effect **second level change** aimed at creating the conditions within community that maintains recovery including improving public attitudes (see me), increasing access, reducing barriers and supporting connections.

4.3 Use a **Link national, act local** response. Set the context for how local partnership conditions make best use of the national programmes, encouraging local action and outcomes measurement.

4.4 **The 'see me' pledge and action plan** seems like a very effective way of demonstrating local commitment and the wider development of community condition. This facilitates involving people, organisations and communities in anti-stigma activities across sectors and communities of interest through integrating with existing programmes and securing commitment through the 'see me pledge' signatory programme. The 'see me' pledge enables us to reach out to mainstream organisation to use their assets to increase awareness of mental health, reduce stigma and ultimately become part of a movement which is combining community action to create the conditions for well-being and recovery.

4.5 **Inform and empower** people experiencing mental health problems and their carers with understanding of their rights and confidence in how to address stigma and discrimination.

4.6 **Changing attitudes to stigma is a long term outcome** and will require the current programmes (e.g. see me) to continue, as attitudes are slowly changing. Therefore continue to fund and support these programmes. Stigma and attitudes can be heavily influenced by engagement rather than only social marketing. An example of a low cost but high impact programme is the Scottish Mental Health Arts and Film Festival.

4.7 **Work at national and local level to integrate with other programmes and complementary messages**. We are often targeting the same groups in society with different messages, at different times in different ways.

4.8 It may be worth **examining employment standards and adopting similar responses to physical disability**. Evaluating the 'see me' campaign as vigorously as possible with linked action plans reviewed at least annually and supported by partners.

4.9 **We need to tackle the mental health risk factors affecting people**, such as isolation, discrimination and hate crime.

4.10 **Engaging with services can be difficult for many even those who work in mental health service.** There are training and development issues across health and social work around the impact of mental health legislation and what that means in practice. Training for all staff (local authority, health, voluntary organisations, and private business) in mental health issues is vital – not just frontline care staff.

4.11 **Lanarkshire Links (Service User and Carer Organisation), highlighted particular points**

- Gather and disseminate Recovery Stories. The public need to see and hear positive experiences of mental health illness and self management for day to day living with a mental health illness.
- Forge a stronger link between 'see me' and 'SRN' as breaking down barriers helps to promote a more fertile environment for recovery.

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

As per question 4.

5.1 A national programme to increase **public understanding of dementia** using the learning from 'see me'.

5.2 Better use of on-line training resources such as MindSET which combine messages on anti stigma, self harm, suicide prevention and general mental health improvement. http://www.northlanmindset.org.uk/

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

Comments

6.1 **Good mental well-being and reduced incidence of mental health problems is important for the healthy functioning of communities**. Real change happens in the neighbourhoods, streets, schools and homes where people live their lives. Locality partnership structures need to focus on addressing the social determinants of health, supporting the reduction of health inequalities, and promoting social capital (inclusion, access, participation, cohesion).

6.2 **The objectives contained within TAMFS are consistent with the vision of a flourishing Scotland.** For example, actions at locality level are directly supporting the North and South Lanarkshire Partnership's Single Outcome Agreement framework which has stated its commitment to reducing inequalities, closing the gap between communities and supporting residents to live longer, healthier lives. This demonstrates how integrate with related priorities such as early years, Equally Well[9], local health improvement plans, Support for Parenting, Curriculum for Excellence[10], Healthy Working Lives[11], alcohol and substance misuse, physical activity, inequalities, poverty and social exclusion, brings multiple benefits.

6.3 **Leadership nationally and locally is required** to link strategically with planning structures, raising the profile of public mental health and establishing public mental health within the service development agenda.

6.4 The strategy should take a **life span and setting approach**, which demonstrates that every effort is made to build the protective factors for well-being and reduce the risk factors for mental ill-health from conception to later life:

6.5 **Older people** play a crucial role in life in modern Scotland. A clear commitment to older people should be visible in this strategy as it was not present in TAMFS. The action plan which followed TAMFS was approved by the Scottish Government. Let's make some specific recommendations in this strategy.

6.6 **Mentally healthy employment and working life & financial insecurity.** The current economic climate and its impact on mental health and well-being must feature strongly in the strategy. Paid or unpaid employment or voluntary work is generally better for mental health than unemployment, but its value depends on both the work itself, and the culture and relations in the workplace. Equally, financial insecurity has been shown to be the single most significant factor impacting on both mental ill-health and well-being. The links between mental health, inequalities and employment have been set out in the three documents *Healthy Working Lives, Equally Well* and *Workforce Plus*. Specific comments include:

- Integrating the Mental Health Commendation Award into the bronze, silver and gold awards rather than an add on. Those who have already completed the awards can still do the commendation awards.
- Continue the free delivery of mental health in the workplace training covering promotion, prevention, retention and rehabilitation.
- Improve the mental health and well-being of those looking for employment and/or requiring financial, debt or welfare advice through links with employment agencies.

[9] Scottish Government. *Equally Well: Report of the Ministerial Task Force on Health Inequalities*. Edinburgh: Scottish Government, 2009. http://www.scotland.gov.uk/Publications/2008/06/25104032/0

[10] Curriculum for Excellence. http://www.curriculum-for-excellence.co.uk/

[11] Healthy Working Lives. http://www.healthyworkinglives.com/

- Improve understanding of the impact of financial insecurity across health and social care staff, ensure staff understand their responsibilities in terms of identifying financial insecurity and sign-posting to supportive services. Programmes such as social prescribing can help.

6.10 **Community Asset Building** – As you will know the assets approach has received a strong positive focus through the Christie Commission report and Chief Medical Officer support. Some national support to progress and evaluate this at a local level would be welcome. The assets based approach is strongly supported by both the adult and children's indicators and links very closely with the recovery approach i.e. is about strengths and in particular, resilience or what enables individuals and communities to survive, adapt and/or flourish, notwithstanding adversity. **Social prescribing (SP)** (sometimes called community referral) is a mechanism for linking people with non-medical sources of support within the community.[12] The 'see me' pledge can form an important part of the Social Prescribing Programme with specific pathways developed to **improve access to benefit, welfare and debt advice, biblio-therapy (through libraries) employment, access to green space, leisure, learning, arts and culture and volunteering opportunities. National support to help embed these programmes across Scotland would be welcome.**

6.11 **Stress Management/ Control** - To complement the above programme community based *Stress Management Programmes* to provide a psycho-social stress management personal development programme at a more accessible level within local communities and develop alternative responses to mental distress and low levels of well-being and expand options would be welcome.

6.12 **Widening access to self help** – There is a national programme to increase access to self-help through building capacity in community partners to deliver the 'Living Life to the Full' programme. Lets move to have this readily available across Scottish Communities.

6.13 **Lanarkshire Links (Service User and Carer Organisation), highlighted particular points**

People must be supported to embrace their own strengths and to change a mindset in acknowledging they have a part to play in their own mental health wellness or illness.

Primary care and in particular GPs have a vital part to play in a person's mental health and wellbeing. If under the GMS contracts GPs are being tasked to have a SMI register then there should be some agreed or negotiated measurable outcomes ie; waiting times, access to appropriate services, early intervention and prevention.

There is evidence that paid peer support workers have an influence on peoples' understanding of their own mental health and wellbeing. We need more peer support in the community.

Service users perceive that services are being 'cut' and a common perception is that this is a financial decision rather than a needs led one. e.g. if a service to support someone for 2 or 3 hours per week is reduced at the wrong time then this

[12] Scottish Development Centre for Mental Health (2007) *Developing social prescribing and community referrals for mental health in Scotland*
www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing
CSIP North West Development Centre (2009) *Social prescribing for mental health: a guide to commissioning and delivery* Manchester

may contribute to a periods of crisis with possible hospital admissions. Prevention is preferred to deterioration.

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

7.1 **Raising the upper age limit of CAMHS to 18** was considered a positive step by all partners. However, the practicalities in terms of achieving this were highlighted. A shortfall in capacity continues despite local improvements and investments to meet all the targets and commitments set nationally. Moving to 18th birthday across the board is for CAMHS a stretch where Royal College of Psychiatry proposed staffing establishments for up to 16yrs are not fully met across the country. Promoting the need for a younger adult's approach encompassing CAMHS and Adult services may provide the capacity to meet the needs of 16-18rs better. We welcome the development of the CAMHS Balanced Score Card which will move someway towards better comparison and learning from other areas.

7.2 A greater national focus on **early intervention of first episode psychosis** would be welcome.

7.3 Ensure all CAMHS and adult teams have had basic a**wareness training on gender, and gender based violence**, to ensure a solid understanding of (in particular) domestic abuse and children's experiences living where there is abuse, the role of the non-abusing parent and what constitutes safe family work in these circumstances.

7.4 **NLC** offered some specific feedback to support the consultation:

The 26 week target seems to be at odds with the importance of young people in the Scottish Governments 5 national objectives. The HEAT target for treatment is 12 weeks it could be argued that this should be the same or a shorter time frame for CAMHS.

Improve colleagues and public understanding of:
What service is provided?
What information and advertising is used to communicate to people?
What are the expectations of CAMHS?
Where does CAMHS sit with other services?

Improving the general access to CAMHS for all patients, implementing the current HEAT target;
Improving access for specific groups such as children with a learning disability;
Improving access to limited treatments such as child psychotherapy;
Improving access to appropriate inpatient treatment and care and reducing the number of inappropriate admissions to adult psychiatric wards

CAMHS services could be better placed physically and strategically linking with education, social services and voluntary organisations. A distinctly different service may be duplicating work and any links to voluntary organisations may not be fully explored.

CAMHS may benefit from more frequent visits from the Mental Welfare Commission and regular national reports on those referred and treatment waiting lists. As there are limited resources it could be suggested that voluntary organisations have an increased involvement in supporting young people. The hours of CAMHS should be meeting needs of its customers and could be similar to the Out Of Hours Service and be available at weekends and evenings.

There is a danger the finite resources of CAMHS is seen as the catch all. Strengthen links between CAMHS, Educational Psychology, Social work , schools, counselling services and other voluntary organisations to improve pathway of care, resource usage and outcomes.]

Transition between services needs to be a priority for young people

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

Comments

8.1 **While the HEAT target is a challenge** for an under resourced service the principle behind it is very welcome in terms of focusing attention and resources at improving access and outcomes for young people.

8.2 **Bench marking data** to allow comparison and read across services to facilitate better dialogue as we move towards the national framework objectives.

8.3 Increase **AHP skills mix** to provide wider range / mix of skills.

8.4 **The strategy must not look at the CAMHS issue in isolation and consider within a wider prevention, promotion, care and treatment agenda.**

8.5 **Mentally healthy infants, children and young people** It is well known that our early years play the most significant role in determining our mental health for life and must be seen as the priority. A mentally healthy child is one with a clear sense of attachment, identity and self-worth, the ability to recognise and manage emotions, to learn, play, enjoy friendships and relationships, and deal with difficulties. A wide range of interrelated factors play a role, such as individual, family, wider society and environmental issues. This informed the priorities and actions outlined in the *Early Years Framework*[13]. This should be reflected within the strategy.

8.6 A useful approach would be to **take a stepped approach** which focuses on children and young people from the ante-natal period through to young people in transition (16-24).

8.7 **Getting It Right For Every Child (GIRFEC)**[14] agenda should be seen as the key foundation for this work supported via the Early Years Framework.

8.8 Scotland's Chief Medical Officer explained the connection between **early years** and a range of physical and mental health outcomes in his *2006 Annual Report*[15].

[13] Scottish Government.The Early Years Framework. Edinburgh: Scottish Government, 2009 http://www.scotland.gov.uk/Publications/2009/01/13095148/2

[14] Getting it Right for Every Child in Lanarkshire http://www.girfecinlanarkshire.co.uk/

Particular emphasis was given to the importance of pregnancy and parenting in defining health outcomes. Key actions relating to positive mental health and well-being included as part of this work are:

Antenatal – National supports to maximise actions and interventions to promote mental health and well-being during the ante-natal period for both the mother and the baby. Suggestions included: enquiry, screening and intervention with a particular focus on vulnerable families; provision of information; sign-posting to opportunities to enhance well-being; reducing the stigma of postnatal depression as a barrier to seeking help if required following birth and strong links between community psychiatric nursing services and midwifery services, supported via a recognised pathway.

Pre-school –The focus on support for parenting and attachment is very welcome.

School age – Suggestions include, Integrating mental health and well-being resources via *Curriculum for Excellence* and monitored via the health and well-being Indicators in a more consistent way (i.e. Positive Mental Attitudes Pack).

Community Activities – The need to provide out of school interventions and programmes which provide meaning and purpose, and enhance well-being and emotional literacy through activities such as sport, arts and culture, volunteering, peer support and mentoring opportunities. Evaluation shows improved outcomes for the young people but also the community in terms of reduced anti-social behaviour.

Supporting high risk groups – It is known that young people experiencing particularly challenging life circumstances are at greater risk of mental health problems:

- **Behavioural problems**
- **Young carers**
- **Looked after and accommodated young persons**

Young people in transitions – Young people in the NEET category require particular focus at this time. Reference should be made to the specific strategies that are being implemented to support young people leaving school into training, education and/or employment.

Further Education - What can happen nationally to making better links with further education establishments?

8.9 **SLC** suggested greater focus on:

Good school responses to developmental disorders/ trauma and loss/ other additional support needs should further enhance children's resilience and improve their capacity to problem solve and cope with difficulties.

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?

[15] Scottish Government. *Health in Scotland 2006: Annual Report of the Chief Medical Officer.* Edinburgh: Scottish Government, 2007. **http://www.scotland.gov.uk/Publications/2007/11/15135302/0**

Comments

See Q 6

9.1 Provide **practical advice on self help methods**. Education with regards to developing skills in coping with stress, practical self help tools.

9.2 Reliance on **IT based content excludes** a certain proportion of our communities. Broader front facing strategies that are delivered without actively 'seeking' the info can engage with someone through their daily routines, e.g. at bus stops, in supermarket toilets, etc.

9.3 Many **older people** do not recognise that mental health problems are not an inevitable consequence of ageing, nor that effective treatments are available. Older people should be supported to learn to recognise and acknowledge issues related to their mental health, perhaps through educational campaigns.

Older people could be encouraged to develop community resources themselves e.g. via lottery funding, with local authority support with the application process.

9.4 **Strong links between national campaigns/programme and local areas** so that marketing can be maximised and also tailored to local needs. Many programmes are not available in all regions.

9.5 Linking all **social prescribing developments with recovery agendas**.

9.6 Improve interface between community mental health services and wider community. Continue to develop the of range of self help materials with a range of options – internet, paper, telephone, face to face contact, group contacts and continue with stepped care model.

9.7 Provide specific workers to involve older people allowing them access to the latest up to date information and access to appropriate services.

9.8 **Lanarkshire Links (Service User and Carer Organisation), highlighted particular points:**

- Requires measurable outcomes around joined up, partnership working of all agencies involved in a person's care including their own natural networks.
- A co-ordinated approach is vitally important particularly around discharge and relapse planning.
- Engage more with service users to help them understand their responsibility as an equal partner in their own care.
- Create independence rather than dependence on services.
- Build on peoples' strengths to give them tools and coping strategies to maintain their mental health and wellbeing.
- Learn from peer support workers and their experience of staying well.
- Engage with advocacy services in order that people can have their voices heard and their rights upheld.

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

Comments

10.1 Make services **more approachable for males**, making it more acceptable to people that seeking help is not something to be ashamed of. De-stigmatise the process.

10.2 Existing services **need to be seen by older people** to be appropriate to their needs. For example, when psycho-educational courses have been run during the day they are well attended by older people, whereas they are less likely to attend evening courses.

10.3 **Primary care:** A focus on improving first response and self-management is welcome. If 90% of all mental health problems are managed at primary care level then the strategy should reflect this, with specific commitments related to improving the primary care response. The GMS contract (QOF and Enhanced Services) may provide a useful framework to progress specific actions which improve access to high demand but low complexity interventions at tiers 0-1, such as social prescribing, stress control, living life and self-help, which also provide alternatives to secondary care services.

Use the patient safety approach from primary care and use the local public partners or identified experts by experience /peer support to share lessons learned with the patient population.

10.4 **Continue to promote a consistent message**. Evolve to promote messages within new media/social networking. Promote back to basics with all staff to spend time listening and talking to people using their service.

10.5 **Recognition of warning signs and management of triggers** to initiate help /awareness of symptoms (as in FAST campaign for stroke).

10.6 For services to **listen** and be available when required.

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

11.1 Given the prevalence of mental health problems, **continue with a population approach to increasing and maintaining mental health literacy** across the population from early years through to later life.

11.2 Everyone **working in front line services** should have a level of understanding of mental health and know how to sign-post appropriately. Enhancing workforce with skills to recognise people with problems, provision of good resources to help sign posting to appropriate service. Better triage services and ability to offer alternatives more suitable to the individual.

11.3 **A whole systems approach** is required including general population approached which increase understanding and information on what supports are available such as breathing space, targeted screening of high risks groups and timely access to appropriate supports across the tiers.

11.4 **A&E is generally not the best place to go if experiencing mental health problems unless** it is an emergency. However, while alternatives are being developed, particular focus is required at A&E which includes ensuring appropriate response in an appropriate environment with strong links to local services.

11.5 **Ensure and monitor that services are provided at the busiest times i.e. evenings and weekends.**

11.6 **Supportive strategies to reduce waiting times**, offering supportive resources or alternatives to those on waiting lists, reducing DNA's and using appropriate screening tools.

11.7 **Using Crisis Standards to improve relationship between emergency services** such as SAS, Police, Acute and Fire and Rescue.

11.8 Staff in **first contact services** need to be aware of risks to mental wellbeing in older people and long-term conditions, and are able to openly discuss these with their clients. This might require additional training/education for primary care and LTC staff.) for services to have provision for working with those with co-morbidity rather than "passing on".

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

12.1 **Complete matrix**, clear guidance on assessment/treatment 'clock' measures and forthcoming reporting requirements issued as soon as possible, to enable service redesign in good time, thereby hopefully reducing additional admin time to collate stats required. Co-ordination of information essential. Connected Government should only need to ask for the information once in one format.

12.2 **Effective clinical supervision** can support this, so the work of NES in developing supervision for psychological therapies is particularly welcome. Also effective supervision of commissioned counselling services and their counsellors.

12.3 It is also important to ensure that an **appropriate level of administrative support** is available, to maximise the amount of time clinicians can spend on clinical rather than admin tasks.

12.4 **Improved IT systems** with appropriate access for mental health, physical health and local authority staff would significantly reduce the amount of time clinical staff spend accessing records and contacting other members of the care team.

12.5 **More emphasis on appropriate skill mix** and integrated service delivery

across /between agencies and sectors within a mixed economy of care would invariably increase the capacity of the workforce to deliver effective care within the current financial constraints across services

12.6 **National benchmarking** helps to compare like with like, but needs to appreciate the specific local issues.
12.7 **Share and publish what does not work in a confident way** and value this information.

12.8 **Implement the quality strategy** with a focus on outcomes.

12.9 Demonstrate improved consultation and **service user and carer involvement**.

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

Comments

13.1 Consider ways to **improve qualitative feedback from service users and carers**, such as interviews or open ended questionnaires. In particular feedback should try to focus on difficulties accessing services and systemic issues rather than just interventions received, waiting times etc.

13.2 **Both NLC and SLC** highlighted that **ICPs remain primarily NHS tools** and there is a need for negotiation around ownership, responsibility, and shared outcomes. (Should we be encouraged to look at **Health and Social Care Pathways** as we move towards closer integration).

13.3 **NLC** also highlighted that while pathways are important to illustrate process this is not an end in its self. **More emphasis should be put on the individual experience and outcome focused solutions**. A good example is the North Lanarkshire Self Directed Support work.

13.4 **Integrated Care Pathways (ICP's)/ Psychological Therapies:** It is recommended that the next strategy should focus on further implementation, with measuring outcomes as a priority, supported via improved data-sets and information technology.

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

14.1 **Continued emphasis on service user and carer involvement** in the core activities of assessment, care planning and review are required with ongoing training for staff in these areas and appropriate reporting frameworks which evidence gaps to be addressed by organisations as necessary. The recovery agenda requires to be integrated into existing policies, procedures, guidance and reporting mechanisms for organisations rather than be viewed as a separate process for all planning partners.

14.2 One colleague with a particular interest in **legislation offered some constructive comments**. Rights based legislation needs to be backed up by individual practitioners understanding that they must be able to translate patients rights into practice. Knowing what is legal is paramount yet the MWC report cases of de facto detention in care settings and ongoing treatment not covered by Section 47 Certificates with those who lack capacity and have no proxy.?

14.3 **Increase effective peer support opportunities. This should be in hospital and community.**

14.4 **Re-state service user and carer involvement as a priority** in the new strategy as per the Mental Health Framework.

14.5 **Lanarkshire Links (Service User and Carer Organisation), highlighted particular points:**

- Encourage planners of mental health services to create meeting times and conditions that will allow sustained involvement of service users and carers.
- Support service users and carers to be involved at all levels to have their voice heard.
- Facilitate networking of service users and carers in order to develop and encourage peer support.
- Invest in existing service user and carer organisations.
- Provide and source training opportunities locally for service users and carers to be involved.
- Develop and promote support, to enable individuals to have their voices heard
- Hold meetings which present topical mental health issues and service provision issues in the statutory and voluntary sector specifically for service users and carers individuals and organisations.
- Produce an update of service user involvement for wider circulation.
- Source and increase the range and flexibility of support and assistance for involvement
- Develop and promote working partnerships with Community Health Partnerships and Community Planning Partnerships.
- Develop and promote partnerships with local stakeholders.
- Highlight access needs of service users and carers throughout Lanarkshire.

Contribute to research and development of mental health issues at a local and national level.

- Arrange ongoing consultation with service users and carers to determine user and carers needs and appropriate delivery levels.

Encourage inclusion in all service developments for individuals who may experience difficulty in accessing services.

- Monitor the quality of the involvement process and the adherence to user and carer guidelines where they are in place in such a way that there is equity across Lanarkshire.

Develop a strategic role for local service user and carer input to influence national mental health issues.

- Constantly review channels of communication with the wider public.

Continue to develop a culture of evaluation, to constantly improve service delivery.

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

Comments

15.1 **Good assessment of information needs** and access to appropriate information.

15.2 **Interactive communication** (e.g. web-based) could be used as a mediation tool between care providers and service users, for some.

15.3 A re-invigorated commitment to the **principles of shared leadership** as was initiated through the Scottish Leadership Foundation and is now being introduced in other health areas where the duty of user focus has meant that the inclusion of service users in governance is now to be expected.

15.4 **Ensure access to advocacy for both service users and their carers** (it may be different agencies)

15.5 Families are key to recovery, relapse prevention and maintenance of well-being. **Make family involvement the expectation**, with appropriate permission.

15.6 See **information sharing guidance** as an aid to support effective communication with family not a barrier.

15.7 One person suggested a greater focus on service user and carer involvement in the **CAMHS service** in the new strategy. Again this would require a specific worker or workersto provide the necessary support for service user and carer involvement in committees, working groups, focus groups etc.

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

16.1 **Continue to resource the SRN and continue with direction of travel**.

16.2 Ensure **local 'recovery networks'** are supported and 'linking nationally and acting locally' to make best use of the national supports.

16.3 All workers should be aware of **person centred principles** with clear links to professional conduct processes.

16.4 Consider using focus groups of service users to gauge **patient experiences** of particular services and identify areas of good practice and those requiring improvement.

16.5 **Use a range of outcomes measures**, My Story CAMHS, My View, Adult Talking Points Social Care already available to use in combination with the SRI and finally use that to complete an action plan which can feed into the improvement work of the organisation.

16.6 **Develop portfolios of good practise examples**, collaborative goal setting / work plans with agreed time scales and nominated individuals. Audits essential and action plans required to close audit loop

16.7 **Joint training with social work**, joint working, basic values training Integration, collaboration, pre and post qualification formal based training.

16.8 **Need to make sure we work at second level, creating the community condition** for recovery other wise people's recovery will be hindered despite good quality person centred approaches.

16.9 **Provide national support for greater self-directed care in mental health**.

16.10 Let's see more evidence of **access to client records** or client held records in practice.

16.11 **Raise awareness among the Judiciary** of mental health and learning disability issues

16.12 **Continue to develop peer support across Scotland** to record / gather / tell / publish recovery stories.

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

Comments

17.1 **Building on good practice**.

17.2 Need to ensure supportive **capacity at a local level** to facilitate the process.

17.3 Make completion of the **SRI a core commitment** for in-patient and community mental health services and in the new strategy and set trajectory with local areas asked to report on, number started, number in progress and number completed. This needs to maintain the principle of supporting service development and not being an audit tool; however it is reasonable to expect services to complete it within an agreed time-frame.

17.4 Build the **SRI as a core expectation** of any commissioned service.

17.5 **Encourage an integrated and partnership approach**.

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

Comments

18.1 The support of the **SRN is greatly appreciated** and respected.
Give SRN targets for completion
Make SRI an national target
Widen it out beyond health focused

18.2 Could potentially be **embedded in pre-registration training**. Both professionals and service users require a clear understanding of a recovery approach to ensure that expectations are appropriate, particularly for patients with long-term or degenerative conditions.

18.3 Ensure **local 'recovery networks' are supported** and 'linking nationally and acting locally' to make best use of the national supports.

18.4 **Greater focus on older people**.

18.5 **Provision for involvement workers or peer support** workers in communities to embed the philosophy of recovery in its most fundamental form.

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

19.1 **Ensure access to advocacy for both service users and their carers** (it may be different agencies).

19.2 Families are key to recovery, relapse prevention and maintenance of well-being. **Make family involvement the expectation**, with appropriate permission.

19.3 See **information sharing guidance** as an aid to support effective communication with family not a barrier.

19.4 Continued training activity is required to **change the culture and approach** of the workforce supplemented by integration of the principles into operational policies, procedures and guidance with appropriate reporting frameworks.

19.5 The creation of **plain English information packs** which are provided to service users and carers together with appropriate involvement of advocacy services can be of assistance.

19.6 **User and carer surveys** provided to individuals at relevant points in their journey such as assessment, care planning and review can provide useful evidence to organisations on what they are doing right and the areas that require improvement. Feedback on the results of the surveys on a quarterly basis and how agencies are trying to address any issues identified also assist in this area. This needs to be independent preferably by peer support workers.

19.7 The development of **newsletters** by agencies and user and carer forums provides another mechanism for involvement in service development and improvement.

19.8 Whilst there is a current carers strategy, there is perhaps a **need to supplement** this for particular groups such as families and carers of mentally disordered offenders

19.9 A key part of ensuring the participation of families is to **consider families own mental health and wellbeing**. Services should be encouraged to promote and support this alongside any intervention the patient receives.

19.10 Consider the idea of **integrating the family contribution into ICP's** to formalise the contribution and makes it more explicit.

19.11 Consider the **family involvement aspect within job profiles** and offer training and development opportunities on how to approach families.

19.12 Use effective discharge planning, **WRAP and My Rap** in Lanarkshire, these

tools support discharge planning as they provide an opportunity to people to plan their support during a period of crisis and their expectations on discharge. We need to ensure this happens in a meaningful way and is recorded.

19.13 Make **better use of carers assessments**, determining the impact of the and how people can be supported in their carers role.

19.14 Need to give specific consideration of **young carers** in the context of all that had has been said.

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

As Q 19. But also:

20.1 In many areas this is routinely done. However where required, some **training for staff** in communication skills, recognising caregiver distress, family dynamics and valuing the carer as having expert knowledge about the patient would be helpful. Staff should be trained to deliver carer-based interventions to help carers cope with e.g. stress and distress in dementia, psychosis distress.

20.2 A properly appointed, well informed and supported **named person.** Input can now be measured in the SRI and that should be encouraged where appropriate.

20.3 **Could technology be used better**, i.e. video links be explores for out of hours meetings? Could these be expanded to offer support after a person is discharged to support recovery and prevent relapse? People respond well to seeing someone – could be linked to homes or GP practises / libraries? Tele-care systems?

20.4 **Look beyond data protection to the importance of care** (information sharing guidance an aid to improving care, not a barrier). Engaging training, regular information for carers and the involvement of advocacy with this area. There is links with the overall carers strategy and should be featured within the Mental Health Strategy.

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

21.1 A Mental Health Strategy for 2012-15 needs to set the tone and direction for services. The outcome as stated is reasonable but fails to acknowledge the desirability of a shift in the balance of care from institutionally based models towards those in the community. We propose changing to an outcome that over the period of the strategy there is an expectation that the proportion of care delivered in community settings as opposed to hospitals will increase and that

resources currently tied up in hospital care should be released to support improved community support and treatment.

21.2 **Having professional dialogue**, support sharing good practice models. Produce a 'best practice' resource? Peer reviewed?

21.3 This is a complex issue, as good practice in service design is **not a 'one size fits all' model**. Redesigned services can be analysed to try to identify the particular factors which led to a successful or unsuccessful outcome. However all service redesign must have the population the service is provided to at the centre of the process, which means a balance between best practice and the need for redesign to be locally planned. With service user and carer involvement

21.4 Whilst there are resource constraints there is still the need for localities to come together around **national networks of interest**. This reduces duplication and shares learning. Examples include the National Mental Health Improvement Network, Choose Life Forum. For mentally disordered offenders the Forensic Network also aims to share information on good practice and research as well as providing a variety of training opportunities for a range of staff. Issue based national short life working groups are also hosted by the forensic network to address issues, develop standards and guidance on good practice.

21.5 Outcomes could be readily identified through the **existing scrutiny bodies** and could be shared across agencies by access to a central website.

21.6 There is an opportunity through local joint priorities and the **Change Fund** to shift the balance of care and provide an evidence base to inform future strategies. Tell us what practice works in other areas, use as direction for future strategy.

An example is the NLC/NHS joint equipment store which is being used well for palliative care.

21.7 Provide resources to allow for independent **service user and carer groups to meet nationally** and share best practice for involvement and service delivery.

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

22.1 Monitoring of the **implementation of equality and diversity legislation** on mental health services such as, equality and diversity impact assessment of new strategies, plans and services.

22.2 **Compare characteristics of patients referred** to services with the demographics of the population (e.g. race, gender, age), and then target under-represented groups for outreach work.

22.3 **Wider work on the involvement of communities**. Tie into the equalities agenda.

22.4 The **existing core national data set and minimum information standards**

should assist in this process, information leaflets in varying languages, use of translators and interpreters also assist.

22.5 Territorial boards and local authorities are aware of the **demographics of their respective populations** and continue a range of assertive outreach methods to engage minority groups at a variety of levels across a spectrum of issues.

22.6 The **promotion of improving physical and mental health and wellbeing** remains the key access vehicle to potential engagement on mental ill health and support services which requires to be both consistent and long term in nature.

22.7 **What data is currently being held and how is it being used and improved?**

22.8 **Should sit stronger within local partnerships** and how do the SRN, See Me and any local groups involve themselves with this area.

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

Comments

23.1 Consider a **joint NHS and SSSC website, or email newsletters** sent to NHS and SSSC staff with good practice updates.

It is vitally important to monitor that information is not just disseminated, but also acted upon.
23.2 **Clinical quality, leadership and supervision structures**.

23.3 **E-bulletins such as 'see me' and Health Scotland are very useful**.

23.4 **Joint training MHO's, GP's and CPN's in diversity, values and equality**. Easier access to translation services. Use systems already there such as Breathing Space BSL online. Community training in mental health and suicide prevention such as SafeTALK and other programmes in Urdu, and other languages. Supportive coordination of information at a Government level.

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

Comments

24.1 The recognition that **older people** are a significant gap in service provision is very welcome indeed. Other gaps which have been highlighted include:

- Young onset dementia
- Services for people with personality disorders. Personality disorder services are also under developed
- Residents of care homes (primarily, but not exclusively, older people)
- Substance misuse in older people
- ARBD services need to be considered across the boards
- Young people in transition
- Young people with autistic spectrum disorder, including Aspergers.
- Homelessness
- Veterans
- LGBT

- Looked after and accommodated
- Those excluded from education

24.2 Young people experiencing **suicidal ideation and supports for people who self harm** to cope with distress. There should be a direct route to problem solving training for the latter group.
24.3 Continued and increased focus on services and interventions that can address **mental health and substance misuse** issues simultaneously or co-operatively.

24.4 **Criminal Justice: Prison population** - With local health boards taking on the responsibility for prisoner health it would be helpful to undertake an assessment of the requirements of effective mental health improvement and service intervention for this population. **Community justice** – It would also be helpful to define the expectations for access to mental health supports for people involved in the justice system i.e. justice colleagues are requesting psychological profiling from mental health services and unfortunately capacity does not exist to provide this.

24.5 **Young people and their carers** are not routinely included in service user and carer involvement around services that are being developed for them

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

25.1 **Single outcome agreement** signed up to by all agencies around person centred care would be of use.

25.2 **Develop shared models** of practice through policy and professional guidelines that are relevant to all staff involved in contributing to the mental health and wellbeing of patients. There is potential for this particularly through closer integration of health and social care.

25.3 A specific comment suggested a national test approach to **identify and reduce areas of waste** in the review process for people who are on GP registers, such as Dementia and SMI, and are being continually supported/reviewed by other key partners. This approach could be incorporated on completion of IRF work to improve the individual care delivery for people being supported by many partners.

25.4 An additional emphasis on **mentally disordered offenders** would assist in raising the confidence of the workforce across agencies in working with this complex group of individuals across the range of systems required and where possible address the sensationalised reporting of media groups which contribute to the ostracisation of this population and their families.

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

26.1 **Improved interagency working around discharges** with the ability of staff from community settings to link into wards and vice versa around the time of discharge

26.2 **Improvement of the identification of Communication Difficulties** is of enormous importance. It has been documented that people with mental health problems and PLD are more likely to have communication support needs than those without these conditions. Between 50% and 90% of people with learning disabilities experience difficulties with communication (Enderby and Davies, 1989; RCSLT, 2006) and 45% present with serious communication problems (Bradshaw, 2007).

26.3 Given the **high prevalence of anxiety and depression** in older people with physical health problems, and the negative impact this has on rehabilitation outcomes, adjustment to illness, discharge placement and future use of services, a focus on the mental health of older people in acute hospitals, similar to the work ongoing around dementia, is worth considering.

26.4 **Improving systems for recording veteran status.**

26.5 **SLC** also offered some specific feedback including **testing prisoners for developmental disorders** would help inform rehabilitation approaches.

Assessing how many **violent offences occur following brain injury** coupled with alcohol use would be very helpful and would also inform the rehabilitative processes.

26.6 **NLC** also offered some specific feedback including integrated working across CAMH's, addictions, housing, justice to reach the National Strategic Objectives which are aimed at making Scotland a healthier society. (5 objectives). Other suggestions include:

- Information sharing
- Joint procurement
- Collaborative Service Design
- Reference to Child Protection and the whole GIRFEC agenda
- Developing Risk Enablement, North Lanarkshire Council and NHS Lanarkshire developed a Shared Approach to effective Risk Management

26.7 Service user and carer involvement requires to be embedded into routine practice, .e.g. implementation of ICPs and their use monitored.

26.8 A greater national focus on the accommodation needs of **female mentally disordered offenders** would be welcome.

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

27.1 Delivery through multi-agency local **Dementia Strategy Implementation Groups.**

27.2 **Needs to be a multi-agency approach**. Joint strategies, joint training, shared priorities and targets where appropriate, more appropriate integration of the scrutiny bodies for particular matters facilitating joint reporting ownership and responsibility.

27.3 **Suggest that NES and SSSC** provide a report of local partnership engagement with the training courses delivered to support Promoting Excellence. The report is then discussed at the SG implementation visits as a specific commitment.

27.4 **Embedding it into the KSF/PDP/appraisal process** and the curricula of pre-registration training for all staff groups.

27.5 **All parts of the system require a level of dementia competence** across the pathway. Match training to the specific roles of staff across the pathway.

27.6 Promote successful outcomes by way of **presenting case studies** based on real people which describe the impact mental health services have had on those who have experienced dementia.

27.7 **NLC** suggested a league table of joint performance, which includes progress in delivering integrated services and also asked the question that if promoting excellence is about dementia what is the model for mental health and is one needed?

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

28.1 Survey of those same staff to find out what (if any) training they have had on gender/ **gender based violence**, and what that entailed.

28.2 Perhaps reference should be made to **Mental Health Officer Services**, service standards, the annual workforce capacity planning activity, the newsletter, the MHO Award training. Uptake of the MDO related training provided by the Restricted Patients Casework Team or the New to Forensics training delivered through the Forensic Network.

28.3 There are **figures from see me**, which highlights mental health stigma in the work place (http://www.seemescotland.org.uk/getinvolved/takeaction/linkstotoolkit/resources/fact-sheets-intro/stigma-and-the-workplace). Perhaps a survey of mental health stigma experienced by Health, voluntary staff, and Social Care staff. Could 'see me' survey pledge signatories to gauge activity across Scotland in building community conditions for recovery.

28.4 **SLC** suggested that it would be useful to gauge how many children are bereaved: pre 5, 6-12, 13-18 and how many prisoners were bereaved as children:

male/female pre 5, 6-12, 13-18

28.5 There are still many **GAPS in the data related to the Children and Young Persons Indicators.** A specific commitment to work to fill these GAPS as well as supporting the use of the indicators at a local level would be helpful.

28.6 A greater focus on **co-morbidity** issues would be welcome, particularly around commitment 13.

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

Comments

29.1 If **trauma and self-harm** is a core area for development, it is essential to assess workforce fitness for safely managing work that does not require specialist input, and up-skill them to offer care and treatment within their own service where suitable.

29.2 Building capacity to deliver effective, **evidence-based psychological interventions to older people**. This involves investing in aligned training places and substantive posts in order to create an appropriate skill mix in the workforce, including CBT therapists, Clinical Psychologists and Clinical Associates in Applied Psychology.

29.3 Training needs to be seen in the context of **significant** work re-alignment scheduled over the next few years.

29.4 **NLC** suggested considering better joint working arrangement to provide a joint service or a dove tail service. A North Lanarkshire council example of this is the joint work with a local provider. Lanarkshire Association for Mental Health staff will be based within Community Mental Health Teams. These staff will be recruited and supervised by LAMH and remain part of their service. Staff will be identified and linked with particular community mental health teams and their day to day work will be agreed with the linked team leader of LAMH and the community mental health team leaders. They will work along side CMHT's on a day to day basis promoting a more integrated approach to information sharing and planning with health and social work staff.

29.5 **Lanarkshire Links** would agree that it is essential that independent providers work alongside statutory services on a daily basis.

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

Comments

30.1 Access to clinical supervision is essential; to ensure that the training people receive is used and maintained appropriately.

30.2 A 'training the trainers' model has been used successfully by NES across Scotland, as a way to quickly and efficiently disseminate training nationally.

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

31.1 While assessing capacity, activity and outputs is clearly essential, it is important that a **focus on outcomes** is also maintained.

31.2 Suggest **more use of mandatory fields** to ensure accuracy of data inputting, with tighter submission timescales to enable more timeous reporting e.g. ethnicity reporting on SMR04 and peoples names being applied to dementia registers after diagnosis.

31.3 Could recording of **veterans** status be incentivised at primary care via the GMS contract

31.4 **Greater focus on AHP activity.**

31.5 The potential to **capture national data from service users** and carers on their views of the services they receive, what works well, what needs to improve, what the gaps are and what needs to be developed would be beneficial. Alternatively a reporting framework that demonstrates that this activity is happening locally and feedback is given for national collation and subsequent dissemination.

31.6 Introduce a **standard A&E data set** which includes mental health components such as improved recording of self-harm.

31.7 **NLC** also highlighted some specific points:

- Greater evidence of the change that data made,
- better understanding of the profile of people who do not attend and what actions are taken,
- sharing the outputs and outcomes achieved through releasing time to care, HEAT and SPARRA data.

31.8 Greater focus on **Health Improvement** activity and wider community approaches to psychological therapies such as Social Prescribing, Biblio-therapy, Stress Control, WISH and local use of Breathing Space.

31.9 The gathering of qualitative data should in terms of user and staff experience should be seen as a complimentary value.

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

Comments

32.1 It is important to **ensure that the outcomes which are measured are perceived by clinicians to be achievable, measurable and relevant to the work they do**. A blanket 'one size fits all' evaluation of outcome is unlikely to be appropriate, and instead a variety of measures need to be considered to ensure

that they are both reliable and valid for the patient group and the type of service. If local services were able to work with e.g. ISD to agree what they were measuring and how they were measuring it, they would be more likely to fully engage with the process.

It's also important to measure more than just symptom improvement. For some patients with complex and long term difficulties for example, improvements in perceived quality of life or relationships are more relevant outcome measures.

Constructive feedback based on the audit data would also contribute to services finding the process meaningful.

32.2 Expansion of the **core national data** set or minimum information standards so that locally developed IT infrastructures integrate outcomes into core operational assessment care planning and review activity for example.

32.3 **Link localised priorities to national support** ensuring it is accessible.

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

33.1 Suggest that **future improvement money** given to Boards should highlight the areas for productivity and efficiency savings in mental health, indicating an expectation for money to be allocated to at least one of those areas.

33.2 More **integration across the existing scrutiny landscape** for particular matters may assist in the integration of the range of improvement work in mental health.

33.3 Better **incorporation of experts by experience** in hospital decision making processes. Expanding community support services (3rd sector) to include supports for people not diagnosed with severe and enduring mental health problems. Their expertise would be extremely beneficial in improving problem solving and coping strategies amongst this group.

33.4 Greater focus on those **client who are difficult to engage** in proactive heath care but engage frequently in unplanned care such as A&E. This can be a small number of individuals but significant in terms of multiple problems and significant service usage. Could we work with A&E to identify those who repeatedly attend with a view to providing more proactive care – similar to the use of SPARRA data to reduce readmissions?

33.5 **Continued focus on commitment 13 with greater national focus.**

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

Comments

34.1 National **support for this is essential**, to both ensure that the focus on

improvement is not lost, and also to help Boards and Local Authorities access training and resources for their senior staff who lead on this work locally. This could be done either by using a national task group, or identifying individuals within existing bodies such as JIT to link with Boards.

34.2 Suggest that the **introduction of a shared electronic one record of care** could host a range of improvements and consistency, integrating the programmes into every day practice without being viewed as different or individual programmes.

34.3 **Further investment into advocacy services** and better support for service users and carers. Recognise organisational power issues and promote power and influence in service users and carers groups.

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

35.1 **Provide up to date learning materials** (e-learning?) on the topic.

35.2 **This could be made part of Health Boards' mandatory training programmes**, perhaps as part of their corporate induction, as is currently the case in some areas. The promotion of available local and national training opportunities across the agencies together with the range of work undertaken by the Mental Welfare Commission currently assists this process.

35.3 **Increase staff access to supervision and reflective practice** and support may aid care. Local authority partners may be able to assist.