CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

Comments

- The overall document is comprehensive, however one observation we would make following consultation with our members is that some of the introductory information and subsequent questions include statements which respondents may feel they are unable to agree with and which subsequently distract and/or lead the respondents inappropriately.

- The main aims of the Strategy are to be commended, however concerns have been raised about linking of suidal ideation and self harm. The focus on Suicide Prevention is a more contencious issue in that suicide is a symptom of underlying causes and as such, a broader focus on mental well-being across government departments and the causes of suicidal behaviour would perhaps prove more useful.

- RESEARCH – in the field of psychological therapies the current 'gold standard' criteria, focus on quantative evidence, lack of inclusion of qualitative service user's experiences and errosion of expertise in existing services is directly undermining access to the range and choice of psychological therapies which are accessible to service users in NHS Scotland. Pschological Therapies which have demonstrated evidence of their effectiveness require proactive support now to ensure continuation of provision if the government is going to be supported to meet their targets and the changing needs of the population. Direct support for research, both in terms of funding, time and expertise is required, as is a commitment to safeguarding the expertise of existing practitioners. The pressure on funding facing commisioners and service managers is resulting in the gradual errosion services. Psychological interventions are being provided in a stepped approach i.e. CBT leaflets, computurised CBT, time limited CBT, however there is no 'one size fits all' therapy and those service users who would gain greater benefit from working from the outset both psychodynamically and 'in relationship' with a therapist are faced with unhelpful delays in accessing these therapies due to the percieved costs.

Art Psychotheray/Art Therapy can actively contribute by :

- Increasing social inclusion for services users who have historically been hard to engage in psychological therapies.

- Providing a non-verbal medium through which service users can more easily access psychological therapies i.e. pre-verbal trauma where words did not exist through which to communicate and reach cognitive understanding ; dementia services where verbal coginition and communication is more challenging but where image based communications can offer a link to memories and cognitive capacity.
- Improve self esteem
- Through wider work with the Arts in Health, improve environments for both service users and staff.
- Contribute to the anti-descrimination agenda through comminicating to the wider public a greater understanding of mental health and well being through exhibitions of work i.e. Combat Stress and work with veterans ; and public events i.e. Tate Britain and Oxleas NHS Trust on Advancing Arts and Mental Health: *What is a Gallery for?*

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
The National Institute for Clinical Excellence (NICE) under which the Scottish Intercollegiate Guidelines Network (SIGN) exists were originally established to assess the cost-effectiveness of pharmacological interventions in the NHS. Whilst they have been and continue to be an effective resource in relation the prescribing of drugs due to their reliable mass reproduction and scientific evaluation of effect, challenges to the impact and appropriateness of the expansion of this model into psychological therapies have been too enthusiastically dismissed and the result is a growing paralysis of choice of psychological therapies for commissioners but most importantly service users. They are no longer treated as guidelines but as rigid directives on services to be commissioned, maintained and developed.

The expertise and knowledge of front line staff of the services available locally for all who experience mental ill health is a vital resource. However when national directives are regarded or interpreted too rigidly as a justification of the culture of abdication of responsibility now visibly present in NHS Scotland, it can make locally informed, timely and effective responses difficult. The combination of the NICE and SIGN guidelines, the Matrix and the increasing pressure on funding, too often results in local NHS commissioners focusing on the minimum level of service that these

documents recommend and patients failing to received the range and choice of psychological interventions which may best meet their needs.

If psychological therapy provision is to be covered by guidelines using an evidence based methodology which is impossible to replicate either in the practitioner, environment or presenting features of patients and which will always fail to address the 'relationship' and therefore 'human' element of therapy, then the government needs to intervene more strongly in encouraging both at a national and local level the continued support into research of psychological therapies who have demonstrated evidence of effectiveness and can provide qualitative evidence.

National and local support should not just be about re-evaluating the criteria for the evidence base but should also be about providing funding for both quantitative and qualitative research. It should allow services to maintain their existing provision in order to have a base from which to conduct that research as opposed to not only the gradual elimination of services but also the downgrading of existing posts so that the expertise required to conduct and guide reseach is lost.

Allied Health Professionals such as Art Psychotherapists/Art Therapists have demonstrated their evidence of effectiveness in order to achieve statutory regulation under the Health Professions Council. They are well positioned to be able to assist in the cross boundary provision of services between NHS Scotland, Social Services, Third and Voluntary sector. They can provide a seemless service to those moving between in-patient and community provision and in so doing contribute to the HEAT targets not only for Psychological Therapies but also Suicide Prevention through maintaining a 'relationship' with service users as they make often challenging transitions from in-patient to community based services on their road to recovery.

It is widely recognised that 'no one therapy fits all'. If in the future NHS Scotland is only able to provide the minimum of choice, there will inevitably be those referrers and patients who will find that their needs will be unmet. This does not fit the philosophy of NHS Scotland being freely available to all.

This question relates to the following statement in the Strategy document :

"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... some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this... 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."

BAAT Member's comment :

'There is some evidence from both the private and public sectors that effective redesign of services requires a systemic approach, and one that involves frontline staff in the process (see, e.g., Seddon 2008, Systems thinking in the public sector). I think the appetite and ability of local

structures to reconfigure themselves would be much helped at national level by doing away with target-driven measures of performance. This would allow the various organisations involved to focus their energies on "value work", rather than wasting time and energy trying to meet (or, more usually, find creative ways to look like they are meeting) arbitrary targets.'

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
This question relates to the following statement in the Strategy document :

"In addition, the current financial climate means that we are increasingly faced with the challenge of delivering improved outcomes with the same or less resource. In agreeing our priorities for the next 4 years we will need to have an eye on those actions which will deliver better outcomes for the same or less resource and those actions which will save money without impacting negatively on clinical outcomes."

BAAT Member's comment :

'I think we need to be realistic in recognising that there are genuine limits to growth and "improvement" (whatever that means), particularly at a time when resources are shrinking. While there are certainly opportunities to learn about and disseminate best practice, the "culture of continuous improvement" described in this document is based on assumptions about unlimited growth that are untenable in the long term.'

BAAT Member's comment :

I find questions like this very odd! Surely there are just two answers:

(1) Look around for natural experiments – compare the outcomes of the various changes that have already been implemented in these kinds of services, and identify the common features of those that are deemed to have worked well (retrospective approach),

OR (2) suck it and see – formulate a plan for change. Ideally this would be based on a number of small, incremental steps with lots of opportunities for reflection and evaluation (particularly by service users and frontline workers). Once the plan is formulated, we can try it out to see how well it works (prospective approach).

I can't see any other way to "understand what changes would deliver better outcomes" and frankly I don't understand why our government needs a

consultation to identify this!! Perhaps I've misunderstood the nature of the question...'

Art Psychotherapists/Art Therapists are recognised as providing a valuable service for those who have experienced trauma e.g. veterans of the armed forces (see The Culture Show
http://www.bbc.co.uk/news/entertainment-arts-15676268)

Current research into the value of Art Psychotherapy / Art Therapy with individuals who experience personality disorders due to developmental trauma is expanding, but the impact of quantative evidence not being readily available at this time is once again resulting in the reduction of choice for patients.

Professions such as Art Psychotherapy/Art Therapy have not become part of mainstream NHS provision without demonstrating their effectiveness. Art Psychotherapy/Art Therapy has grown in the NHS over 70 years because the value of using imagery was recognised, supported and encouraged by healthcare professionals who could 'witness' the benefits for both individuals and groups. The 'witnessing' of these benefits continues to be captured (as in the clip above) but the current 'evidence based' criteria and agenda is in danger of erasing nearly a century of these services within NHS Scotland.

Art Psychotherapy/Art Therapy can demonstrate its ablility to be cost effective by engaging with groups and individuals who may struggle to access more formal and individualised therapies. The ability to work with both verbal and non-verbal communications makes Art Psychotherapy/Art Therapy a unique service which can meet the needs of a wide range of age groups, from early years i.e. developmental disorders, through adult trauma and into older age i.e. dementia – at each stage offering a medium when words are either yet to be learnt and given meaning or fail to be the medium through which cognative communiciation is any longer a realiable or accessible option.

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
BAAT Member's comment :

'First thing we can usefully do is to stop lumping self-harm and suicide together in this way. Suicide is still very stigmatised; so long as self-harm is misunderstood as the first step on a slippery slope to suicide, those who self-harm will continue to be reluctant to come forward for intervention. Any action we can take to reduce anxiety around the potential consequences of seeking help will have a positive effect.

On a related note, we need to disseminate (through training) a broader understanding of self-harm, which as art therapists we know can carry a

wide range of meanings and fulfil a number of different functions, sometimes within the same person and at the same time.

It is important to recognise that, because self-harm is often used as a coping strategy, if we manage to reduce it then the use of other coping strategies is likely to increase. That's just common sense – focussing on the symptom (self-harm) doesn't get rid of the cause (the distress behind the self-harm), which has to be dealt with somehow. Efforts should be directed towards proactively preparing people to use healthier coping strategies, for example using PSHE time in schools to promote resilience and increase awareness of risk factors for mental ill-health.

It would be useful to develop for Scotland one unambiguous care pathway for people presenting with suicidal ideation. At the moment, each area deals with this slightly differently (e.g., different referral pathways for crisis services), making it difficult for service users - and frontline staff – to know where to go for help.

We know that discharge from inpatient services is a time of increased risk for suicide, so any action that improves the interface between inpatient and community-based mental health services should help to reduce suicide rates.

Given the links between trauma, self-harm and suicide, developing services for survivors of trauma and abuse (see Question 2) should impact positively on self-harm and suicide rates by extension.'

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
BAAT Member's comment :

'*Good psychological therapies require therapists working in psychologically oriented organisations. Progress will depend upon acknowledging psychological mindedness as a common value that all parties can adopt. Historically, attitudes have been as large an obstacle to the use of psychological therapies as have lack of resources. These attitudes have included the stigma against people who seek therapy, unjustified scepticism about its effectiveness and the failure of different groups of clinicians and therapists to respect one another's work. In each case changes in attitudes have been necessary for services to improve.*'

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
The 'culture' of stigma and discrimination is changing, but until there is a culture of services users being embedded at all levels of consultation and representation, a proactive approach will be required nationally to ensure

stigma and discrimination continues to be challenged and the culture of 'them and us' is lost.

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

Comments
Michael Matheson, Minister for Public Health clearly states in his introduction:

'*Services, delivered by the NHS, local authorities, the third and private sectors, need to support and enable people to keep well and take responsibility for their mental health. When people do experience mental health problems and mental ill health, they should know how to access help, and services should be able to intervene quickly. Services should put the person, their families and carers at the centre of care and treatment.*'

For individuals to 'take responsibility', we need to be 'given responsibility'.

A system for healthcare regulation already exists to ensure that service providers meet the standards of proficiency to practice (GMC, HPC, NMC, PSNI, GPhC, GosC, GOC, GDC, GCC etc) and that their profession has been able to demonstrate a level of effectiveness.

There exists no evidence base for the intervention of community mental health nursing and yet it is an accepted service provision based on the regulation of professionals by the NMC and the requirement for ongoing Continued Professional Development.

Taking responsibility' means being given a range and choice of local and national services and the control to make decisions as to which services we feel best meets our needs and those of our families and carers. We should be able to build trusting relationships with our local healthcare providers whom we can in turn trust to make informed decisions on our behalf when and if we cannot decide for ourselves. Those local providers should in turn be 'given responsibility' to place trust in the existing regulatory system and assess standards in local provision through local service user led audits.

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
BAAT Member's comment :

'Investment in the CAMHS workforce is great, but simply training up more people to use CBT-based approaches isn't going to cut the mustard. In my area what I need is better access to specialists who have a systemic understanding of children's difficulties. There may well be more psychologists but, as the consultation document identifies, we need improved access to "limited" treatments such as child psychotherapy and,

particularly, family therapy. At the moment, these are like gold-dust. In particular, we need more Tier 2-type services for families in difficulty.

A focus on best practice in assessment, for all frontline staff (including those working in education), would help to make sure that children and young people are referred in a timely way to the appropriate service to meet their needs. At the moment, what I see happening in schools is that harried, overworked teachers make a number of simultaneous referrals in a scattershot way to any service they can think of, in the hopes that one of those services will pick up the case quickly. As a result, children actually fall through the cracks because the various services (each of them overstretched in their own way) experience a diffusion of responsibility, with everyone assuming that someone else is better placed or has greater capacity to actually do the work.'

There is a growing recognition in the field of CAMHS that children, who are accessing services at the point of crisis where their level of distress is high, are unable to utilise purely verbal forms of communication as they struggle to find the words to use. This is where image based psychological therapies such as Art Therapy/Art Psychotherapy are a vital resource in ensuring that services are accessible, timely and proactive in preventing the development of long term mental ill health. The SAMH and Barnardo's Scotland highlight that 'one in ten 5 to 15 year olds experiences a mental health problem (The Mental Health of Children and Young People in Great Britain, *Office for National Statistics, 2004).* The lifetime costs of a single case of untreated childhood conduct disorder are approximately £150,000 (Friedli, L. and Parsonage, M.: *Mental health promotion: building an economic case.* Northern Ireland Association for Mental Health, 2007).'

BAAT Member's comment :

'Any action that improves interfaces between services, and between the various tiers, would help to improve timely referrals through the mental health system. A precious commodity here is time – professionals at all levels need protected time to develop links with others in their local area. In my experience, good working relationships with colleagues in related services are absolutely key to making sure that the distribution of labour works well, and that children and young people get to the most appropriate service(s) quickly. Those good working relationships don't come about magically or by accident – I cannot form and maintain them unless I'm given time to do so.'

'Proactive monitoring of children who are known to have had difficult starts and the offering of services (e.g., nurture groups) before difficulties become entrenched.'

BAAT Member's comment :

'There should be a multi agency approach to expanding the specialist CAMHS workforce to include specialists from professional backgrounds other than psychologists, e.g. art therapists, social workers, early years practitioners.'

'There is currently no mention of the 'GIRFEC' approach to placing the child at the centre of their care and ensuring that relevant information is shared

across all agencies.'

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

Comments
BAAT Member's comment :

'The heat target to deliver access to CAMHS within 26 weeks is a significant period of time for a child or adolescent to wait for any service intervention. For a 6 yr old, this is 1/12 of their life. There could be too much deterioration on a child's situation in a six-month period and there is also potential for the situation to drift from an agency perspective. This timescale needs to be improved.'

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

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

Comments
BAAT Member's comment :

'There is a huge problem here with negative evidence – mostly we don't think about our mental health (or indeed our physical health) until there's a problem with it. So any approach that encourages people to (a) be aware of and thankful for their positive mental health, and any resilience/protective factors helping them to maintain their mental well-being, and (b) pick up quickly on changes in their mental well-being or in their personal resilience and risk factors, should be of benefit here. I'm thinking of approaches like mentalisation and mindfulness, which could be embedded in schools' PSHE agendas from a very early age.'

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

Comments
BAAT Member's comment :

'As art therapists, we know that active engagement with creative processes can be hugely beneficial in maintaining a sense of mental well-being. Scotland's mental health is therefore likely to be negatively affected by cuts in public spending e.g., on art teaching in schools or the provision of arts-based activities in the community. So we need to be mindful of the bigger social and political picture when thinking about mental and emotional well-being, not just the direct impact of health services.'

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
This question relates to the following statement in the Strategy document :

"We already have HEAT targets to ensure that no one waits longer than 18 weeks from referral to treatment for a psychological therapy and that no one waits longer than 26 weeks for referral to specialist CAMHS. These are powerful drivers in the system to speed up the time it takes for people to access treatment."

BAAT Member's comment :

'I strongly disagree with this statement. The HEAT targets are powerful drivers for professionals wasting precious time and resources coming up with creative ways to make it look as though they are meeting the targets, so that they continue to be funded and can offer a service to those who need it. In the process, often the intervention offered ends up being compromised or diluted because that's the only way to get anywhere near the target. All of this diverts attention away from actually delivering the value work of the organisation. This kind of target-driven 'gaming' is endemic in the NHS and other public services and can only be eliminated by doing away with arbitrary targets altogether, in favour of redesigning systems that fit the needs of service users.'

BAAT Member's comment :

'Mental health problems occur in a systemic context, so the way we design services needs to be systemic too, rather than piecemeal and scattershot.

Again, improved training for frontline workers in mental health assessment tools/techniques would likely have a huge impact. Frontline staff, including those in education, need to be able to recognise the early warning signs of mental distress/illness and more importantly, what they can do about it. Training for frontline staff has benefits at two levels – not only will it speed up access to treatment, but it would also help specialist (e.g., CAMHS) staff to be more confident that the referrals they receive are appropriate.'

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
BAAT Member's comment :

'It would be helpful to know what is meant by "nonvalue adding activities" here. As noted above, allowing workers in all sectors time to build their professional relationships and networks is extremely important – when it comes to making referrals and getting them picked up quickly, often it's really isn't so much what you know as who you know. But I suspect this kind of networking is one area that would be dismissed as "activity that doesn't add any value for the service user" in the relentless target-driven push for increased clinical activity.

In any assessment of "non value-adding activity", we need to keep in mind that sometimes indirect clinical work – such as liaison between professionals, or between workers and families – is just as valuable in the overall care of the patient as direct patient contact.'

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

Comments

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

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

Comments
BAAT Member's comment :

'We tend to take an us-and-them view of mental health – there are "patients" and then there are "staff", and these are two mutually exclusive groups. Actually, we may be able to learn much from staff members who are recipients of mental health services and/or who have had mental health difficulties. For example, a national conference targeted towards mental health staff who have accessed mental health care would be a fertile ground for learning about services from the inside-out. It would simultaneously contribute to the de-stigmatisation of mental health difficulties within mental health services. The current issue of 'Inscape' has a relevant article.'

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

Comments
BAAT Member's comment :

'Good quality, accessible information. Careful attention to power-based issues such as informed consent, which is a problematic concept; see Gallagher, M., Haywood, S.L., Jones, M.W., & Milne, S. (2010). Negotiating informed consent with children in school-based research: A critical review. Children and Society, 24, 471-482.'

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Comments

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

Comments
BAAT Member's comment :

'Local champions? And/or access to expert support for individual services.'

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

Comments
BAAT Member's comment :

'Professionals need time to engage with the Network and with the Recovery agenda.'

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
BAAT Member's comment :

'Give them easy access to relevant, good quality information and the opportunity to share their experiences with other carers/families. Provision of respite services. Reduce redundancy in administrative systems across services, so that families and carers are not having to supply the same basic information again and again. Support the costs of transport to and

from appointments. Provide "doorstep ambassadors" to take mental health services and support to families and carers in their homes, rather than expecting them to attend clinics. Legislate time for family members/carers to attend appointments within employment law, so that they are able to get the time off from work that they need.'

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
BAAT Member's comment :

Signposting to centralised and easily accessed repositories of relevant, evidence-based information. (see, for example, the Directory of groups and activities for Young People in North Lanarkshire, produced by NHS Lanarkshire, Strathclyde Police, the Lanarkshire Alcohol and Drug Partnership, and North Lanarkshire Council). Once again, professionals need time to engage with families and carers, and to look for information that may be useful to them.

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
BAAT Member's comment :

'There is a danger in believing that you can simply take what works in one area and transpose it onto another. Across Scotland there are a wide variety of environments, communities, centres of population, remote and rural areas, island communities etc. What works well in one area may be contra-indicated in another – an example of this was the imposition (financial penalties if not followed) of the Purchaser/Provider split in the 1990's which whilst it may have been efficient in the central belt, was ineffective and inefficient in the islands. There has to be a recognition that what works for one does not always work for another and that local knowledge and expertise has to be given weight. For some smaller communities, there is service user evidence that the option of being away from that community during a mental health crisis is preferable to being visible in a small community during that crisis and the subsequent difficulties this can cause on the road to recovery. A fast track, generalised approach to mental health and well-being across vastly culturally different communities and environments will increase inefficiencies and distort outcomes.'

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
BAAT Member's comment :

'Information on who is using services and improving access to services has to take into account the changes that have been made to the range and choice of services available. It cannot be based on services, which simply exist at this time, without looking at services that have been 'cut'. Reduction in admissions cannot be 'praised' in isolation, but needs to be assessed against recovery or deterioration in mental health and well-being, and a communities assessment of the quality of their overall healthcare provision. Any evaluation of current service provision in this way has to take into account service user's, families, carer's, healthcare providers and communities opinions and should be undertaken in terms of overall quality of life'.

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

Comments
BAAT Member's comment :

'Local champions?? e-learning. Packages of localised training.'

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

Comments
BAAT Member's comment :

'Self-harm – there is a dearth of evidence-based information about what actually works.'

'Mental health and family breakdown/family issues.'

'Anger and disaffection – perhaps sounds trivial, but "anger management" is something that young people, families and schools ask for from the service I work in, almost more often than any other kind of help. Huge numbers of young people – and adults - are significantly affected by their inability to understand and manage their angry feelings. Clearly the causes of anger and disaffection are broad and very much affected by the social and political context. So this isn't just a mental health issue, but since it impacts on well-being, I think it deserves some attention within this kind of consultation.'

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

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
BAAT Member's comment :

'It would be helpful for teacher training to include elements of mental health and suicide awareness. Teachers would also benefit from time and support to discuss their difficult interactions with students, in a supervision-type forum.'

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments
BAAT Member's comment :

'Psychological treatments need to better reflect effectiveness rather than simply the amount and quality of research undertaken. There needs to be investigations, which will evaluate the acceptability and availability of

psychological therapies. Information on services and patient experiences should be audited and assessed in order to increase the range of choices of treatments.
Important to collect data on service user experience of psychological therapies, however the difficulty can be in how to include data where there is often limited choice of psychological therapies available to patients.'

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

Comments
BAAT Member's comment :

'There is a need to build upon the evidence of innovative psychological therapies treatments not represented in the Psychological Therapies Matrix. These treatments can struggle in having sufficiently powered outcome studies that meet the evidence threshold set by the Psychological Therapies Matrix.'

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

Comments
BAAT Member's comment :

'Within the Psychological Therapies Matrix there is much attention paid to training, competency and safety however surprisingly little focus on regulation of psychological practitioners. How do we ensure the safety of the public when there is inconsistency surrounding state regulation of psychological therapists? At present the professions of Practitioner Psychologists, Child Psychotherapists and Arts Therapies are the only psychological therapies regulated by the Health Professions Council.'

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
BAAT Member's comment :

'There is little evidence in this section of the document of the governments engagement with service users and evidence given by service users in the evaluation and outcomes of the strategic efforts undertaken to date. There appears to be a limited 'evidence base' on which to rigorously evaluate any

strategy outcomes within a wider framework of understanding. Statements of success prior to posing a question are leading and seek to influence the response – this choice of format only serves to leave the consultation open to criticism.

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

Comments
BAAT Member's comment :

'It is reassuring to see 'measures of inputs and outputs' being recognised for their inability to assess quality of services but at the same time worrying that outcome measures are seen as simply there to 'complete our understanding of services'. Surely outcome measures and therefore 'quality' should have been evaluated prior to 'input and output'.

The reality is that access to services has reduced and outcome measures on quality are undertaken only on the services that have survived the impact that the SIGN guidelines and the Matrix. Whilst the SIGN guidelines and the Matrix state that 'no evidence is not evidence of ineffectiveness' and that existing services can be used by locally informed referrers, the reality is that these services are no longer available to referrers unless they are able to argue and justify in detail why they are not following the guidelines.

Therefore, in order to capture a realistic assessment of psychological therapies, any standardised clinical outcome measure should be undertaken across not only the NHS but also Social Services, Third Sector and Voluntary Sector provision. This should be a nationally inclusive evaluation of all psychological therapies regardless of where they are delivered and the outcomes should ensure that commissioning, funding, training and support for research is directed appropriately.'

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

What evidence is there to support the statement above i.e. 'that 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'. Whilst the latter part of this statement about 'change being complex etc.' may be accepted by many, for it to be linked with a all encompassing statement that what is happening is 'improvement' and is 'supported' unanimously by every manager, service lead, practitioner

and service user lends the statement vulnerable to question.

The pressure on staff to achieve increased 'productivity' and 'efficiency' within the mental health system implies that there have historically been inefficiencies and lack of productivity in services. This in itself is a demoralising implication for staff across all areas of mental health service provision. Services across Scotland are struggling to meet the demands being placed on them without the additional undermining of morale. The pressure on services to provide only positive messages to the government and to reframe any sense of 'dis-ease', should perhaps serve as a warning sign to accompany the statement above.

It would be interesting for an evaluation to be undertaken of the change in staffing in light of the recent 'improvement' in service redesign as there is a danger that more experienced staff are taking early retirement, redundancy or simply choosing to leave NHS Scotland, leaving a less experienced and historically knowledgeable staff group who will inevitably provide fewer informed challenges to the process of 'improvement'. The Scottish Government will in turn have fewer resources to evaluate the changes being made. This can only be a loss for Scotland as a whole.

Unless staff are given the opportunity to express concerns freely, statements such as those above will continue to be made, will continue to be believed by those less well informed by the clinical realities of staff on the front line of services and will continue to influence the direction that services in Scotland are travelling.

The 'Boorman Review' (Nov 2009) undertaken by the Department of Health investigated the health and well-being of NHS staff. It identified that NHS organisations that prioritised staff health and well-being achieved enhanced performance, improvement in patient care, retained staff and had lower rates of sickness absence. Productivity improved and agency staff costs reduced. It recommended that NHS organisations should have 'prevention-focused health and well-being strategies and that senior management should be accountable for staff health and well-being, measured as part of the annual assessment of NHS performance.

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

Comments

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

This is a huge area to be covered in one simple question, as it would require a detailed understanding of the 'Mental Health (Care and Treatment) (Scotland) Act 2003'; the 'Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report, As Presented to Scottish Ministers March 2009' and the 'Scottish Government Response to the 'Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report 2010' as well as the Milan principles that underpin that legislation. Any response to this question would also require the respondent to have an understanding of 'Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007.

In order to support staff so that care and treatment is delivered in line with legislative requirements – a commitment to significant 'nonvalue' time would be required to allow them to undertake the necessary research and evaluation of the above mentioned documents in order to be able to make an informed contribution and be able to clearly articulate their support needs.