DATE: 30 January 2012

RESPONSE OF: The Royal College of Psychiatrists in Scotland

RESPONSE TO: Consultation on Mental Health Strategy for Scotland: 2011-15

We are pleased to respond to this consultation. This consultation was prepared by the Royal College of Psychiatrists in Scotland. For further information please contact: Rebecca Middlemiss on 0131 220 2910 or e-mail rmiddlemiss@scotdiv.rcpsych.ac.uk

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

The Royal College of Psychiatrists in Scotland (RCPsychiS) welcomes the opportunity to comment on the Mental Health Strategy for Scotland: 2011-15. The College sought a wide variety of views to inform a response to the strategy, this included service user representatives, carer representatives and members of the college in Scotland. All the faculties of the Royal College of Psychiatrists in Scotland were consulted representing all psychiatric specialties including Child and Adolescent Mental Health Services, Old Age, Addictions, Forensic, Learning Disabilities, Psychotherapy, Liaison, Rehabilitation and General Adult.

The College would like to make the following general comments;

The consultation has been a welcome exercise and the College recognises the need for a refreshed national strategy for mental health. Combining the service strategy with the mental health improvement strategy makes sense as a whole system approach is necessary in challenging times. The consultation sets out the broad outcomes and the College supports working with those but suggests the Strategy itself will need to set some clear direction. This should include realistic ambitions and targets for the promotion of positive mental health and the delivery of improved services over the period from now to 2015.

Much of the Strategy should be about continuing to build on the progress that has been achieved in recent years. Many of the commitments in Delivering for Mental Health and Towards a Mentally Flourishing Scotland remain relevant and as the consultation suggests the Strategy for 2012-15 should be a continuation and update with improvement where that will be helpful.

Gaps in the key challenges identified

There is a lack of services for younger people with neuro-psychiatric disorders (including early onset dementia, post-traumatic brain injury, Huntington's Disease and alcohol related brain damage.) There are high quality services in Scotland, but these are limited in their capacity and consideration of how best to meet the total population need is required.

There should be more reference to the importance of Mental Health issues in general health settings, including Acute Hospitals. The RCPsychiS supports the comments of the Emergency Access Delivery Team on this topic. Similarly, the importance of awareness of mental health issues and competence is responding is essential in children's services.

Dementia

The College welcomes the continued focus on Scotland's Dementia Strategy. The recognition of the impact of dementia on a wide range of services has driven forward positive changes in dementia care and support in Scotland.

The assessment of complex early presentations of dementia is notably absent from the planning process. This is a highly specialised practice dealing with only a very small number of the total population but this group is proportionately one of the most ill and most expensive to deal with.

The College reiterates the view of the Old Age Faculty of the Royal College of Psychiatrists in Scotland. It is disappointing that no reference at all is made to other mental disorders in older people. Presentation, management and outcomes of mental health problems can be very different from those in younger people. Access to psychological services, liaison services, crisis services and primary care services is much poorer for older people, as referred to in the Royal College of Psychiatrists position statement of 2009, *Age Discrimination in Mental Health Services: Making Equality a Reality*. The Strategy is a major opportunity to address this, and this must not be lost.

The College supports the particular emphasis on the need to improve the quality of care for people with dementia in the general hospital setting. College members are keen to develop staff skills and effective care pathways to improve the patient experience in this setting and post-discharge. If practice in general hospitals is to change the training of general nurses must include how to nurse patients with dementia.

People with Dementia benefit from general health improvement actions, including improving diet and increasing physical activity. This should be recognised in national strategies.

Research

There is a pressing need to continue to advance knowledge of mental health problems and psychiatric illness. Psychiatric disorders tend not to attract the levels of charitable research funding of other health topics. It has been estimated that Mental Health research attracts less than half the research funding of neurological research, despite its considerably greater public health impact. Mood disorders, Schizophrenia, Dementia and Substance Misuse are major causes of disability. Mental health issues account for 17% of the health burden in the UK each year. These mental health issues represent the major health challenge for Scotland. The cost to the NHS each year is 10.4 billion and the cost to the economy from working days lost is 77 billion. The budget allocated to mental health is only 6.5% of the UK health research funding each year. Mental Health research should therefore be a high research priority.

RCPsychiS supports the comments made by the Child and Adolescent Faculty. Key challenges include building an evidence base in Child and Adolescent Mental Health. There needs to be a clear emphasis on the importance of an academic/research infrastructure for this group as well.

There are a range of drugs and psychological treatments in dementia that can either slow the progress of the disease or improve the functioning of the patient.

More research in this area is needed to continually improve these treatments and the College would like to see more support for the Scottish Dementia Clinical Research Network.

Suicide and Comorbidity

If the current economic situation leads to a worsening of circumstances in the most deprived communities, the gains made in tackling suicide in Scotland may be at risk of reversal. Research shows that economic cycles give a clear indication of suicide trends, and recessions have been shown to be accompanied by an increase in suicide rates.[1] The people most at risk of suicide at this time are those who are experiencing financial problems. This includes people who were already suffering from poverty prior to the credit crunch and are now struggling further with rising costs of living, those who have recently lost their jobs or who have been unemployed for some time, those who are affected by a downturn in business, those who are in low-status occupations and those with existing mental health problems.[2]

The importance of alcohol and drug misuse in suicide in Scotland has been emphasised in previous reports.[3] Co-ordinated working between mental health and addiction services continues to be a challenge at all levels.

A strategy document fit for the next 5 years must address this issue and support the implementation of previous documents like Closing the Gaps, which became Commitment 13 in Delivering for Mental Health. The use of the Care Program Approach (CPA) in some of these complex cases needs to be considered. Examination of the role of CPA in co morbidity should take place as part of a broader consideration of service philosophies in mental health and substance misuse.

The College believes that is important to target activity toward high risk groups such as those with mental health problems. Specific high risk groups include those who misuse substances (including alcohol), trauma survivors and those who have previously self harmed. Effective preventive and service improvement approaches for these issues are likely to reduce suicide rates.

Recruitment

Recruitment, training and education are core functions of the College. The College is closely involved in workforce planning, post graduate standards and delivery of training. Recruitment to psychiatry remains challenging and it is of increasing importance to improve undergraduate medical training and support postgraduate

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[1] 1) Stack, S., *Work and the Economy*, in *Comprehensive Textbook of Suicidology*, R.W. Maris, A.L. Berman, and M.M. Silverman, Editors. 2000, The Guildford Press: New York. p. 193-221.

[2] 7) Stack, S., *Work and the Economy*, in *Comprehensive Textbook of Suicidology*, R.W. Maris, A.L. Berman, and M.M. Silverman, Editors. 2000, The Guildford Press: New York. p. 193-221.

[3] National Confidential Enquiry Into Suicide and Homicide by People with Mental Illness – Lessons For Scotland, University of Manchester 2008

training and recruitment in all areas of mental health. It is important to ensure good recruitment of psychiatrists and other mental health staff throughout Scotland and achieving geographical equity should be part of the aims of all workforce activity.

There is currently a recruitment campaign underway targeted at medical undergraduates and doctors early in their careers. Scotland has historically recruited well to Psychiatry and the College's UK campaign is chaired by Dr Tom Brown, the previous chair of RCPsychiS. Starting from next year, the College will begin to do twice yearly recruitment to ST4 level.

Job plans should ensure adequate time for psychiatrist and other staff to train both specialist and general staff and engage in public education on mental health issues to promote recruitment. The new consultant contract reduces time available to senior doctors to provide input to train the next generation of psychiatrists or engage in research.

Question 2

Care needs to be taken in use of term "trauma." This can refer to psychological trauma or brain injury, both important areas, and it is important to be clear which is referred to. It is recognised that there is a service gap for personality disorder treatment, including Borderline Personality Disorder. Improvements here have been more limited than for other psychological therapies. It is imperative that here is recognition of the importance of personality disorder in prison and homeless populations and those misusing substances. Psychiatrists, including medical psychotherapists need to be involved in these developments.

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Challenging the stigma around mental health should be a core part of the strategy, and there should be a greater focus on the community level. This should include more school level education and creative community events to achieve social awareness and reduction in stigma. In addition to this, key indicators to measure progress on reducing stigma should be developed.

The strategy should consider how the issue of isolation is addressed. Many service users are not in relationships, do not have family and friends around them and feel isolated. This should be acknowledged, and thought through within the strategy.

Stigma and recovery should be linked together in terms of their aims.

It is crucial that there are not perverse incentives for diagnosis. Children and young people should not be denied appropriate services if their developmental difficulties fall short of diagnosis but still adversely affect health. So many young people show developmental difficulties that it is important to support them not to see themselves as different or abnormal. Self esteem and confidence are important to

this group of patients, this can be addressed through psychological therapies and training and support to families, carers, teachers and other involved professionals.

There have been several good examples of the portrayal of mental health problems in the media, including in dramas and work should continue to encourage this. The College recognises the success of Make Me Happier, the STV series on Mental Wellbeing.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

The College welcomes the priority given to Early Years and work must continue to translate this recognition into sustained and coordinated action. The introduction of a waiting times target for Child and Adolescent Mental Health Services is welcome, but 26 weeks remains too long. There remains a considerable unmet need for Child and Adolescent Mental Health Services in Scotland. Efforts should continue to reduce the admission of children to adult facilities.

The provision of effective universal services to children and families in early years, such as Health Visiting, is essential to identify and intervene with developmental issues which can have a lifelong impact on mental health.

Effective perinatal services offer considerable health, social and economic benefits for women and infants. These are a fundamental part of an effective early years programme. Helping women with mental health problems in pregnancy and in the first year post-partum offers considerable long term benefits

A focus should be placed on young people's transitions, and there should be specific support around this age, for example setting up young people's health services which have an emphasis on young people's mental health. When a young person is unwell there should be a push to help them at home or in the community where this is possible.

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.

This is a laudable outcome and a shift from community based service delivery to self-directed access to information and treatment where appropriate is one of the aims of the work that is being developed and promoted by NHS 24 amongst others. RCPsychiS will continue to support the development of this work as earlier intervention at lower tiers may in some cases help to prevent escalation and the development of treatment options at this level could potentially relieve some of the pressure on tier 3 services.

Some of the initiatives to improve mental health depend on the skill of members of the public (for example, to access information through workplaces, the internet, etc.). This creates a risk that people with learning disabilities may experience

disadvantage unless there are special efforts to support them in having equal access.

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.

Effective frontline services must be protected in the NHS and partner agencies. Many of the most effective and innovative services have been in community teams. These are potentially vulnerable to staffing reductions, and this can attract less attention than ward closures. Support for these teams is essential to maintain an effective and efficient range of services. Much of mental health care, particularly for severe mental illness, is delivered jointly by primary care and secondary care. Peer support and support for carers is essential for a comprehensive service. Structured development and evaluation of these collaborative care models should be encouraged.

More use should be made of technology within mental health, research should be carried out to consider how this could best be developed. Areas where this could be developed included the development of advanced statements, consideration of telephone and internet counselling to facilitate access.

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

The Integrated Care Pathway (ICP) project is now over 5 years old. The main obstacle identified to making rapid progress at the outset was the lack of good IT systems for managing and collating clinical data. A system for collecting good clinical information, using ICPs as a framework for doing that, would drive service improvement and would also have huge potential for research. The Scottish Diabetes Research Network is an example of excellent progress dependent on a SCI-DC clinical information system. A similar system for mental health would drive forward our ICP, clinical governance and research capability.

It is recognized that systems such as Multi Disciplinary Information System (MiDIS) have potential but there is a risk that the clinical aspect of information systems will be a secondary priority to the recording of activity. There is a need for both and for quality of patient care the clinical information systems are more important.

ICPs need to be supported by dedicated IT systems which reduce duplication, reduce errors and increase efficiency. The time lost to care resulting from recording processes for ICPs is substantial, but does not seem to have been measured as part of their implementation. There is so much paperwork generated by some ICPs that vital information is lost.

The adoption of electronic case records containing ICPs needs to be supported by robust and up to date IT systems which are accessible in both NHS and non-NHS

premises. Automatic population and updating of ICPs and electronic medical records by integrating GP and secondary care IT systems will improve communication, reduce duplication and crucially reduce medication errors.

GP practices have made significantly better progress in making their information systems increase efficiency and knowledge than secondary care. IT staff are part of the clinical service, are managed alongside other staff and are often based in the same building. The Diabetes Network has similar arrangements. mental health IT systems should follow these examples.

The strategy should set a commitment or target for NHS Boards to have information systems in place that can gather clinical data in a way that can be used for service improvement within an agreed time.

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

Despite growing evidence that recovery from severe mental illness is significantly helped by the provision of meaningful activities to patients on discharge from hospital, provision of services specifically designed to meet the requirements of this group of patients is patchy. Access to effective vocational and educational opportunities is vital to support patients and their families. Close and effective joint working between agencies is essential for these opportunities to be meaningful, and the protection of employability and educational services for these groups is vital.

Local authorities should be encouraged to give greater priority to the provision of services for mentally disordered patients in line with the statutory duties placed upon them in terms of section 25-27 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Recovery should not become seen as a service or a term which is fixed in its meaning. People with mental health problems should guide how the concept of recovery grows and develops in the future.

Recovery for individuals should be celebrated and information systems should be able to track recovery outcomes for people in treatment.

Provision of effective recovery-oriented services must be maintained. This is particularly important for those with long-term mental illness and for people with drug problems, as part of an integrated treatment and harm reduction approach.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

There is a continued need to ensure that the way in which policy and strategy develops is steered by those with mental health problems and suggestions from users and carers should be valued.

Peer support should be included in the strategy as there are many situations where support from someone who has recovered can be inspirational in terms of their own recovery. This could be talking therapy and also assistance with social issues such as housing, benefits and employment issues. The importance of both individual and collective advocacy must continue to be recognised.

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

The appropriate balance is dependent on multiple factors and especially on the range and capacity of community services developed within an area. There is a need to ensure that lessons are learned from areas where redesign has taken place and applied in other systems where redesign is proposed.

It is important that the strategy acknowledges that change and redesign will be necessary as services strive to continue to improve in difficult financial circumstances. Service developments in one aspect of the service may need to be funded by doing less of other parts of the service. This may require difficult decisions as reducing any service, however ineffective it has been shown to be, is likely to be unpopular with some people.

The strategy should acknowledge that improvements in care can be delivered through redesign and moving resources from less efficient parts of the service to support this will be necessary.

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.

There is a lack of communication and a lack of mental health provision for asylum seekers and refugees. The social isolation, lack of networks, and barriers in terms of language and cultural differences, combined with sometimes extremely difficult circumstances for seeking asylum that this issue should be given priority.

Suggestions from a services perspective included cultural awareness, clear pathways for people who have been discharged from services and the provision of appropriate advocacy services. There was also a community level perspective which related to integration of asylum seekers and refugees into the community, and breaking down barriers.

There is a disproportionate likelihood that adults with learning disabilities will be identified as having mental health problems.

There should be early intervention for all marginalised groups, such as BME communities, prison community, LBGT, homeless people, asylum seekers, new migrants and low income households.

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.

The importance of different parts of the mental health service working together is emphasised above. This applies in all settings. The use of Care Programme Approach would be one way of ensuring better integrated working for those at higher risk.

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.

Training of staff, junior and senior in all disciplines, is part of the core business of NHS organisations and needs to be reflected in the priorities of Health Boards. The implementation of Enhanced Appraisal for consultants and specialty doctors is an opportunity to improve personal development planning for this group and Boards need to ensure they capitalise on this to develop to align the skills of these doctors to the priorities in the strategy. It is also vital that the role of senior medical staff in training junior medical staff is enhanced through faculty development and the quality management of training placements in Boards. The roles of NES Specialty Training Board for Mental Health and the role of the College in this are both vital.

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.

There has been much work to improve benchmarking of mental health services at local and national level, statistical information is routinely collected on psychiatric contacts, and mental health indicators are being developed.

The same arrangements are not in place for people with learning disabilities, even though they experience much higher rates of mental health problems than the rest of the population. At present the eSAY database (National Learning Disability and Autistic Spectrum Disorder Database) cannot be linked to Information and Statistics Data or local health data. The GP learning disabilities registers (quality and outcome framework) cannot be linked at an individual level with other local or national health data, nor in an aggregated fashion with other reported Quality Outcome Framework data. Relevant mental health indicators are not available for people with learning disabilities and we are not aware of government supporting their development. This inequity should be and could easily be redressed, so that the mental health needs of adults with learning disabilities does not remain hidden, benchmarking between Board areas becomes possible, and progress can be monitored.

The College suggests that for each mental health patient group (adult/child/adolescent/elderly/learning disabilities) a toolkit should be developed which includes very brief common mental disorders outcome measures (e.g. a score out of 10) to be used at each secondary care health psychiatry and psychology contact and to be recorded in the clinical IT system. This could then be included in statistical reporting/safe haven repositories. Consistency across Scotland in this regard would allow benchmarking of population mental health impact on services, and both individual and aggregated clinical outcome measures following service contacts.

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.

It is especially important that clinicians in the earlier parts of their careers are given the opportunity to learn and practice leadership skills. Some clinicians already benefit hugely from opportunities to participate in initiatives through the National Leadership Unit hosted by NHS Education Scotland. Leadership skills are important for those from all disciplines who will assume high level clinical responsibilities and there is a need to broaden the access to supported learning in leadership and management training for these 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.

In line with the requirements of the Equalities Act 2010 there must be an elimination of discrimination in provision of services to individuals with mental illness, learning disability and personality disorders.

As stated above, local authorities should be encouraged to give greater priority to the provision of services for mentally disordered patients in line with the statutory duties placed upon them in terms of section 25-27 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The College recognises the success of the Charter of Rights for People with Dementia and their Carers in Scotland developed by the Cross-Party Group on Alzheimer's in the Scottish Parliament. In addition to this there should be development of a charter of rights for individuals in Scotland with mental illness, learning disability and personality disorders and their carers.

The Bucharest Declaration on the Health of children and Young People with Intellectual Disabilities and their Families was issued by the World Health Organisation in November 2010. The strategy is an opportunity to explicitly address the needs of intellectually disabled children and young people by adopting the Declaration in Scotland.

Summary

RCPsychiS agrees that the outcomes as stated in the consultation on the strategy cover the important areas that need to be addressed as we move to an integrated mental health improvement and mental health service strategy.

The translation of the consultation responses into a coherent strategy with realistic, measurable outcomes will undoubtedly be challenging but is a necessary next step. The broad thrust should be a continuation of the current direction of travel, with a few areas of different emphasis, and an incremental step forward in the ability of services to collect, analyse and use data to drive service improvement.

RCPsychiS members will continue to contribute to the development and implementation of the 2012 mental health strategy and look forward to seeing the output following the consultation phase.