## 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.

As Scotland's largest solely Scottish children's charity, we welcome the introduction of the strategy, coming as it does so soon in this parliamentary session, as a welcome reflection of the pre-eminence attached by government to the importance of mental health.

Appearing just a few months after the publication of the recommendations of the Christie commission into the future delivery of public services it is clear that the Scottish Government regards the promotion of positive mental health as an agenda which has a place at the heart of the prevention agenda and rightly so. According to the office of national statistics, the lifetime's cost to the state of a single case of untreated childhood conduct or behavioural disorder are approximately £150,000 per case in terms of economic inactivity and statutory interventions from health, social work and criminal justice. Coupled with the fact that 10% of 5 to 15 year olds will exhibit some form of mental ill health, promoting positive mental health in children and young people is undeniably at the apex of the preventative spending agenda.

Work towards a draft strategy has to this point been heavily focused around primary healthcare interventions, HEAT targets and the role of health boards. Whilst the role of these protagonists is critical, so too is that of voluntary sector and community led interventions. Greater focus must be given to innovative service provision, coordination and collaboration between the statutory sector and the voluntary sector. At the same time consideration should be given to the increasing importance of neuropsychology in determining the impact of behavioural and mental health disorders on future life chances in the context of the preventative agenda.

We are hopeful that the development and implementation of this mental health strategy will also be met with the full implementation of the Framework for Children and Young People's Mental Health framework by 2015. Similarly we are hopeful that the advent of this strategy will see a renewed determination towards the delivery of Equally Well and the improved joint working between NHS, local government, the Third Sector and other with community planning partnerships that it requires. In addition, specific Government action in the delivery of this should be emphasized across portfolios and directorates.

**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.

The advent of local government elections in May of this year will herald a refocusing of the settlement between the Scottish Government and COSLA, if this entails a wholesale review of the 15 national outcomes and 45 indicators contained in the original concordat, we would suggest that a specific national outcome be framed that captures the stated objectives of this strategy. In supporting Local Authorities to draft and sign off on Single Outcome Agreements the Scottish government could hypothecate local outcomes and indicators that promote the objectives of this strategy, as it did with the Early Years Framework which local authorities might wish to include in their SOA.

**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.

**2.1: Delivering better outcomes: investing in improving mental health in children and young people beyond CAMHs**

Investment in improving positive mental health among children and young people must be extended beyond Child and Adolescent Mental Health Services, the provision for which is both inconsistent in Scotland. Additionally, given the undeniable importance of mental health in the early years and through adolescence, the government target of reducing waiting times for CAMHs targets to 26 weeks by 2013, even if achieved will leave already vulnerable children and young people waiting far too long.

If we are to establish a level of provision that adequately meets the needs of children and young people, investment should be targeted at promoting positive mental health in early years education, and support for parents in terms of building their capacity to promote positive mental health through health visitors, primary health care practitioners and other points of contact.

**2.2 Delivering better outcomes: delivering change through teacher training and CPD**

**a) Improving awareness of and techniques for dealing with the mental health issues exhibited in looked after and accommodated children**

Research shows that children looked after at home or in accommodation are 6 times more likely to have a mental disorder than those children living with families in the community. Issues connected with loss, trauma and attachment disorders are commonplace in this demographic of children and young people and all too often, those who have a responsibility for the development of that child through their role as corporate parent, i.e. teachers and other professionals are ill equipped with the skills necessary to understand and deal with negative or erratic behaviour and associated with these very specific causes of mental ill health.

Many looked after children come into the care system with a considerable record of educational difficulties and a poor pattern of attendance and achievement. The later in their school career that many children become looked after the more likely it is that educational difficulties are firmly embedded.

***These are our Bairns*** calls for schools to work in a child centred way, promoting attendance and making additional arrangements where necessary We work closely with schools to ensure each young person has as normal and positive education experience, where possible creating a flexible package of education support. But when things get difficult at school pressure comes to bear from a range of quarters and understanding among teaching staff of the very specific needs of looked after children can be varied. Not all teachers and schools deal with this effectively. The Looked After Children Strategic Implementation Group has pointed to research that **trauma connected to attachment has a measurable physiological impact.** Understanding this can help improve the effectiveness of support.

In our experience, when schools are supported to understand the impact of trauma and attachment and are supported to work with looked after children, placements are more successful and school exclusion is reduced. A balance of the right package of child centred support which has the option of support in school must be established. Employing standard mainstream techniques for policing disruptive behaviour can serve to compound attachment disorders as well as feelings of loss and isolation already prevalent in looked after children

**b) Improved understanding in teachers of the health and well being outcomes and Support for delivering curriculum for Excellence health and wellbeing outcomes**

During initial training and throughout their continuous professional development, teachers should be supported to fully understand the needs and requirements associated with delivering the health and well being indicators prescribed in the Curriculum for Excellence.

**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?

Funding for replication and continuation of innovative voluntary sector services designed to tackle this issue are required.

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

**Greater support for care leavers**

Similarly, given that the cohort of young people who have been looked after and will experience mental ill health is so disproportionately large, we would suggest that support for Scotland's care leavers is of vital importance in addressing the rates of ill health among that demographic in this country. It is a myth to suggest that these young people become mentally unwell as a result of their experience of care, the 12 UK academic studies that examine the effect of care on children and young people, all identified that children entering residential care in general had serious problems but that in fact their welfare improved over time in a residential setting.

*What is the Impact of Public Care on Children's Welfare?* A report by Dr Donald Forrester at Cambridge University[1] into residential child care in England and Wales, states quite clearly that the life chances of a young person leaving care are more likely to be adversely impacted by experiences prior to and after their experience of care, that is the chaotic or destabilising domestic circumstances that led to a young person being accommodated in care in the first place and the through-care or lack thereof that they receive for those crucial initial years of independence on leaving care.

As such we believe that the 5 years which immediately follow exit from the care system are as important as the first 5 years of life. As such, public investment in support for young peoples in the 5 years after leaving care should be comparable to those afforded to the early years. This model would suggest that through-care should be as important as the support given to a child while they are in care. As such the corollary to this is that hard outcomes should not be measured after this extended through-care

[1] What is the Impact of Public Care on Children's Welfare? A Review of Research Findings from England and Wales and their Policy Implications, Forrester, Goodman,, Cocker, Binnie, Jensche, Cambridge 2009

support when young people will most often be in their early twenties.

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?

See Me has delivered and continues to deliver an effective and wide reaching campaign to build public awareness around the issues relating to mental ill health. Aberlour have recently joined their campaign on child and adolescent mental health and hope that the government continues to support its efforts in this area.

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

**Tackling dependency as a symptom of and catalyst to mental ill health in families.**

Parental substance misuse is closely correlated mental ill health as well as child neglect and abuse, and there is a compelling need to tackle this problem – especially prevalent in Scotland

Our experience of providing outreach and residential treatment services to families affected by parental substance misuse spans 3 decades. The families we work with have a huge range of complex needs with many being involved with statutory social work. Aberlour dependency services have considerable experience working with children affected by parental substance use, providing residential and outreach services throughout Scotland. We distinguish ourselves from social work services in that we seek funding to allow us to work in a preventative manner (with the obvious long-term benefits to children, families and society) not just in a crisis. This ties into the key preventative spending agenda laid out by the Christie Commission.

Through our outreach services we aim to encourage better parenting and enhance childhood experiences by meeting the needs of disadvantaged children (5 – 16) and families in the areas in which we work. The aim is achieved through a variety of methods including:

- Comprehensive and expert family assessment to establish needs
- Individualised care plans and support packages to meet these needs
- Parenting work to improve child-care skills and keep families together
- A focused approach on the safety and wellbeing of children
- Breathing space for parents experiencing drug and/or alcohol issues to explore, consider and choose positive lifestyle options
- Individual support for children to increase their resilience during difficult times

Whilst our model of intervention has a proven track record and, in terms of our residential services are entirely unique in Scotland. There are many other proven models of intervention across both voluntary statutory and private sectors.

Joint working between NHS local authorities, justice services and most

critically the voluntary sector must be incentivised to ensure maximum value and coordination.

**The link between employment, poverty and mental health**

As the government launches its youth employment strategy, we call on the architects of the mental health strategy to coordinate their efforts with those responsible for youth employment. Chronic levels of self esteem brought about by a range of factors in adolescence are inexorably linked to life chances and employability later on. As such certain aspects of the two strategies should walk hand in hand. Indeed renewed efforts to bring waiting lists for Child and Adolescent Mental Health services below the existing Government target of 26 weeks should be seen as a priority for the youth employment strategy as much as the mental health strategy. So too should the role of the voluntary sector be considered as critical going forward.

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

As stated previously, even if the government's projected target of limiting waiting times for CAMHS provision to 26 weeks is achieved within the next financial year, this is still far too long to wait particularly for younger children. Put simply, even in the event that this target is achieved, younger children could potentially be expected to wait a significant proportion of their life waiting to access CAMHS. This is even more troubling when considering the needs of acute cases in adolescence where self harm is a factor.

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

Mental ill health is all too often linked to low self esteem and feelings of disempowerment. In acute cases this in itself can act as a barrier to people having the drive to accept that they are unwell and proactively seek support. Similarly stigma can have a prohibitive effect on a person's willingness to grapple with the fact that they are unwell.

Much as within the GIRFEC agenda, coordination of services, information

sharing and adequate training of frontline service providers in identifying signs of mental ill health and being able to sign post interventions with sensitivity is critical.

From a public perspective, awareness and stigma campaigns such as SeeMe can prove invaluable in encouraging people to seek help when they need it.

**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?

There needs to be a clear line of referral for families from health visitors and general practitioners who are often the first port of call for vulnerable families with clear parameters for access to triage systems within Community mental health services. Clear functional guidance on referrals to CAMHS as experience indicates that services and acceptance for an initial assessment varies greatly across authorities.

**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?

Aberlour have insufficient experience of NHS boards to comment on this matter.

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

Aberlour have insufficient experience of NHS boards to comment on this matter.

**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?

The involvement of families in service design is crucial if we are to encourage families to openly access mental health services for themselves and their children. Ensure that service users are consulted on a regular basis, through mental health forums, surveys and appropriate representation on significant strategic groups.

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

The use of the "Moodjuice" website is widely used across Scotland and has seen a significant increase in families being able to access a service however this is only available to families who have access to the internet. Therefore the use of alternative widely accessible material is essential. We are aware that for many vulnerable families access to public transport is difficult and appointment keeping at times can be difficult so a more flexible drop in service with easier access to transport is vital.

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?

Outcomes measurement is particularly complex, particularly in something as spectral as mental health. There are however tools, such as the client record management software employed by Penumbra that have a proven record of success in accurately capturing outcomes and should be considered for wider use.

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

Aberlour have insufficient experience of SRIs (predominantly used only in Psych wards) to comment meaningfully.

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

Aberlour have insufficient experience of the Scottish Recovery Network to comment meaningfully.

**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?

As with question 15 the use of alternative widely accessible material is essential. We are aware that for many vulnerable families access to public transport is difficult and appointment keeping at times can be difficult so a more flexible drop in service with easier access to transport is vital. Transport always appears to be a key factor in missed appointments and will get worse due to rising costs of public transport. Consultation at every level…regular media awareness, regular campaigns.

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?

Frontline staff should be equipped with appropriate knowledge and training with regard to care, treatment and possible outcomes.

**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?

Aberlour have insufficient knowledge of inpatient services to comment meaningfully.

**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?

Aberlour have insufficient experience of the information management systems of existing mental health services to comment meaningfully.

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

There are a range of existing networks both in the voluntary and statutory sectors that could be mobilised in the dissemination of learning about improving access to services.

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

Self esteem work and opportunities for therapeutic intervention is a major gap for both the children and adults we work with. We are dealing with adult parents who have often missed out on early intervention and/or therapeutic work as children and there is a real deficit in the provision of this. We have clear evidence to indicate the actual benefits to not only children receiving the input but also to children whose parents receive input.

Bereavement work with children is also an area we have found to be lacking due to the limited resources available to children and subsequent lengthy waiting lists.

**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?

Aberlour have insufficient experience of the national dementia demonstrator to comment meaningfully on this matter.

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?

We would suggest that a renewed focus on therapeutic intervention and creative therapies is crucial in this regard.

**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?

Aberlour have insufficient experience of the Promoting Excellence model to comment meaningfully on this matter.

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?

A national survey of care leavers would be helpful to ascertain the extent of mental ill health in this vulnerable group as part of designing after care support services.

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

Aberlour have insufficient experience of the mental health workforce to comment meaningfully on this matter.

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

**Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.**

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Ensure a truly representative spread across geographic areas.

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

Aberlour have insufficient knowledge of clinical outcomes reporting to comment meaningfully on this matter.

**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?

A better understanding of the range of voluntary interventions currently delivering meaningful interventions and coordination with statutory provision is essential.

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

Multi-disciplinary team working which includes the involvement of children's services in order to identify the social needs of families is necessary.

**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?

With robust Learning and development practice within the organisation, coupled with stringent organisational compliance.