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 We welcome the continued focus on psychological approaches, and the continued direction of travel..

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
Consideration should be given to the ongoing costs and benefits of Learning Disability remaining a separate department from Mental Health at Government for projects such as this.

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
Some groups, e.g., people with Autism Spectrum Disorders (ASD) who do not have a learning disability (and particularly adults with ASD), have not been factored into the current resources. They are generally not seen in Adult Mental Health (AMH) services unless they have a specific diagnosed Mental Health problem or Psychiatric Disorder. They do, however, have pertinent needs in respect of their mental health and wellbeing. They are not seen in LD services because they do not have a global LD, and often believe they should not be associated with that service user group.

LD services are likely to have the skills to support these people, but not the resources. They need to be involved in training AMH staff. However, a more fundamental issue is that AMH services need to ensure inclusion criteria and workforce knowledge and skills which meet this group's needs. Or separate services need to be developed. This has happened in some areas, however developments are patchy and many areas do not have access to such a service

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

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments
Continue to press for cultural changes regarding attitudes towards alcohol based on clear evidence base. Alcohol related problems have spread to groups previously less involved such as women and people with a learning disability, which may be having a knock on effect on self harm and suicide

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

Is this something that should be taken into schools? Health initiatives are often interpreted as purely about physical health and need to encompass mental health. Many children will have first hand experience of Mental Health problems via parents or other family members. It is also likely that they will recognise that some of their peers have difficulties/ issues. Trying to give children clear/ non-discriminatory information regarding Mental Health in a way that they understand could be one way. LD groups have undertaken some projects in local schools relating to bullying and some of these have been very successful, but they are project based and do not happen across all schools.

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
Service User involvement is going some way to address this, but the process is very slow.

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

Comments
Similar to Q4 – some of the work on emotional intelligence and wellbeing/ psychoeducation can be started in schools and in further education. Web based resources could be maintained and administered centrally at relatively low cost. Attention should be given to emerging evidence about benefits.

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
Workforce data needs to be closely scrutinised in order to be clear how these are being used to achieve HEAT targets, and to ensure equity for diverse groups such as those with developmental and learning disabilities from all disciplines. For these latter groups, close liaison with paediatrics is required.

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

Comments
Practical workshops to help different areas learn from each other about IT systems, structures and redesigns, in terms of good practice, successes and overcoming barriers.

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

Current campaigns which incorporate very short simple visual messages are welcomed and can benefit a wide range of the population e.g. Steps to Stress; Five Things You Can Do..... They need to be made more widely available and consideration given to TV/media campaigns.

Self help might only refer to individuals who have cognitive capacity / literacy skills to access such resources. If the expectation is that people with Learning Disabilities have to be treated in the same way, there will need to be a development of such resources (there are few already available), and some extra support to help people access them appropriately, or to use with carers (both paid and unpaid).

The capacity of care staff to understand the very specific needs of their clients (i.e. their mental health problems rather than generic care standards) needs to be further developed via service specifications and council contracting, thus enabling them to understand the priority of seeking appropriate help and giving them ability to support their clients.

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

As above, and ensuring GPs also consider those with a learning disability equally when considering routes to get intervention for psychological difficulties.

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
Ensure schools and paediatric services screen for specific developmental disabilities routinely (such as ASD, ADHD, LD) in order to meet needs in an evidence based way rather than offering a very generalised label of needs "Additional Support for Learning" and having children become adults who

could easily have received a more specific and appropriate diagnosis in order to access specific help and transition appropriately into adult health and social care.

More training for GPs regarding referral criteria/ needs etc might be a way forward here, along with better communication and liaison from services. Ensure suitable liaison services are in place to support primary care in determining appropriate referral e.g. psychiatric or LD liaison nurses linked to practices to offer advice to primary care staff and GPs.

Ensure Boards have an identified service for people with ASD and that they are not excluded.

Revisit learning materials for GPs developed by ?NES/MCN several years ago and re-raise awareness amongst GPs and other health professionals. Screen primary care and A&E patients appropriately for trauma related issues and help patient take decisions about whether they wish any help.

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

1. Guide Boards to be more targeted in implementation and monitoring of various generic policies, procedures and mandatory training.
For example NHS mental health and LD hospital or inpatient services are expected to meet HEI requirements in respect of HAIs. However, they are also expected to provide homely/ ordinary environments to aid recovery. As MH and LD patients are not usually physically ill, do they need to have the same HEI requirements? Other examples might include E&D monitoring where no feedback is ever given, or data usefully utilised, or blanket application of CPR training for less appropriate groups of staff.

2. Ensure clinical staff have adequate admin support to avoid their wasting time typing their own letters and reports, entering data into numerous new IT systems, including clinical outcome data, many of which are new tasks. These may achieve savings in some other support department but have become additional burdens for clinicians, and often provide little useful data..

3. Boards require clear guidance to timeously disinvest in services which are proven to be ineffective, even when this seems unpopular.

4. Explicit consideration should be given to clarification by every discipline in mental health services that they are delivering effective, evidence based

approaches, and that those staff are competent to deliver such interventions. If this is not the case, those resources could be transferred to more useful tasks, or competence and governance increased.

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

Some leadership, some training and some nationally developed recording tools and patient information about ICPs would be useful, rather than spending a lot of time locally developing recording tools and information materials, taking the focus away from care.

Staff training in evidence based approaches to assessment and intervention as outlined in ICPs.

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
One important aspect is accessible information and accessible CPA materials and approach. Whilst there has been a considerable focus on this in LD services (Fife has developed a local web based resource and a set of standards for developing such materials), it has become apparent that these materials may be of use to some other groups with cognitive impairments or for whom English is not a first language. Support for this work nationally would make sense.

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

Comments
Services need to individually adopt values which endorse real partnership working with patient at the centre of care e.g. real involvement in care planning and use of accessible CPA materials.

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
14 and 15 above

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

Comments

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

Comments

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
Involving families and carers, along with paid support staff, in CPA meetings and multidisciplinary reviews can help to promote their involvement in care and treatment and improve communication between health professionals and families. There has been an emphasis on involving families in treatment for people with psychosis for a number of years and this has also been promoted in work with people who have learning disabilities and psychosis, e.g. Haddock et al, 2004.

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
See 19 above

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

It is not always necessary to evaluate services over and over again at a local level. There is a fair bit of literature on this which has been published over the last twenty years– for example the two Mansell Reports in LD and Challenging Behaviour services, and a range of Health Economics related work by Eric Emerson commissioned by DoH. There are times when one specialty could learn a lot from others – e.g. mental health from learning disabilities, and older adult has learned a lot about challenging behaviour also from LD literature. There perhaps needs to be a national group/ team who are tasked with drawing this type of information together *across care groups* and checking that good practice is being addressed in all health boards.

Joint Improvement Team probably have a lot of this expertise.

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

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

Comments

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

Comments
More robust mainstream services for people misusing drugs and alcohol and greater clarity as to whether NHS considers these areas a priority or not.

ASD
Women in prisons and with forensic health needs.
Forensic populations more generally.
People with every kind of brain injury.
Psychological services for those with psychotic symptoms.
Services for in-patients with mental health problems.
Personality disorder.
Out of area patients – partnership working should develop more effective models for local service provision with long term plans where possible.

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
The links between CAMHS and LD Adult services needs to be strengthened. Transitional work is very important. In NHS Lanarkshire a Transitions Practitioner was employed – a post which received a great deal of positive feedback from QIS. However, when the person left the post, due to CRES savings being required, this post was not filled and this left a gap in the services. NHS Borders also employs a Transitions Worker who helps to facilitate a smooth transition between child and adult services for young people with learning disabilities. It will be important for NHS Fife to retain its Transitions post and perhaps develop this aspect of its work to ensure

children and young people are not harmed through poor continuity.

Health and social care can work together to deliver care to those with mental health needs in the community with oversight or additional expertise delivered by health practitioners. These kinds of partnership projects should be further developed and barriers to financial partnerships overcome.

Consideration should be given to whether the benefits outweigh the costs for people with a learning disability to remain in a separate department from mental health at government level. Whilst this remains the position permanent mechanisms must be in place to ensure attention is given and equity of access to mental health initiatives and improvements in clinical governance around psychological interventions.

NB. LD is noted as a priority service, however, the psychological therapies training programme produced by NES does not reflect this. The Positive Behavioural Supports Training which was very much welcomed, and delivered to increase capacity at a high standard, is not being repeated in this round and there is only 1 specific training event devoted entirely to LD. The result is a very small number of people who have received this high quality training. Although services could deliver this themselves locally, unlike other care groups (forensic, older adult), no resource has been made available to do this via a local or central Psychological Therapies Coordinator or Trainer/ School of LD Mental Health.

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
Issues around long term conditions will be applicable also to people with a learning disability in terms of increased numbers of health conditions experienced.

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?

Potentially, a great deal of time could be spent on the implementation of measuring the 18 week referral to treatment HEAT target by front line clinicians who could be delivering Psychological Therapies.

Comprehensive Board wide surveys at a national level are useful because they ensure Boards do not omit certain services, perhaps assuming they are not included in the HEAT target.

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

Comments
The 18 week Referral to Treatment HEAT target focuses only on Psychological Therapies. This is only a part of what is delivered to service users of AMH/LD/ Older adults services etc. The Government needs to ensure that other essential services are not being eroded because of the focus on the HEAT target.

In Learning Disability consideration needs to be given to the feasibility of LD nurses covering the wide remit of both mental and physical health, whilst maintaining competence, standards and clinical governance in both areas. Perhaps job descriptions which distinguish these roles more, or specialism at some point in careers would make sense. Further priority for clinical supervision for nurses involved in delivering or supporting psychological therapies would be helpful – it remains hard for them to prioritise the time.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?
The recent training initiatives have been welcome though not necessarily made available to staff in LD services. However, to ensure these are effective, a strategy for delivery of psychological interventions has to be developed in order to develop any necessary redesign and target staff appropriately in this context. Thus a 5 -7 year strategy with some assurance of funding for training is required, in order for service improvement plans to take best advantage.

Rolling training programmes (like the supervision training) need to be in place and there needs to be some protection against skill loss due to staff turnover.

NES need to retain central library of training resources to make available to local trainers. Clinical psychologists learn to deliver staff training during their basic training and should be freed up to be utilised within Boards.

Clarity about standards should be sought given recent training events have not trained people to accreditable levels, despite having some real benefits in increasing psychological awareness and in various professions ability to support and work with evidence based approaches.

Long term evaluation of the impact on services should be carried out via managers and supervisors, rather than course participants.

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

The national developments should include support and funding for further targeted research projects to aid the development of suitable measures. For care groups who do not have capacity to self report and for those groups who are very small other approaches may be required and this needs to be made explicit.

Central procurement / delivery of various elements of the psychological interventions programme would mean easier evaluation of outcomes for services.

Opportunities for local IT leads to get together and share best practice. Availability of support from the centre to share best practice as local services struggle to develop data capture systems and processes.

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

Comments
This needs to be embedded into Clinical Governance/ Audit processes. Also there needs to be an awareness that there will be some types of input with service user groups where there are no standardised outcome measures (e.g in some aspects of LD service provision).

1. *services need to start purchasing, supplying and requiring pre-post measures from staff routinely .*
2. *services need a senior IT manager linked and committed to the project who understands the national agenda and who links into national steering groups*
3. *services need resources to develop IT and support data collection, analysis and reporting in an ongoing fashion – this cannot just happen with no resource.*
4. *national consortium purchase of web based data collation and analysis*

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
The recent developments in mental health have benefited from a large amount of goodwill from individuals and their Boards in terms of time advising and working with Government. Over the next few years as senior NHS staff may retire at greater rates than previously, and numbers of senior posts may reduce, the NHS should be cautious about ensuring adequate capacity for leadership. Those leaders who remain may be at risk of being overwhelmed and unable to participate in national projects without additional administrative and backfill resources.

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?

Employment of a clinical advisor on legal matters (MHA, AWIA, Adult Care and Protection) can be a very efficient resource. NHS Fife has benefited from such a post which was initially funded via Mental Health Act monies and which supports both Mental Health and LD services.