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 approach to addressing mental health service and public health policy under one strategy.

We feel that the broad outcomes are generally the right ones, however we feel that there should be more explicit links made with the Reshaping Care for Older People agenda, the Early Years Framework and the anti-poverty strategy. The document would benefit from greater emphasis on the support provided from Primary care and the need for people to be supported to achieve meaningful paid work to aid mental health recovery and prevention.

We agree with the key challenges identified.

We welcome the approach of continuing to build on the progress already made and agree that radical changes in direction are not required.

We note the references to the contributions NES has made to the Mental Health agenda in the document.

We will continue to support implementation of the final Mental Health Strategy through:

1. pre and post registration education of the core mental health disciplines.
2. training and education of wider health care disciplines in mental health and psychological awareness, especially in Primary Care.
3. training and education of multiagency staff, educating social care and third sector staff in mental health and psychological awareness, developed alongside or adapted from 1 and 2 above wherever possible.

Please see **Appendix 1** that describes NES' contribution to Mental Health (this is a paper that was approved at NES's Board Meeting on 26th January 2012).

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

NHS Boards and partners have to respond to a number of policies, strategies and initiatives. National leadership in integrating and connecting these will be crucial. For example, we feel throughout the document more explicit links should be made with RCOP. It may also be helpful to establish clearer links between the MH strategy and other related policies (e.g. poverty strategy, early years framework).

Support from the Mental Health collaborative has been very helpful. This function has now been taken over by MH QuEST and some concerns have been raised about whether or not there is sufficient capacity to support boards with redesign particularly in older peoples' services, as well as CAMHS.

The demonstrator sites in relation to Dementia and Reshaping Care for Older Peoples' Services is a useful model for national support for change. It is important that this is evidence based and that equal attention is given to dissemination.

We are in broad agreement with the need to offer faster access to Psychological therapies which are evidence based, safe and effective. We are keen to re-inforce the guidance in the text of The Matrix around the need for patient choice. One size does not fit all, and there is not a simplistic relationship between mode of therapy and diagnosis. The Matrix is a useful tool, but it is essential that it is used as it is intended-in an advisory rather than a prescriptive way- to ensure that the needs of the many patients whose problems are not adequately reflected in the research studies are appropriately treated.

We would stress the need to continue to gather evidence on the effectiveness of the provision of low intensity therapy in reducing the demand for services at higher tiers.

Whilst the implementation of the Dementia Strategy will involve some redesign of services there will also need to be sufficient numbers of qualified staff to diagnose and treat patients with dementia, train and provide consultation to other involved services, medical and non medical and provide leadership to services providing for patients with dementia. This will involve their being sufficient numbers of trained Consultant Psychiatrists in Old Age Psychiatry. With the increasing numbers of elderly people there will be an increased demand on these services.

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

There needs to be a continuing focus on the evidence base to inform the changes we deliver. Robust evaluation of the impact and outcomes of the existing national programmes and initiatives will also be crucial.

Rather than support very disparate local initiatives, use resources to support a coordinated programme of developments in specific areas which can be compared to tell us more about which service changes were most effective in improving both service quality and through-put.

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

We note the inextricable links between positive mental health and economic and social issues. We welcome the work that has been undertaken around suicide prevention and the self harm strategy. However, to achieve all the ambitions related to outcome 1, there needs to be link with wider social policies attending to health inequalities and health deprivation in Scotland.

In order to protect and promote mental health we need to be aware of the integration/interaction between risk areas – eg Alcohol and Suicide.

We welcome the emphasis on raising basic psychological awareness linked to self harm across NHS, social care and voluntary staff.

The development of a website which addresses suicidal thoughts/ideation and encourages appropriate action e.g. contacting NHS 24, Breathing Space, GP etc may be helpful. This resource would need to be easy to access, and non-stigmatizing.

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

We recognise the contribution of See Me to reducing stigma, and the Scottish Recovery Network in promoting positive attitudes in mental health recovery. We welcome the work on addressing stigma and support increasing emphasis in addressing discrimination.

We support the continuing use of public health campaigns and think it is useful to increase the visibility of MH materials in public areas such as supermarkets and sports centres. The use of high profile people with MH problems may also be useful in reducing stigma.

It is helpful to acknowledge the complex interactions between MH risk areas and to avoid referring to people in single diagnostic categories.

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

MH Services should be required to demonstrate the MH promotion work they are undertaking and their partnerships with other agencies to provide this.

Increasing the training that medical undergraduates get in Psychiatry and giving more foundation doctors experience in Psychiatry will go some way to changing the experience that people with mental health difficulties receive in the wider NHS services. We know that trainee doctors are often put off a career in Psychiatry by stigmatising attitudes and this might be a place to start changing attitudes from within the profession.

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

Comments

There is considerable confusion in services about the distinctions between MH promotion, early intervention and prevention in MH, MH improvement and it would be helpful if greater clarity about this could be achieved.

It would be useful to build on the evaluations of the outcomes of Towards a Mentally Flourishing Scotland and the impact this has had on public mental health.

Alongside a continuing focus on mental health improvement and preventative activity, attention needs to be given to issues such as asset based approaches and community capacity building.

Investment could be made in community groups which offer social networking opportunities, and low level information badged as 'stress support', insomnia classes etc. Alcohol interventions for older adults require increased focus.

MH promotion should begin earlier - education programmes during primary school would be beneficial, as would education for parents.

Stronger collaboration and partnership working in MH promotion activities should be encouraged between MH and primary care level services.

National Co-ordination and support for web based resources such as Mood Juice and Mood Cafe.

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

We welcome the increased workforce capacity in CAMHS and the detailed data that is now available to monitor this. In a time of constrained resources it will be important to maintain scrutiny to ensure that these gains are not eroded. It will also be important to ensure that the skill mix reflects the need to maintain and develop a high quality clinical service with appropriate supervision and clinical governance structures.

It will be important for CAMHS to define its role in the early intervention agenda.

We support the use of CAMHS staff in developing the knowledge/skills of others who come into contact with children. This requires an acknowledgement that indirect service provision (e.g. supervision, training, consultancy) is an effective use of CAMHS staff as well as direct delivery of clinical services.

Further clarification is required on future models of working with partners in education, social work and the third sector.

We welcome the focus in evidence based parenting programmes for 3 & 4 year olds with Disruptive Behaviour Disorders required by the Balanced Scorecard.

There is an area of potential difficulty in the transition from child to adult services. Closer links with adult mental health during the transition from child to adult services might improve user experience.

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

Comments

Additional training is required to ensure that staff have the required competences to deliver child and adolescent mental health services. Essential CAMHS is a foundation level learning resource that NES has developed, building upon the NES CAMHS competence framework

Additional support for service re-design to local Boards will be helpful.

NES is well placed to continue providing and supporting the local delivery of training in Psychological Therapies for CAMHS, Leadership Development for CAMHS Lead Clinicians.

National support for face to face events to share good practice across Boards will continue to be important alongside e-resources.

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

The development of a central Scottish mental health information website which provides basic information on good mental health (normal functioning and coping with normal life situations), mental health problems and treatments, both psychological and psycho-pharmacological would be helpful.

Information in an accessible format needs to be provided about the evidence base (or lack thereof) for a range of interventions.

Health education requires a certain level of empowerment and capacity. Research suggests that it is accessed by and of use to those with higher levels of education and from more middle class backgrounds – need to be mindful of these barriers/limitations.

We need to continue working closely with NHS 24 to introduce C-CBT, self help, on-line CBT and support boards to provide the required additional assistance from CBT therapists/self help coaches.

Further awareness raising is needed about the risk of developing MH issues in the context of health-related functional disability. This is particularly relevant for older people since the majority of the main causes of disability are age-dependant long-term conditions i.e. more likely to develop in later life. It would be helpful to produce learning materials which are relevant to long term conditions in older people and can be accessed in relevant settings e.g. GP surgeries, district hospitals, out-patient clinics etc.

Staff delivering Mental Health Services need to be psychologically literate and have access to reflective practice in order to have an understanding of the potential impact of their work on their own mental well being and vice versa . The presence of Medical psychotherapists in services delivering mental health can help to focus the organisation on the provision of a healthy working environment for staff and patients alike.

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

Comments

Education for primary care teams on early identification of symptoms of mental health problems.

Direct access options to mental health services.

Media campaigns that are positively focussed.

Higher levels of psychological literacy in the wider health service and the confidence to raise mental health issues.

Further awareness raising of the risk of developing MH issues in the context of health-related functional disability.

Written materials or web based resources which reassure people by acknowledging prevalence of MH issues in the context of LTCs are helpful in decreasing stigma/promoting self-help/help-seeking in general.

OP and LTCs present readily in same settings eg day hospitals and out-patient clinics – provide relevant stepped care treatment in these settings rather than stigmatising by requiring referral to MH services.

Need to take stock of any barriers to access or issues with acceptability of existing initiatives. For example, telephone based CBT.

Need to ensure that a range of supports that reflect the diversity of Scotland's population are available.

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

Training primary care and other staff in recognition of MH difficulties and in what they can to do to promote good mental health

- Also in management of 'low level' difficulties

We note the encouraging focus in some areas, e.g. dementia strategy in early intervention. We would support the redesign of services to continue to focus on early intervention approaches that are evidence based in terms of preventing journeys into the secondary care system.

It will be important for CAMHS to define its role in the early intervention agenda.

We support the use of CAMHS staff in developing the knowledge/skills of others who come into contact with children. This requires an acknowledgement that indirect service provision (e.g. supervision, training, consultancy) is an effective use of CAMHS staff as well as direct delivery of clinical services.

Further clarification is required on future models of working with partners in education, social work

and the third sector.

Recognition that these strategies may increase the demand on CAMHS services as other agencies increase their ability to identify mental health issues.

Resource allocation should be based on epidemiological and prevalence data and on evidence base for efficacy of interventions.

Ensure that primary care and MH staff have good links and develop a shared understanding of local referral pathways and services.

Introduce flexible means of delivery

- Clinicians working in more accessible settings and at times that are suitable to clients
- Recognise that this will require flexibility of time management.

Wherever possible stop relying on letters and opt in systems and move to using telephone for initial contact. Develop direct access options to mental health services.

Develop social marketing tools aimed at helping people develop their ability to recognise distress.

Develop good quality, comprehensive information freely available to users and carers.

Develop educational material aimed at school children and school staff to increase awareness of mental health and mental wellbeing. Provide additional support to education staff for early identification of mental health issues.

Many services accessed by Older People are delivered in medical settings where staff may not readily recognise psychological, social and environmental aspects of a patient's presentation. This leads to psychological distress and mental health difficulties being under-recognised or attributed to physical medical conditions. Considerable work is required to increase staff awareness of MH and to develop shared understandings about referral pathways.

There is also a need to increase awareness of the efficacy of mental health and psychosocial interventions in later life and redesign our services using matched care models.

Services need to be increasingly alert to the presence of personality disorder and the impact this has on morbidity and service utilisation and cost. There are very few dedicated services for Personality Disordered Patients and they generally do not have quick access to treatments.
We need more dedicated services for patients with personality disorder.

As the summary of the evidence base in psychological services it is really important that the Matrix is updated regularly. It is important the Government puts in place a robust and sustainable mechanism to oversee the widening and updating of the content of the evidence tables, and that Psychiatry and Medical Psychotherapy continue to contribute expertise to this process alongside their colleagues in Nursing, Psychology and Allied Health Professionals.

We are keen to reinforce the competence-based approach to training and supervision laid out in The Matrix, and would stress the importance of the role of Consultant Psychiatrists in Psychotherapy as well as Clinical Psychologists in training and governance of psychological therapies in the NHS.

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

We note there has been investment for NHS boards for service improvement approaches, e.g. mental health collaborative, dementia demonstrator sites, and releasing time to care.

We also note that the planned patient safety programmes in mental health will provide opportunities for NHS boards to implement further service improvement approaches. It would be useful to evaluate the outcome and return on investment of the national service improvement initiatives taken forward to date, prior to planning further activity to enable further understanding of facilitators and barriers to bringing about change.

National guidance could be made available to help services make effective and efficient use of administrative and clinical staff to help clarify roles and responsibilities.

Training should be offered to support the development of cultures of continuous feedback and service improvement.

More education and training in systems re-design and demand-and-capacity modelling.

More support from MHQuEST – particularly in Older Peoples' services where capacity is very restricted.

Reviewing some of the mandatory training requirements

Continual monitoring and scrutiny of the use of evidence based interventions

Support for managers on 'de-commissioning' activities which do not add value.

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

Comments

We note the significant support provided to NHS Boards to implement ICPs both in terms of national programmes and local infrastructure. Plans for further support need to be informed by careful analysis of the successes and challenges in implementing ICPs to date.

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

We need to continue to provide support and appropriate remuneration for people to be meaningfully involved in service design and delivery and in the care provided.

Education and training for staff in enabling meaningful service user involvement remains a priority but also needs to be progressed in a way that reflects contemporary emphasis on issues such as human rights, personal outcomes based approaches and co-production.

Draw from the practice that colleagues in other fields are developing e.g. community development, where community members are truly partners in processes of designing and delivering services.

Embed service user involvement and feedback into our core clinical skills training.

Training primary care staff to recognise psychological issues within physical health.

Require services to involve service users in evaluation.

An omission in the strategy appears to be direct reference to the self-directed support strategy and the impact this should have on the way mental health services and support is delivered.

The introduction of peer support workers has made a useful contribution to promoting service user involvement in their care and we would support the continuation of peer support working in Scotland.

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

Comments

We are uncertain about the use of tools in this respect but we have a number of policies and drivers that stress the need for mutually beneficial partnerships, for example, the self-directed support strategy, the dementia standards, the principles of the mental health care and treatment act and the 10 Essential Shared Capabilities for Mental Health.

Develop advocacy services.

Involve service users in staff training.

Incorporate basic psychological approaches into all NHS staff training in mental health.

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

The Scottish Recovery Indicator has been designed to specifically support practice development in relation to person centred and values based approaches in mental health settings. We would support the continuing emphasis on requiring NHS Boards to implement the SRI2.

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

Comments

NES has been working with the Scottish Recovery Network to establish learning networks to support implementation of the Scottish Recovery Indicator and more recently SRI2, and also to provide direct learning support to NHS Boards. The networks enable participants to develop as key facilitators for SRI to support implementation in their local areas. Since the networks have been established SRI usage and completion has significantly increased. It is intended that NES and SRN continue to work together to provide learning support for SRI2 implementation.

To encourage implementation of the Scottish Recovery Indicator, it would be useful to make explicit links across to other policies such as leading better care and explore the extent to which SRI could measure care against the Standards of Care for Dementia in Scotland.

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

Comments

We note the significant contribution the SRN has made to promoting recovery focussed practice and services. The question around embedding recovery approaches across different professional groups is perhaps not about the effectiveness of the SRN but different groups' engagement.

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

Education and training for staff in enabling meaningful carer involvement remains a priority but also needs to be progressed in a way that reflects contemporary emphasis on issues such as human rights, personal outcomes-based approaches and co-production.

It would be very useful if the narrative contains more explicit links to the aspirations of the carers and young carers' strategies.

Provide information specifically targeted at families and carers e.g. Scottish Mental Health website, which describes mental health and wellbeing, assessment of mental health problems, psychological and pharmaceutical treatments and the help available to support families and carers.

Ensure that staff training helps develop recognition of the contributions of families and carers to mental health wellbeing and recovery.

We need to continue to provide support and appropriate renumeration for people to be meaningfully involved in service design and delivery and in the care provided.

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

The meaningful involvement of families and carers needs to involve significantly more than the provision of information and requires a skilled workforce who are able to demonstrate the right attitudes and deliver interventions specifically designed for carers.

NES is currently scoping education and training requirements needed to support implementation of the carers and young carers' strategy. On the basis of this we will design education and training to support staff development in working with carers.

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 would be useful to focus on outcome evaluation of service redesign to share learning on a national basis.

Various methods for sharing good practice should be developed/maintained (e-portfolios of exemplar work, live and virtual seminars, collaborative working across health boards, managed knowledge network, national meetings).

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

Data monitoring systems need to be comparable across boards.

National audit of minority and high risk group referral and treatment completion rates.

Provision of awareness training to GPs and other PC practitioners on the mental health needs of minority and high risk groups, including differences/similaritites in presentation.

Make the service accessible at places where minority groups may present with issues e.g. community spaces, religious spaces, pharmacies for older adults.

We should take steps to ensure any recommendation around Scotland's mental health and race programme are implemented and monitored.

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

Comments

Provision of awareness training to primary care staff.

There have been some interesting pilot projects that have directly focussed on increasing access for 'hard to reach' groups across NHS Scotland and elsewhere, share this learning across the Knowledge Network and/or newsletter formats, NHS conferences.

More emphasis placed on training about minority groups across professional groups at undergraduate and postgraduate level.

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

Comments

Our understanding is that the provision of intensive home treatment and crisis services are inconsistent across Scotland as are services for early intervention for psychosis. There are also significant services gaps for younger people with a diagnosis of dementia.

There is significant distress in individuals who are carers and care - workers and there are gaps in the interventions and support currently being provided to this group.

There are gaps in the effective provision of interventions to individuals who present with multiple physical, mental health and social care needs.

It seems to be difficult to engage young men. More research must be done on the most effective ways of reaching this group, who are at high risk of suicide, but there is some evidence that they more likely to engage with services which are not labelled as 'mental health', but focussed on particular symptoms, eg insomnia.

Other gaps in service provision include mental health services for prisoners, older people, people with Brain Injury, people with long term conditions and looked after and accommodated children.

The Homeless population is one area where there is a significant gap in services. Research carried out in Edinburgh on 140 consecutively presenting chronic homeless people showed - (amongst other statistics):
30% had a previous severe head injury, > 50% had an ongoing chronic mental illness, 70% had a diagnosable personality disorder and 40% had spent some time in prison. This demonstrates significant unmet need in this population.

There is also significant unmet need for services for Personality Disorders and all prisoners. There are likely significant overlaps between all these groups and similar difficulties in engaging and maintaining them in treatment programmes. This calls for particular training in risk management, the assessment and treatment of co- morbid mental illness, organic disorder and personality disorder which necessitates combined pharmacological and psychological treatments and the coordination of services from both health and other areas. Medical Psychotherapists have this training and will be needed to develop and maintain such new services.

There is a gap in infant mental health provision and very early year's provision. At present, infant mental health is directly promoted through the Family Nurse Partnership pilot intervention for young mothers living in difficult circumstances and for infants of mothers with severe mental health difficulties who receive specialist treatment in Mother and Baby Units. Service provision to promote a healthy mother-infant relationship for mothers who are experiencing mild to moderate symptoms of postnatal depression is not routinely available.

In addition there needs to be greater thought about transition and what successful transition means from CAMHS to Adult Mental Health Services.

The mental health needs of at risk groups such as those involved with Youth Justice is also a gap in many areas.

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

Put this information on the QIS Hub/Quality Portal so that examples of good practice can be shared with other NHS Boards.

The Scottish Recovery Indicator has been designed to specifically support practice development in relation to person centred and values based approaches in mental health settings. We would support the continuing emphasis on requiring NHS Boards to implement the SRI2.

Implementation of the integrated resource framework and strategic guidance for boards re partnership working.

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

Developing a common shared language across NHS and its key partners.

Provision of basic education across health, social work & prison services in psychological awareness and identification of mental health problems.

We welcome the emphasis on dementia standards in acute hospitals but feel there needs to be a similar emphasis on dementia standards in mental health hospitals.

More emphasis on liaison/joint working between medicine for OP/general OP health services and OPMH services

Mental Health liaison services with health services in primary and secondary care.

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

NES and SSSC are undertaking a partnership programme of work to support implementation of Promoting Excellence across the health and social services workforce. This involves the production of educational resources, delivery of training and establishing infrastructures to ensure sustainability. This programme is being delivered between 2011-2013. As the Dementia Strategy evolves there will likely be further priority areas identified that have implications for education and training for the health and social services workforce.

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

In terms of **psychological** therapy, we support the plans in support of the HEAT target to survey what modality psychological therapists are trained in in addition to counting just how many there are. This will include staff from a range of professions including psychiatry, psychology, nursing and AHPs. A range of therapists are needed who can deliver therapies to an accredited level. It is important to note that recent changes in the psychiatry curriculum mandate that psychiatrists train in the provision of psychological therapies throughout their entire six year training period. This brings with it increased demand on Medical Psychotherapists for supervision, coordination and organisation of such work and it would appear that not all boards have access to this which has potential impact on training placements.

Additional surveys that may be useful are - training in Evidence Based Parenting Programmes, training in trauma skills and competences.

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 self-directed support strategy for Scotland will have implications for workforce development and planning as will a focus on personal outcomes approaches, community capacity building and co-production. The early interventions and early years focus will also have workforce development implications with the potential for new ways of working and new role development. Care of older people and people with dementia will continue to be priorities for workforce development

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

Comments

Continue to support a centralised, strategic and long-term approach to the planning and delivery of psychological therapies training, which takes account of the needs of the NHS Boards in relation to the HEAT Access targets, the evolving evidence base, the skills of the current workforce (as established through structured workforce surveys), and the need for regular supervision as one element of a sustainable educational infrastructure. The opportunity to plan training over the longer term would enable building on current training, with increased focus on establishing quality standards and achieving accreditation where possible. Establishing cohorts of experienced and accredited practitioners will create a pool from which future trainers can be recruited and trained as 'trainers'.

The training strategy should take a broad view, aiming to ensure appropriate levels of psychological literacy at the lower tiers of the system (including establishing the foundations of psychological literacy during undergraduate training programmes), and building skills upon this to populate the low and high intensity levels of delivery. It should recognise the need to 'seed' high-level practitioners and supervisors in key modalities in all areas to cascade training, to support the increase in capacity needed to meet Government targets, and to provide the necessary clinical governance in ongoing practice.

NES's Psychological Therapies training programme which focuses on the priority areas of Older Adults, Forensic, Trauma, Substance Abuse and Learning Disability has already provided 700 multi professional staff with CPD opportunities in Psychological Therapies. NES has also provided 120 training places to develop psychological skills in staff working with children with physical health problems and trained 90 practitioners in evidence based parenting programmes.

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

We note the progress in providing benchmarking information and the support for staff to use data to improve care. We welcome the creation of the monitoring and implementation groups to support the Psychological Therapies HEAT target, the CAMHS HEAT target and the delivery of the Dementia Strategy. The sets of Mental Health Indicators for Adults and Children and Young People are also positive developments.

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

Comments
It would be helpful to have a national agreement about standardised outcome measures.

Routine session-by-session outcomes monitoring has been achieved in English IAPT services. It would be useful to learn from their experiences.

Electronic data capture systems with sufficient administrative support are required to engage clinicians. Regular clinician and team level feedback are necessary to maintain motivation as well as initial and refresher training in the use of tools and systems.

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
Development of a leadership strategy for Mental Health to identify and exchange information about effective leadership, management and operational practices.

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

Comments
We note there has been investment for NHS boards for service improvement approaches, e.g. mental health collaborative, dementia demonstrator sites, and releasing time to care.

We also note that the planned patient safety programmes in mental health will provide opportunities for NHS boards to implement further service improvement approaches. It would be useful to evaluate the outcome and return on investment of the national service improvement initiatives taken forward to date, prior to planning further activity to enable further understanding of facilitators and barriers to bringing about change.

Perhaps a central online resource with online information and practice tools that services can use should be considered.

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

In 2011 NES produced two educational resources to support staff delivery care and treatment in line with legislation requirements. This includes an updated educational resource in the Mental Health Care and Treatment Scotland Act 2003 and Respecting and Protecting Adults at Risk in Scotland – legislation and practice.

The Mental Welfare Commission will continue to play a crucial role in monitoring and implementation of the act.

NES Contribution to Mental Health

1. Introduction and Context

The Scottish Government are now consulting on proposals for a new national mental health strategy, bringing together work to improve mental health services and mental health improvement, and to set out the direction of travel for the next 4 years to further improve mental health outcomes.

Mental health and dementia are national clinical priority areas for NHS Scotland. A range of current policy and legislative drivers have been in place to drive service improvement in mental health services in Scotland.

Key policy drivers have included:

- The Mental Health of Children and Young People: A Framework of Promotion Prevention and Care' (SEHD, 2005) and the related report 'Getting the Right Workforce, Getting the Workforce Right' (SEHD, 2005), that set out clear priorities for CAMHS workforce development
- 'Delivering for Mental Health' (SEHD, 2006) which introduced new HEAT targets, and a number of related commitments, intended to drive improvement in mental health services in Scotland.
- 'Rights Relationships and Recovery' the National Review of Mental Health Nursing in Scotland and its accompanying action plan (SEHD, 2006), with a 'refreshed' action plan published by the Scottish Government in 2010.
- Towards a Mentally Flourishing Scotland (TAMFS) - Scotland's mental health improvement plan (SG, 2009)
- Scotland National Dementia Strategy (SG, 2010) that outlined a number of change actions and priorities.
- Realising Potential: An Action Plan for Allied Health Professionals in Mental Health (SG, 2010)

Scotland also benefits from a range of human rights based legislation key to the development of mental health services including:

- The Adults with Incapacity (Scotland) Act (2000)
- The Mental Health (Care and Treatment) (Scotland) Act (2003)
- The Adult Support and Protection (Scotland) Act (2007)

NES past, current, and planned work programmes provide a significant contribution to supporting workforce development to drive implementation of this range of policies and legislation. NES makes a very significant contribution to the mental health and wellbeing of the population of Scotland through the education and training of the workforce. The NES consultation response makes a number of specific points but is broadly supportive of the proposed strategy and direction. NES will continue to support implementation of the final Mental Health Strategy through:

a) Pre and post registration education and continuing professional development of the core mental health disciplines
b) Training and education of wider health care disciplines in mental health and psychological awareness, especially in primary care
c) Training and education of multi-agency staff, educating social care and third sector staff in mental health and psychological awareness, developed alongside or adapted from a) and c) wherever possible.

2. Executive Summary

The purpose of the paper is to advise Board colleagues of NES's contribution to Mental Health in Scotland in the context of the Scottish Governments Consultation on Mental Health Strategy Scotland which closes on 31st January 2012.

The government wish to continue:

promoting good mental health
ensuring services are person centred, safe and effective
embed a culture of continuous improvement

Our contribution response indicates broad support of the Government's proposals as well as highlighting some additional areas that may require additional emphasis (e.g. closer links with re-shaping care to Older People, clearer recognition of the contribution to Primary Care and the implications of education and training to achieving the Government aims). The strategy document makes several references to NES and is supportive of us continuing with many of our existing work streams. This paper provides a summary of NES's current contribution to mental health.

The final MH Strategy with set the direction for the education and training needed to implement the strategy. This will have implications for education and training across the healthcare disciplines at pre and post registration levels, as well as multi-professional and multi-agency education and training more broadly.

The education and training that NES provides/commissions to support the delivery of the Mental Health Strategy will have an impact on all the Quality Ambitions

Every aspect of the strategy has potential training/education implications. Ensuring sufficient focus to deliver high quality education and training may be challenging if the scope of our efforts is too broad. Proposal to mitigate risk – Develop a prioritised action plan.

Proposed Mental Health Training Priorities

1) Pre and post-registration training of mental health disciplines (maintain and develop excellence in core activity)
2) Mental health and psychological awareness training for pre and post-registration healthcare disciplines, especially in primary care (focus on this to increase within current core)

3) Mental health training for social care and third sector staff. Developed alongside/adapted from 1&2 wherever possible (expansion required within constrained resources)

3. Education and Training of Core Disciplines for Mental Health

3.1 Psychiatry Training

The NES Medical Directorate is responsible for the commissioning and delivery of postgraduate medical education in Scotland. The **'Scottish Specialty Board for Training in Mental Health Specialities'** advises NES on matters pertaining to psychiatry via the Medical Director and the Medical Department Executive Team. It has strong links to the Royal College of Psychiatrists in Scotland and the UK nationally, with representation on the Scottish division and on the Royal College of Psychiatrists' "Heads of Schools Committee". The board oversees recruitment and speciality training in psychiatry in: Core Psychiatry, Child & Adolescent Psychiatry; Forensic Psychiatry; General Adult Psychiatry; Old Age Psychiatry; Psychiatry of Learning Disability; and Psychotherapy.

All Psychiatry trainees undertake a minimum of 3 years of Core training. The competencies to be gained are specified in the Core Curriculum of the Royal College of Psychiatrists, approved by the GMC (General Medical Council). The trainee must also pass the MRCPysch (Member of the Royal College of Psychiatrists) examination (currently 3 written papers and the clinical CASC (Clinical Assessment of Skills and Competences) exam). Core trainees gain experience across the range of Psychiatry including Old Age Psychiatry to gain dementia competencies, developmental Psychiatry to gain competencies in Children and Adolescent Mental Health, Autism and ADHD as well as global learning disability. Trainees also must gain competence in Psychological therapies undertaking 2 cases in 2 different modalities.

Thereafter the trainee competitively enters advanced training in one of the 6 Psychiatric specialties, again following the GMC approved curriculum designed by the Royal College of Psychiatrists.

Each trainee has an approved Clinical and Educational Supervisor and a Training Programme Director overseeing their training. Trainees also undertake a number of specific courses. Each Deanery area provides an MRCPsych course for Core trainees and speciality academic programmes for advanced trainees. Attrition from Core training is significant but virtually every entrant to specialty training completes the programme and emerges with a CCT. Presently academic programmes are also being developed in Scotland eg PsySTAR.

The quality of psychiatry training is Scotland is excellent,as evidenced by gmc trainee survey data,and our good recruitment figures -ct1 fully recruited 2011 in Scotland. We have a robust trainee assessment process, ARCP (annual review of competence progression) standardised across Scotland in psychiatry,ensuring the quality of graduates from our training programmes.

Programme Specialty	**2011 Figures**
Psychiatry Common Core	134
Child & Adolescent Psychiatry	36
General Psychiatry	79
Old Age Psychiatry	27
Psychiatry of Learning Disability	20
Forensic Psychiatry	19
Psychotherapy	6
Total	**302**

3.2 Pre Registration Mental Health Nursing

NES under takes a performance management and enhancement function of the pre registration nursing and midwifery programmes on behalf of the Scottish Government. There are 6 Universities who are commissioned providers of mental health nursing education in Scotland and one further non commissioned provider. Noting an overall trend for a reduction in student nurse numbers, there are around 400 students recruited to the 3 year pre registration nursing programmes each year.

To reflect the values based and recovery focussed ethos of Rights, Relationships and Recovery, NES worked with Universities and service partners to develop, on behalf of the SG, a National Framework for the Pre Registration Mental Health Nursing Programmes in Scotland in 2008. This framework has at its core, competencies and performance indicators that promote person centred, values and recovery focussed practice, and also emphasises the involvement of service users and carers in the design and delivery of the programmes. Since the frameworks publication we have supported and monitored its implementation on behalf of the SG and in 2011 we are working with representatives from universities to update the framework in light of new NMC standards, published in 2010.

3.3 Training of psychologists for NHS Scotland

The NES Psychology Directorate is responsible for the commissioning and delivery of the pre-registration education of clinical psychologists and clinical associates.

Currently there are two clinical psychology programmes in Scotland at the University of Glasgow and the University of Edinburgh. These programmes combine placement experience (as NHS employees) in one of the 14 health boards across NHS Scotland, teaching as well as research over the course of study to allow trainees develop to core competencies in clinical psychology. Both of these courses are approved by Health Professions Council and represent the highest level of training in Psychology. There are currently 205 trainees. Recent developments include the design of aligned training pathways to reflect particular needs in CAHMS (Child and Adolescent Mental Health Services), Older Adult and Forensic services.

There are two 1 year Masters Programmes - Psychology Therapy in Primary Care, jointly run by The University of Stirling and The University of Dundee and Applied Psychology for Children and Young People run by The University of Edinburgh. Trainees are employed in NHS Boards and provide clinical services as part of supervised practice during training. These courses focus on the development of competences relating to a specific area of focus. Graduates can therefore enter the workforce quickly and respond to pressing service demands (e.g. support for NHS Boards to meet the CAMHS and Psychological Therapies Heat Targets).

All psychology programmes are subject to NES Educational Governance policies and procedures. We gather data to track our trainees into the workforce. Attrition from clinical psychology training is very low (<5%) and retention in the NHS Scottish workforce is very high (average of 90% since 2003).

Additionally, The University of Glasgow is running a post-qualification course in Clinical Neuropsychology, offered as a postgraduate diploma or MSc as well as an option for Continuing Professional Development (CPD) to develop specialist skills for working with people with acquired brain injuries, epilepsy, dementia and other neurological conditions.

Programme/Speciality	**2011 Figures**
Doctoral Trainees in Clinical Psychology • aligned to CAMHS • aligned to Older Adults • -aligned to Forensic	**209** 20 9 11
MSc Psychological Therapies in Primary Care (PTPC)	**22**
MSc Applied Psychology for Children and Young People (APCYP)	**17**
Health Psychologists in Training	**4**
Total Psychology Trainees	**253**

4. Education and Training of Healthcare Disciplines in Mental Health

4.1 Pharmacy

The NES Pharmacy Directorate currently provides various open and direct learning opportunities for pharmacists and pharmacy technicians in Scotland, in relation to mental health. A distance learning resource pack 'Introduction to Pharmaceutical Care in Mental Health' is available as a hard copy and on the NES website as a pdf, and covers the main areas of mental health. The pack also covers the key areas of mental health legislation and the 'See Me' campaign. There is also an educational resource (as a pdf) available on the NES website which focuses on 'Depression' and how to deliver pharmaceutical care specific to these

patients. As part of our direct learning programme, and in line with the Dementia Workforce Development Plan in response to the Dementia Strategy for Pharmacy, we are also in the process of delivering local evening courses on 'Pharmaceutical Care of patients with Dementia' including input from the Scottish Dementia Working Group, Dementia Leads and Alzheimer Scotland.

The directorate are supporting educational solutions in relation to people with learning disabilities with direct learning events and plans for an open learning resource for 2012. We have also supported direct learning and webinars in 'Mental Health First Aid' and 'Stress Management' for pharmacists in Scotland.

The team link in with the Scottish Specialist Pharmacists in Mental health group to address educational issues for pharmacy healthcare staff.

4.2 General Practice/Primary Care Education

Providing care for people with mental health problems is integral to the work of the GP, represents a significant workload and has implications for the practice population.

The vast majority of people with mental health problems are cared for entirely within primary care and around 30% of people who see their GP have a mental health component to their illness.

All GP Speciality Trainees receive training in Mental Health as part of the curriculum which includes general Mental Health issues as well as focusing on learning disability and drug and alcohol problems.

A proportion of trainees will have experience in Psychiatry hospital posts but this is not available to all – the others achieve their competencies in general practice. The deaneries also offer educational programmes to complement work place learning typically involving mental health professionals from the hospital and community sectors. Mental health topics play a major part in the continuing professional development programmes that deaneries offer to GP practices.

The vast majority of patients with dementia, and other mental health problems will remain in the community with the burden of care falling upon their families and the Primary Care Teams that support them.

Adequate training for the members of those teams should be supported including not only CPD (Continuing Professional Development) programmes but also adequate exposure through early years training (including in General Practice or Psychiatry for doctors in the Foundation Programme) and by increasing the proportion of GP Specialty Trainees that undertake a Psychiatry post (hospital or community) as part of their GP Specialty Training programme.

There is potential to build on the success of the current NES post-CCT (Certificate of Completion of Training) GP fellowship and scholarship schemes to include Mental Health themes and thereby develop a cohort of GPs with Special Interest, for example in Addiction Services, Forensic Medicine or CAMHS.

There is potential to implement brief psychological therapies as part of routine Primary Care by loosening some of the current contractual requirements that add little value and by providing appropriate training.

Changes to roles within general practice and the development of extended general practice are being supported by NES through the Practice Nurse Knowledge Network and General Practice Nurse VTS (Vocational Training Scheme). Increasingly within general practices the Practice Nurse is a first point of contact and can be vital in detection of problems and helping to signpost patients to appropriate avenues of help.

Support for the development of CHPs (Community Health Partnerships) and the integration of health and social care is imperative in the implementation of this Mental Health strategy. The potential for GPs and other Primary Care professionals to play a leadership role is significant and the current initiative between NES and the RCGP (Royal College of General Practice) in the area of leadership is helpful in this regard.

GP Specialty Training with Psychiatry Posts 2011	
East of Scotland	20 trainees (approximately 70%)
South East Scotland	38 trainees (approximately 60%)
West of Scotland	94 trainees (approximately 60%)
North of Scotland	23 trainees (approximately 40%)

5. Multiprofessional and Cross Sectoral Training

5.1 Increasing the Availability of Evidence-based psychological Interventions and Therapies

NES is working in partnership with Scottish Government and NHS Boards to help build effective, equitable and accessible Psychological Therapies services across Scotland through education, training and workforce development. NES develops and supports sustainable training in the evidence-based interventions required to allow NHS Boards to meet the HEAT target and accredit the ICPs.

In collaboration with the Reshaping Care and Mental Health Division, and other key stakeholders, NES has supported quality improvement in psychological therapies services by producing 'The Matrix-2011: A Guide to Delivering Evidence-based Psychological Therapies in Scotland' which offers guidance on the safe and efficient delivery of effective, evidence based care[1].

5.1.1 Improving quality by establishing training standards

NES has been

- Working with 'Skills for Health' to produce Competence Frameworks which will set standards for staff training and performance in psychological therapies, clinical supervision and CAMHS services.
- Working with current training providers (including CBT, Psychodynamic Psychotherapy, Mindfulness-based Cognitive Therapy, IPT etc) to re-structure Psychological Therapies training based on the competence frameworks and future service needs;
- Developing innovative ways of assessing competence in CBT
- Producing a competence-based curriculum for Psychological Therapies supervision training, and rolling this out using' training for trainers' model. 16 Psychological Therapies Supervision Trainers were trained in 2010-11, and by the end of March 2012 these trainers had, in turn, equipped 231 psychological therapists with the knowledge and skills to supervise other trainee therapists and practitioners.

5.1.2 Training and Workforce Development

The Psychological Interventions Team (PIT) is supported by the Reshaping Care and Mental Health Division and hosted within NES. The team has contributed to the development of the

[1] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix.aspx

HEAT target, and focuses on organising the training required to improve general access to psychological interventions and therapies in SGHD priority areas – Older People's Services, Forensic Services, Alcohol and Substance Misuse, PTSD and Trauma, and Low Intensity Treatments.

In 2010-11 training in a range of evidence-based psychotherapeutic interventions was delivered to 592 staff from a range of disciplines, including 274 nurses, 141 psychologists and 70 AHPs.

In addition to the work of the PIT, NES is supporting the training of frontline staff and 'cascade' trainers in a range of therapeutic approaches recommended in The Matrix.

5.2 Person Centred, Values Based and Recovery Focussed Mental Health Practice

In 2008 and 2009 NES published 2 sets of learning materials - the 10 Essential Shared Capabilities (ESCs)[2] and Realising Recovery[3] materials (the latter in partnership with the Scottish Recovery Network (SRN). The Scottish Recovery Network is an initiative funded by the Scottish Government and launched in 2004 as part of the National Programme for Mental Health and Well Being. The SRN is managed by a host agency, Penumbra, a mental health charity in Scotland, who employs the SRN staff and is legally responsible for the Network

The ESC and realising recovery learning materials have as their main emphasis supporting cultural change in services by promoting person centred, rights-based and recovery-focused practice, encompassing learning in areas such as:

- Involving service users and carers
- Values based practice
- Equality and diversity and challenging health inequalities
- Promoting socially inclusive practice
- Therapeutic use of self
- Person centred planning
- Enabling self determination

Between 2008-2010 we supported NHS Boards and partners in disseminating this training via 2 'training for trainers' initiatives. Health in Mind and Penumbra were commissioned to take this training forward and a key to its success was the active involvement of people with lived experience of mental health problems as part of the training team. Over 70 values based and recovery focussed mental health practice trainers were prepared including: mental health nurses, AHPs, partners from the voluntary sector and local authorities, and mental health service users. NES also funded 3 Regional Co-ordinators posts to provide direct support to networks of trainers and NHS Boards. An external evaluation evidenced positive impacts in promoting person centred practice as an outcome of this initiative, and in 2011 we launched an updated version of the 10 ESCs learning resource.

We are also working with the SRN to support NHS Boards and other service providers in implementing the Scottish Recovery Indicator (SRI). The Scottish Recovery Indicator (SRI) was developed by the SRN and launched in 2009. Commitment 22 in 'Towards a Mentally Flourishing Scotland' (SGHD, 2010) - the action plan for mental health improvement, required 'the SRI to be in use by the majority of mental health services by 2012' and the Scottish Government are monitoring its use. An updated version of the tool SRI-2[4] was launched by the Minister for Public Health on the 31st of October 2011.

---

[2] http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/publications-and-resources/the-10-essential-shared-capabilities.aspx

[3] http://www.nes.scot.nhs.uk/media/376420/13875-nes-mental_health-all_modules.pdf

[4] http://www.sri2.net/

The tool enables mental health services to assess and develop practice and is focussed on ensuring the recovery of the people who use their services. In doing so it highlights issues in relation to inclusion, rights, service user and carer involvement and equalities and diversity The draft mental health strategy continues to affirm a commitment to drive use of the SRI across all statutory and voluntary sector mental health services.

NES and the SRN have been working in partnership in 2010/2011 to develop and deliver 3 Regional SRI Learning Networks which include participants from all NHS Boards in Scotland and local authority and voluntary sector staff. This has been taken forward by a jointly funded post hosted in SRN via Penumbra. The first cohort of 60 participants has completed and a second cohort of 90 participants commenced in November 2011. Demand for places on the second cohort has out weighed supply. The learning networks provide participants with the resources, knowledge and skills to support mental health service to undertake the SRI through to full completion in a meaningful way that results in recovery focused service development. Since the networks were established SRI usage and completion has significantly increased and it is the intent to continue to support these networks in 2012-13.

5.3 Education to Support Working with Carers

NES has benefited greatly over the years from active involvement of Support in Mind - Scotland (formally the National Schizophrenia Fellowship - Scotland) in our mental health work programmes, in particular the contribution of the Chief Executive Mary Weir who was and active member of the Editorial Board that developed the 2011 version of the 10 ESCs Learning Materials.

We are currently working with Support and Mind to develop an educational resource '10 top tips for working effectively with carers of people with mental health problems'. These 'tips' have been formulated by Support in Mind by the findings 2 surveys and additional extensive work undertaken with carers of people experiencing mental health problems in Scotland.

5.4 Supporting Implementation of Rights Based Mental Health and Wider Legislation

Our work programme on supporting implementation of a range of Scottish legislation has includes the development of educational resources to support implementation of:

- The Mental Health Care and Treatment Act[5] with an updated version produced in 2011
- The Adults with Incapacity Act and the Adult Support and Protection Act. A Learning Resource 'Respecting and Protecting Adults at Risk in Scotland was published in 2011[6]

Learning resources have as a specific focus on ensuring staff has the knowledge and skills to exercise their duties under the Acts and enhance capability within services around the needs of vulnerable patient groups and the appropriate application of legislation to ensure the promotion of human rights principles and safeguards. We have also supported learning networks to aid implementation of training in the Adults with Incapacity and Adult Support and Protection Acts.

5.5 Mental Health Improvement

We have supported delivery of the HEAT 5 target by ensuring that suicide prevention training is embedded in the National Framework for Pre Registration Mental Health Nursing Programmes in Scotland.

We have also worked in partnership with Health Scotland to:

- to match submissions from NHS Boards against national suicide prevention training requirements
- pilot video-conferencing delivery of 'Safe Talk' training to staff in remote and rural areas-led REAHL and establish an out of hours mental health crisis course in partnership with BASICS.
- scope out the learning needs of staff to contribute to improving the physical health of people with long standing mental health problems, and produced guidance to inform developments.

5.6 Mental Health issues in Physical Health settings

Through the Psychology and AHP Directorates, NES is developing a work-plan to increase the understanding among all NHS staff of the role of psychological factors in physical illness, particularly long-term conditions. This includes the identification and treatment of mental health problems which may affect physical health outcomes.

5.7 Forensic Mental Health Care and Services

NES has worked in partnership working with the School of Forensic Health to develop and support dissemination of the 'New to Forensics' learning programme -a work based, mentored programme that equips staff new to the service to develop the knowledge and skills to practice safely and effectively in forensic settings. We have also provided funding to the School of Forensic Mental Health to develop Masters level modules in the 'Legal Aspects of Forensic Mental Health Care' and 'Risk Assessment and Management'.

---

[5] http://www.nes.scot.nhs.uk/media/350773/interactive_mental_health_act_resource_april_2011.pdf

[6] http://www.nes.scot.nhs.uk/media/351190/respecting_and_protecting_adults_at_risk_in_scotland_2011.pdf

5.8 Dementia Care and Services

A paper was presented to the NES Board in November 2011 regarding progress with the NES/SSSC dementia work programme to support delivery of Scotland's National Dementia Strategy, therefore a summary is provided here.

In 2011 NES produced a Knowledge and Skills framework 'Promoting Excellence'[7] and a Dementia Workforce Development Plan designed to support implementation of the framework. NES/SSSC is undertaking a range of activities to implement a strategic Dementia Workforce Development Plan to support delivery of the change programme and actions outlined in Scotland's National Dementia Strategy.

This phase will focus on supporting implementation of the framework including: the development of educational resources; delivery of education and training: creating infra structures and partnerships to ensure sustainability; and impact evaluation.

Activities being taken forward include:

- Supporting a standardised approach to dementia education being embedded in all undergraduate and postgraduate health and social services professionals' educational preparation by providing guidance and supporting materials[8].
- Developing targeted educational responses to support health and social services' workforce knowledge and skills development in 'Dementia Informed' and 'Dementia Skilled' Practice' (as defined in the knowledge and skills framework) - including the development of a range of educational resources including DVDs and learning packages.
- Revising and developing vocational qualifications for health and social services' staff to reflect the knowledge and skills outlined in the framework based on a revision of the National Occupational standards and Dementia Skills set.
- Providing education and training for the health and social services' workforce to increase access to evidence based Psychological Interventions and Therapies for people with a diagnosis of Dementia and families/carers of people with Dementia
- Undertaking accelerated activities to increase access to psychological interventions and therapies for distressed behaviours perceived as challenging, by providing informational material and training in evidence-based non-coercive approaches for both staff and families and informal carers of people with dementia.
- Supporting the development of the health and social services workforce to improve the care, treatment and outcomes for people with Dementia admitted, or at risk of admission, to acute general care settings. Activities in this area include; training 100 people as acute hospital Dementia Champions this year, and thereafter further supporting their development as change agents by establishing regional learning networks; and establishing a leadership and development programme for the Dementia AHP consultants and Alzheimer Scotland Nurse Consultants.
- Creating the infrastructure for development and leadership for change in the Social Services sector to support implementation of Promoting Excellence in this sector.
- Improving health and social services' workforce capacity and capability in palliative and end of life care for people with Dementia by working in partnership with Alzheimer Scotland to train 75 people as dementia palliative care trainers.
- Evaluating the impact of training in post diagnosis support and early intervention to inform future developments in this area.

[7] http://www.scotland.gov.uk/Publications/2011/05/31085332/0
[8] http://www.knowledge.scot.nhs.uk/dementia/promoting-excellence/information-for-educators-and-trainers.aspx

- Developing and delivering Post Diagnostic Training and learning materials in partnership with Alzheimer Scotland for health and social services staff based on the principles of co production, personalisation and outcomes based approaches.
- Improving knowledge sharing and management across the health and social services workforce through developing and sustaining a Dementia Managed Knowledge network[9].

The NES/SSSC Dementia Work Programme has benefitted greatly from the productive partnership our organisations have established with Alzheimer Scotland. This partnership has been crucial in ensuring that our work programme is grounded in, and is informed by, close working relationships with a chartable and campaigning organisation representing the rights of people with dementia and their families and carers.

In addition to the change actions currently set out in Scotland's National Dementia Strategy the Deputy First Minister & Cabinet Secretary for Health, Wellbeing and Cities Strategy has recently announced the SG commitment to guarantee that people with dementia will receive post diagnostic support and intervention for one year after their initial diagnosis. This marks a change in current service provision and has been informed by a vision for new approaches to post diagnostic support that Alzheimer Scotland has been campaigning for. There is SG intent to develop a target for implementation. SG are considering whether the target will be a HEAT target, or taken forward as a target set in the context of the wider integration agenda, in particular Reshaping Care for Older People.

NES/SSSC are currently working with Alzheimer Scotland to develop, pilot and further disseminate education on model of post diagnostic support that will support taking this agenda forward. In the longer term there will likely be significant work force development needs in post diagnostic support across all sectors.

5.9 Child and Adolescent Mental Health

5.9.1 CAMHS Competences Framework

A competences framework was commissioned through NHS Education for Scotland (NES), and developed by a team at University College London and from within NES. The CAMHS framework draws on research evidence for the effectiveness of interventions in CAMHS settings, supplemented by the professional expertise of an expert reference group of clinicians and clinician-researchers. All the work has been subject to peer review by national and international experts in the field of CAMHS.

The resource, which is web based[10], is available to all relevant stakeholders as a tool to support curricula development, individual and team reflective practice and service and workforce redesign.

The competence framework has already informed two training curricula – for Essential CAMHS and the English IAPT Children and Young People Phase 1 National Curriculum.

5.9.2 Essential CAMHS

Essential CAMHS is a modular interactive learning package which is being developed for multi-professional staff entering in to the CAMHS environment. The package is designed to support staff in developing the fundamental skills, knowledge and attitudes required to work safely and

[9] http://www.knowledge.scot.nhs.uk/dementia.aspx
[10] http://www.knowledge.scot.nhs.uk/home/learning-and-cpd/develop-your-career/competence-framework-for-child-and-adolescent-mental-health-services.aspx

effectively with children, young people and families. The intended learning outcomes are drawn from the recently completed CAMHS Competence Framework, which was developed in conjunction with University College London, and are set at SCQF level 10.

The content was developed in consultation with a steering group of leading CAMHS clinicians from across Scotland who represent the range of professions working in the CAMHS setting. While much of the content delivers a basic grounding in the facts and skills required for CAMHS work, the associated activities promote a reflective approach to both the learning experience and the subsequent clinical application of the knowledge and skills. Throughout, the package encourages the learner to explore the experience of the service user and to maintain a person centred approach to their clinical work.

The resource is designed to be used within clinical supervision where the learning needs of the individual can be discussed and the relevant modules identified. Learners are asked to maintain a portfolio of their learning and to reflect on the content within their supervision. This portfolio can be used iteratively to revisit learning as skills and knowledge develop.

Two early implementer sites have been identified and roll out will begin in January of 2012. A comprehensive evaluation will include both the learners and supervisors experience of the content and the implementation process. This will inform the subsequent dissemination of the package.

5.9.3 Child Psychotherapy

Six child psychotherapy training places have been funded from September 2009 for a training which will complete in 2013. This has made child psychotherapy available to children in more NHS Board areas than had previously been possible. Discussions are underway about planning for the future of child psychotherapy training in Scotland once the current training has been completed.

5.10 Psychology of Parenting Project

This project, established within NHS Education for Scotland in 2009 has sought to:

- Encourage the commissioning of training (for the specialist CAMHS and wider children's sector workforce) in relation to parenting programmes already in existence whose evidence base is strong.
- Promote evidence-based practice which is faithful to these programmes (in delivery and delivery support).
- Promote the practice of integrated service delivery.
- Promote the practice of the thoughtful targeting of resources to where evidence is particularly strong.
- Increase the workforce capacity around evidence based parenting interventions.

The work of the project is being closely linked to cross-directorate developments within the Scottish Government supporting the early years agenda and with the relevant parts of the modernising nursing in the community agenda.

A Scotland-wide plan has now been developed which addresses:

- The training and educational infrastructure required to make available the benefits of two programmes, Incredible Years and Triple P, delivered with fidelity, to parents of 3-4 year olds who have been identified as having significantly disruptive behaviour.
- The organisational supports required to complement this initiative.

- The preliminary costings for the roll-out of the plan. This includes all training, support and delivery costs but excludes the staff time, screening and evaluation components.

The plan has been shared and positively received by a broad range of stakeholders, including representatives of several key Scottish Government directorates. Further core training is being delivered in both Incredible Years and Triple P, and the supervisory mechanisms to support delivery with fidelity are in the process of being developed. Funding for core staffing has been agreed while other aspects of the roll out are under discussion.

It is anticipated that a range of staff (including some CAMHS workers and other health service staff such as public health nurses and health visitors) will feature in the profile of staff delivering the parenting programmes.

5.11 Mental Health and Learning Disabilities

NES is taking forward a separate learning disabilities work programme, however, there are particular issues relating to the mental health of people with learning disabilities.

The population of people with a learning disability is increasing;

- with an increase in children born with developmental delay and associated learning disability. This is linked to: increased survival rates in premature babies a current and predicted increased incidence of foetal alcohol syndrome disorder; an increase in children with very complex needs, in turn surviving into adulthood.
- in common with the general population in Scotland, the learning disability population is an ageing population with a higher than average incidence of dementia among some groups.
- a third of people with severe and profound learning disability also have an associated Autism Spectrum Disorder linked to an overall increase in Autism Spectrum Disorders.
- people with a learning disability have a higher risk of morbidity and early mortality compared with the rest of the population; health screening shows high levels of unmet physical, sensory and mental health needs.
- the increasing population of people with a learning disability with complex needs including co-morbid complex health problems and behaviours perceived as challenging.

NES has taken forward a number of educational activities to support the mental health needs of people with a learning disability, including:

- the development of a wide scoping work based educational resource: 'Working with People with a Learning Disability and Complex Needs- the Essentials'[11] - targeted at health, social care and voluntary and private sector staff.
- the development, delivery and evaluation of training in positive behavioural support for people with a learning disability who display behaviours perceived as challenging, focusing on skills development for learning disability nurses and allied health professionals.
- The development of an educational resource on positive behavioural support[12]
- Development of a Learning Disability Portal supported by NES Knowledge Services. The portal supports the broad health and social care workforce working with people with a learning disability[13].

[11] http://www.nes.scot.nhs.uk/media/579631/complex_needs_final.pdf
[12] http://www.nes.scot.nhs.uk/media/570730/pbs_interactive_final.pdf
[13] http://www.knowledge.scot.nhs.uk/home/portals-and-topics/learning-disabilities-portal.aspx

6. Conclusions and Recommendations

NES contributes to the mental health and well being of the population of Scotland through the education and training of the workforce involved in the delivery of mental health services. NES has involvement in the education and training of staff delivering services at all levels of need across all ages. NES has significant responsibility for pre-registration education and training of the core mental health disciplines in psychiatry and psychology and for supporting the enhancement of pre-registration training in mental health nursing. NES also provides considerable support for Continuing Professional Development for health and social services staff in mental health.

In recent years a growing additional area of responsibility for NES has been in multi-professional and cross sectoral education and training in response to Scottish Government priorities. The current strategic context and SG plans for the integration of health and social care would suggest that there will be demand for additional growth in multi-professional and cross sectoral training to be provided to staff supporting people in community/primary care. There are to be considerable challenges in meeting this demand in the context of constrained public sector finance.

NES will need to review its contribution to mental health once the Scottish Government's Mental Health strategy is finalised. Every part of the strategy has potential training implications. It will be important that in responding to these NES does not compromise the quality of the education and training we offer by broadening our scope too quickly. It is proposed that the priorities should be:

a) Pre and post registration training of mental health disciplines

b) Mental health training for pre and post registration healthcare disciplines with particular focus in primary care

c) Mental health training of social care and third sector staff to continue to be developed alongside or adapted from a) and b) wherever possible.