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

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

The NHS needs to limit itself to what only the NHS can do. Need to make better use of voluntary organisations and public education via schools, college based evening classes and the media. For example, in Dementia, Acquired Brain Injury and Mental Health much more in terms of support, low-level psychological/social interventions and signposting to other services could be done by Voluntary Organisations if they were properly resourced. Media could be used much more to education people in self-efficacy. NHS should not be providing basic self help. Voluntary organisations and media (especially TV) could do this. In terms of Psychological approaches, expert resources should be concentrated on those who are able to benefit (not the most chronic nor those who are best "managed" rather than treated). A radical way to deliver most benefit with same resource in terms of psychological services would be to withdraw expert providers from Primary Care and concentrate the resource on

psychological assessment, neuropsychological and developmental assessment and treatment of complex/high benefit patients, particularly in Older Adults and Physical Health. In Older Adults there is so much unmet need that only Clinical Psychologists can meet (neuropsychological assessment for diagnostic purposes, behavioural interventions for challenging behaviours and staff training). In Physical Health, the same applies and I believe concentrating input here would have an overall greater pay-off than in, for example, general adult mental health (especially Primary Care). Medically unexplained symptoms, for example, cost the NHS a ridiculous amount of money every year.

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.

The NHS needs to limit itself to what only the NHS can do. Need to make better use of voluntary organisations and public education via schools, college based evening classes and the media. For example, in Dementia, Acquired Brain Injury and Mental Health much more in terms of support, low-level psychological/social interventions and signposting to other services could be done by Voluntary Organisations if they were properly resourced. Media could be used much more to education people in self-efficacy. NHS should not be providing basic self help. Voluntary organisations and media (especially TV) could do this. In terms of Psychological approaches, expert resources should be concentrated on those who are able to benefit (not the most chronic nor those who are best "managed" rather than treated). A radical way to deliver most benefit with same resource in terms of psychological services would be to withdraw expert providers from Primary Care and concentrate the resource on psychological assessment, neuropsychological and developmental assessment and treatment of complex/high benefit patients, particularly in Older Adults and Physical Health. In Older Adults there is so much unmet need that only Clinical Psychologists can meet (neuropsychological assessment for diagnostic purposes, behavioural interventions for challenging behaviours and staff training). In Physical Health, the same applies and I believe concentrating input here would have an overall greater pay-off than in, for example, general adult mental health (especially Primary Care). Medically unexplained symptoms, for example, cost the NHS a ridiculous amount of money every year.

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?

Psychiatric hospital staff need to much more psychologically skilled in creating relationships with patients/ward atmospheres generally that inspire hope and zest for life rather than simply containment. You should also consult eg Health Psychologists on this issue as I think there are some public interventions which they will be aware of.

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

Much more in way of self-help for psychological disorder programmes on TV etc would reduce stigma through simple desensitisation to the issues and fostering public discussion of such disorders. We need a "Gok Wan" for psychological health!

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?

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

As above plus social engineering! Create small, strong, self-monitoring communities and you would instantly improve well being as well as reduce suicide rates. Not sure how to do this though!

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

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

Comments

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?

As above

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

As above

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?

As Q12: Public education and reservation of most expert resource for those with severe disorder and who are most likely to benefit i.e. first episode rather than chronic sufferers.

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?

The biggest non-value adding activity for clinicians is administrative tasks. Financial constraints have meant less (less expensive) admin staff and therefore, clinicians (more expensive) are expected to do more of their own admin and have less time for clinical work. Saving on admin support is a false-saving! The Psychological Therapies HEAT target presents a real threat to clinical work because of the amount of data-input which will be involved for clinicians. For example, scoring a 'CORE' at every session is a waste of time in that session and inputting such information to a database afterwards is highly time consuming. We will lose thousands of clinics across the country if this is made a requirement. We need to introduce data collection gradually and assess what is practical along the way. There is a real danger that the reporting requirements of this target will actually decrease access to clinical services.

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

Simplest way of focusing on patient and their pathway is to forbid, at a national level discriminatory and illogical service boundaries, the most obvious of which is age. For example, we have a Neurological Service in Ayrshire which excludes people if they have reached their 66th birthday.

In terms of Psychological Services and age, there should be national investment, mush as there has been in CAMHS, to bring the number of Clinical Psychologist in Older Adults Services to at least the same level as that in Adult Mental Health.

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?

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

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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?

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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?

This is not a mental health service solution though caring for, especially, someone with severe challenging behaviour creates mental health problems. Vastly more needed in terms of practical help at home, respite care and specialist, skilled residential care facilities.

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?

This is not a mental health service solution though caring for, especially, someone with severe challenging behaviour creates mental health problems. Vastly more needed in terms of practical help at home, respite care and specialist, skilled residential care facilities.

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?

In relation to releasing time to care, it should be noted that recent introduction of electronic systems whilst having many advantages, has decreased time to care in both in-patient and out patient settings. The ratio between clinical time and "bureaucracy" ie form filling is now spiralling way out of proportion.

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?

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

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

There is a gap in terms of Clinical Psychologists and Clinical Neuropsychologists within all physical medical specialties. I would like to comment also on the three areas of acknowledged gaps.

Older Adults: Investment needed for Clinical Psychology to bring resource to at least same level as for Adult Mental Health.

Discriminatory and unethical age limits to access any national health service should be prohibited at a national level, public should be made aware of this and services which persist in this practice should be prosecuted.

Developmental Disorders (DDS): Generally children with DDS and Adults with a DD and a Learning Disability are reasonably well catered for. However, young adults and adults who have a DD but do not have a Learning Disability are not. There should be specific specialist services for these individuals, with access to such services determined by expert psychological and psychiatric assessment (to exclude/re-direct those mild/inappropriate presentations that are increasingly coming into Mental Health Services because they "think they might have ADHD, Aspergers etc).

Trauma: Clinical Psychologists and CBT Therapists, with the support of Assistant Psychologists and other professions for in vivo work, can provide excellent treatment for people with PTSD as part of general Mental Health Services. There should not however, be 'specialist' services for those suffering from childhood trauma/sexual abuse. These presentations should be assessed for suitability for treatment and treated if appropriate, within general Adult Mental Health Services. The danger of creating a specialist service for this group, is that it will prioritise a group of people who, due to personality disorders, are the least able to benefit and for whom management is probably more appropriate than treatment. This is unacceptable given the dearth of resources available to those who would benefit, for example, Older Adults, those with Physical Health problems, those with DDS, etc.

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?

As in answers above, increase level of expert Clinical Psychology and Clinical Neuropsychology resource in Older Adults and General Medical Settings. Savings on proper treatment of Medically Unexplained symptoms alone would fund all the current gaps!

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

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

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

Comments

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

Comments

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

We are attempting to meet the PT HEAT target by "training up" and supervising non-psychologists/expert Psychological Therapists to deliver low intensity interventions. However, in order to do so we need more High Intensity practitioners. In addition, skilling up others does not produce a Clinical Psychologist or CBT Therapist. The only way we will come close to the HEAT target is by "dumbing down" what we offer patients (i.e.) by giving them a lower lever of intervention than that supported by the evidence base. If you want to ensure sufficient local training and supervision capacity you need to increase the numbers of staff who are able to provide this whilst still delivering expert specialist and High Intensity interventions themselves. This resource is most lacking in Older adults and General Medicine (need for more Clinical Psychologists) and in Adult Mental health (need for more Clinical Psychologists and other expert Therapists).

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

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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.

Adequate administrative support will be increasingly critical as data entry, monitoring and analysis requirements increase. Otherwise reporting will overtake clinical work and the whole exercise will be self defeating. Perhaps a national survey of how much time Clinicians are spending on admin tasks might throw light on why they are finding it difficult to meet Government targets.

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

As Q31

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?

As Q31

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

Much more in way of self-help for psychological disorder programmes on TV etc would reduce stigma through simple desensitisation to the issues and fostering public discussion of such disorders. We need a "Gok Wan" for psychological health!

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