National Mehtal Health Improvement Network
Consultation Response to The Mental Health Strategy for Scotland
Tuesday October 11th 2011
Edinburgh Training and Conference Centre

Prepared on behalf of the Network by NHS Health Scotland MHI Team

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.

General Comments
The MHI National Network is pleased to comment on the Mental Health strategy for Scotland: 2011 – 15.

The move towards an integration of mental health seryices and mental health improvement into one strategy is welcomed, with mental health requiring cross-cutting responsibility and action. However, it was felt that the present document does not recognise the growth of mental health activity through previous policies and local implementation, particularly those relating to mental health improvement. Network members are concerned positive mental health and wellbeing is submerged within the document, and without explicit recognition the message that wellbeing as a national priority is minimised.

Comments on specific aspects of the pverall approach of the document include:

Vision
The vision established at the outset of a document is presumed to be the national direction, and is critical to supporting local leadership in delivery. The current vision lacks a public health perspective which is disappointing. It is not clear what the overarching vision for an integrated approach to mental health is and it was felt to lack aspiration towards a mentally healthy Scotland. This could be established through including commitment from the (Deputy) First Minister in the fonward stating mental health is everyone's responsibility and that all policy areas contribute.

Context
The context lacks explicit recognition of the current demographic, economic and political realties including employment, poverty and inequality- and the implications of this on mental health within Scotland – important in guiding local planning for mental health actions for the future.

The Network would value explicit reference to other sectors and policies

contributing to improvement in mental health in Scotland e.g. early years framework, the economic strategy, physical activity strategy etc. in order to evidence a contribution to these outcomes across central government, and particularly at local levels.

Broadening the context would support a system-based approach that draws from across services and wider policy areas e.g. CAMHS focussed work should be described within the context of Integrated Children's Services.

Specific significant gaps include reference to wider public sector agendas; co-production and asset based approaches.

Audience
It is unclear who the document is aimed at given the heavy focus on the NHS examples, and actions. At present the document reads as a functional action plan, is overly focused on mental health services and therefore should be a CEL. However, from a health service perspective, the wider NHS audience are also not adequately considered, more could be said about the role of those supporting people with long-term conditions and at risk of depression, general medicine and surgery addressing stress and anxiety and maternity and children's services contributing to the infant mental health.

Currently, the medicalised philosophy underpinning the document and the focus on mental health services delivery needs to be re-balanced in order to reflect a social model and establish an equal weighting on promotion and prevention It may be beneficial to develop two linked strategies simultaneously one majoring on continuous improvement of mental health services and the other focusing on promotion of wellbeing, prevention and early intervention.

Structure of Strategy
The document lacks a theoretical framework; and the relationship between the priorities and outcomes is unclear. It is not clear who has responsibility for delivery of the actions. At present the scope and reach of most of the outcomes falls short due to their reactive focus and subsequent treatment and care actions.

The fourteen outcomes do not demonstrate the cross cutting nature of mental health and wellbeing as they are more statements of outputs than outcomes, lacking coherence and cohesion. The key challenges do not have clarity about what achievement of the outcomes would be and this heeds to come after each outcome statement. This section could be left for each local area to respond to individually.

Core Consultation Questions:

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

As mental wellbeing encompasses such a broad agenda, then unless it is explicit within a mental health strategy for Scotland, it can get lost in other agendas. Any new strategy is critical in giving legitimacy to mental health improvement at both national and local level. It is essential that the document links to Single Outcome Agreements and legislative frameworks

to achieve Local Authority and Community Planning Partnership buy-in; examples of practice and guidance for local areas to support their implementation could be provided.

There is a distinct lack of reference to the importance of partnership working throughout the document. The NHS focus, described above, creates a barrier to multi-sectoral engagement and undermines the collaborative approaches initiated by TAMFS.

The current approach suggested by the strategy leaves no opportunity for local innovation or interpretation or indeed the creation of a more robust evidence base for mental health improvement, as resources will be allocated through stated priorities.
Respecting local experience of plausible theory, qualitative measure and areas of enquiry is important; this document should not be restricted to data measures alone. The application of evidence such as the Mental Health Indicators for Scotland provide useful indicators of change.

Sections on 'what has been achieved to date' minimises the mental health improvement achievements resulting from TAMFS.

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 lack of a monitoring and evaluation framework within the document was reported as a key weakness in respect to the multi-sectoral approach advocated by the Network. However it was recognised that much of the suggested monitoring, focused on NHS delivery, would be picked up at the biannual MH Team Board visits, as well as Boards' Annual Reviews. It would be helpful if the document clearly described how impact would be measured with progress indicators determined. The timeline of the strategy needs to be clarified as a four or five year document but should be set in the context of a longer term vision. Clarification over responsibility for implementation of the strategy is critical. It would be helpful to set out a national framework against which local actions can be developed and monitored.

The mental health and wellbeing issues associated with inequalities, at risk groups, substance misuse and deprived communities are not mentioned. There is an over-emphasis on individuals and national services. This is not reflective of current good practice a local level.

Specific Outcome Feedback (questions 3-35)

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

Outcome 1 was of particular interest to many network members who felt that mental health improvement was central to actions related to individuals and communities in the protection and promotion of the mental health and wellbeing. It is not clear if this is an action and not an outcome, however.

Members expressed concern over a medical model shaping the wellbeing agenda within this outcome. As it stands, the outcome focuses on individuals and their relationship to mental health services and does not acknowledge the many players and champions within communities nor does it reflect the growing evidence base on co-production, asset based approaches and building resilience, all of which contribute to achieving positive outcomes.

It was suggested the lack of clarity in this outcome was indicative of a need to have a more robust vision for a mentally healthy Scotland articulating a broad approach to wellbeing as a priority and necessity. This outcome should set out and champion the role that many agencies and organisations can play in driving the agenda forward with a shared intention.

The clarity provided by TAMFS, and the strategic commitment to the promotion of wellbeing at national and local level, is missing from the document.

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

Continuing with, and completing, the current self harm work was identified as core to progressing the agenda but additionally increasing NHS Boards accountability, through improved data collection of both self-harm and suicide rates (attempted and completed). An example of this is in Perth and Kinross, where the Police now share with the NHS Board the number of calls they receive.

Question 4. What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?
A national work programme focussed on anti-stigma for those experiencing dementia was proposed.

Enhancing the voice of those with lived experience of mental ill health was a specific action identified.

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?
Championing both See Me and Choose Life programmes.

Tackling staff attitudes towards those with mental illness- within NHS services, including mental health services, but additionally primary care, children's units and addiction services were highlighted as several key health service target groups. Multi-sectoral education and anti-stigma promotion was identified as being essential to have a consistent national message and approach.

It would be helpful to consider anti stigma work as being integral to the wider work done with both individuals and communities around mental health awareness , around use of language, knowledge and understanding of mental health (as described in response to question 6.)

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?
Within cbmmunities, members felt that there are strong foundations already in place that can be built upon and are not currently identified within the document. This includes shared outcomes between Local Authorities and NHS services through the SOA.

It was suggested that building capacity within and across the system (professionals, individuals, communities) is essential. Development of knowledge and skills around wellbeing, mental health awareness and how to identify how and when to seek help, or how to take protective measures was noted as critical.

Enhancing support for those experiencing individual distress, but are not mentally ill was also see to be important.

The role and contribution of the community and voluntary sector was highlighted as a major gap within the document.

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

Overall Network members indicated that outcome 2 focuses too heavily on CAMHS and does not recognise or support the multi-sector effort required to put children at the heart of the outcome. Broadening the actions to include upstream and early intervention approaches was strongly supported by all respondents. Whilst CAMHS was recognised as effective for treatment and care, for the vast majority of children and young people, who do not require health service intervention- mental health promotion occurs through schools, youth work, leisure activities and spirituality, driven within communities and families. This needs to be reflected in the document.

The evidence base relating to parenting, particularly in the earliest years, in the promotion of mental wellbeing and prevention of mental ill-health is not identified within the document. Nor is there reference to the value of family support and school based interventions. There were identified as major gaps.

Mental health and wellbeing issues relating to poverty, inequalities, particularly around looked after children, young carers and those with learning disabilities were all highlighted as areas for further attention.

Question 7. What additional actions must we take to meet these challenges and improve access to CAMHS?

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

Outcome 3. People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.
This outcome needs to be significantly broadened including reference to improved public knowledge and understanding of mental health. This is compounded by the lack of priority throughout the strategy around preventative approaches.

The shift towards individuals taking greater responsibility for their mental health and identifying their own needs will only be achieved through improved understanding of mental health. Additionally, it is important to acknowledge that the shift in responsibility towards

individuals can potential lead to stigmatization of those experiencing mental ill-health, where it is perceived to be 'their own fault' if they have not sought help earlier.

Question 9. What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?
The strategy needs to set out clearly the ways in which multiple agencies can connect with their communities to aid mental health literacy. Mental health awareness and education, and discussion of emotional wellbeing needs to take place out-with NHS contexts in order to reach the vast majority of the Scottish population.

Improved understanding of the protective factors and behaviours for mental health is required and this requires investment in mental health literacy (not just on specific conditions i.e. anxiety and depression) of the general population, as well as professionals. Examples of opportunities to educate and inform include the use of community/ youth groups/ media outlets to encourage discussion of the positive, and/or negative, aspects of mental health.

Preventative spend approaches have not been identified within the strategy; it would be helpful to include: npn clinical approaches including social prescribing, self-help approaches around depression and anxiety; specifically reference to GPs to recognise, respect and promote services within local communities and promoting anti stigma messages around engaging with services. The strategy should also link to wider policies contributing to prevention and promotion agenda. There needs to be some reference to the ability of this agenda to access Change Fund monies, whether it is for older people, children, LD etc

Question 10. What approaches do we need to encourage people to seek help when they need to?
This outcome could be interpreted as people with mental health problems hold responsibility for their own treatment. This does not support those who may not be able to recognise that they are mentally ill.

The strategy should make explicit reference to issues relating to mental health and substance misuse, support improved links with addiction services and to improve mental health awareness of both staff and patients..

It is important that the strategy targets children and young people and their families through Curriculum for Excellence: up skilling those who work in schools , parents/carers and pupils in order to improve mental health

It would also be helpful to recognise the multiple services that support the agenda , and can improve mental wellbeing, including housing, social inclusion, employability and anti-social behaviour teams etc.

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?

Investment in pre and post-graduate education on mental health and wellbeing for medics, particularly GPs is critical. They are the first point of contact for most people but are often not confident of their mental health knpwiedge and understanding.

Investment in safe crisis services that don't require MH services intervention but are seeking a non-threatening, less formal point of contact for people to get the advice/ support they need.

Emphasise the importance of partnerships where mental health services respect referrals from voluntary sector organisations.

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?
Providing regular information to GPs and other referral providers on the actual waiting times- as they often don't refer because they think they are longer than they are.

Question 13. What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?
Better integration of all mental health services locally is required, by the provision of a generic national Integrated Care Pathway that provides a clear directive.

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?
Put wellbeing at the centre of treatment and care provided to patients.

First level change in individuals is required to be engaged in choices, but second level changes to create conditions required for recovery delivered through close links with MH services, SRN and See Me.

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

The 'whole-person' is not just the person who is ill for an acute period but a holistic approach is required through the life-course, embedding wellbeing.

Improved understanding of carer/ family mental health needs is required identification of their wellbeing needs supporting them through making difficult decisions. Additionally, providing information to family and carers is important to improve as they are often left-out of decision making processes but then have to support a person through the approach/ treatment that has been made.

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?

Use of the potential self-directed support bill and increasing personalisation agenda both offer major opportunities to focus on the whole-person.

Consider evidence of self-management approaches to date.

Closer links with community services (local authority/ self-help/ voluntary sector) so support continues beyond acute illness.

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

Ask areas to report of the number of SRI's completed.

Question 18. How can the SRN develop its effectiveness to support embedding recovery approaches across different professional groups?

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?
Carers need respite and good crisis service provision. They also need support with their own wellbeing and mental health protection.

Relates to person-centred approach; we need to see people as a whole-person in the context of their lives, including their carers and family. There are issues relating to the measurement of this

Question 20. What support do staff peed to help thepn provide information for families and carers to enable families and carers to be involved in their relative's care?
Direction to keep carers and families actively involved and informed.

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?
Not just an NHS Issue but needs to be agreed through CPPs and CHPS to avoid gaps and duplication across voluntary sectors/ local authority/ NHS providers

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?
This is not just about increasing reach but also about recording and supporting existing services in the community.

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

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

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?

Question 26. In addition to the proposed work in acute hospitals around people with dementia and the work identified 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?

Dual diagnosis/ co-morbidities continue to be a real problem leading tp gaps in service provision

What happened to Joint Future?

Other services (housing, education etc.) need to be given a clearer steer in their role in delivering and maintaining an environment that promotes positive mental health.

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: A framework for all health and social services staff working with people with dementia, their families and carers* across all health and social care settings?

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?

Question 29. What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?
The broader workforce needs to be considered e.g. teachers, youth workers etc. as it is important their skills development is also taken forward in line with the national direction.

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

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.

Who decides what is appropriate 'benchmarking'? This needs to be a joint development process.

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

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 these challenges?

Question 34. What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?
Integration- without true integration who will lead and who will be led?

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?
Include the requirement to look at what is being down under section 26 and how this is being monitored.

Incorporate lived-experience in all levels of training and service planning.

Personality disorders are still mostly used as exclusion criteria for services.

Reform interventions on mental distress- not medical labels.