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
I think that it is crucial to acknowledge that the 14 outcomes have implications for every age group and specialty within the broad church of mental health. The interpretation of the Strategy by many has reflected for example a perception that children and adolescents are only dealt with in certain sections. The whole strategy has implications for CAMHS.

It would have been helpful to consider our approach in a broader way for example acknowledging legislation and practice in other domains. Education and the delivery of the Curriculum for Excellence is directly related to Mental Health Promotion and Prevention. As are overarching GIRFEC principles and a wealth of policies relevant to all agencies but most obviously referred to in local government. In this respect the MH Strategy differs hugely from the Scottish Strategy for Autism, where these links are made more specific.

A more systemic approach would also have been helpful. Service users and their carers are families in different stages of the life-cycle. Service users may be children or adults. They may also be parents, grandparents, sibs, etc

The Mental Health Division and some Health Boards seem to have a rigid view of when childhood ends and adulthood begins. Transition is mentioned but it would be helpful to encourage flexibility here as many disorders span both. Developmental stage is more important than age, and this perspective is lost when rules become too fixed. Continuity of service provision including approach is important, and the separation of the style and philosophy of service delivery at different ages and stages is not appropriate.

Disappointed that the document failed to emphasise the valuable role of Primary Mental Health across all ages but especially important in Childhood and adolescence. Supporting professionals in Tier 1 and working across agencies and especially in schools to raise awareness and support prevention and health improvement/promotion and early intervention. The delivery of training and consultation is a crucial way of building capacity.

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 Ideal areas to implement the required changes.

Comments
The comment about the challenge of organisational boundaries is well made. A clear steer at national level with regard to joint working with local authorities does not seem to have been met with a uniform response. Respecting that we are ih different organisations, joint working at national level might better support local joint planning and service delivery.
E.g Could CAMHS Lead Clinicians who meet quarteriy be supported to meet with SW Directors and/or Directors of Education ; or at a national level with Youth Justice or the Police. Stakeholders meetings rarely manage to bring these groups together. Is there a way of iricentivising this so that within each of our agencies there is a model from the top down to foster joint work

There is a need for national training initiatives to continue to be rolled out especially as our context is NHS Boards with apparently less money to spend on training. The challenge is also to employ technology to make this accessible for thse at a distance from centres for training. EG a recent example of a nurse from Dumfries attending traing in Edinburgh – Board would not permit overnight stay. Start time too early for her to make it on first possible train etc etc
The IT infrastructure is missing and needs investment to support Videolinks, Skype etc.
Similarly the IT infrastructure requires considerable development to record any meaningful data about client contacts, esp in rural settings, and Outcomes.

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
What changes would deliver better outcomes is not a question to be answered easily especially as there has been a diminution in the Academic base for CAMHS. Prevention and health promotion, awareness raising and early diagnosis should lead to better outcomes. In developmental disorders which are often life-long there is evidence that eariy interventions can lead to a reduction in challenging behaviours and therefore more socially appropriate living situations which mean that young people with ASD do not have to live in specialist residential care or hospital at a distance from family (a cheaper as well as more 'normal' solution). In the case of the ADHD population the answer may lie in follow-up and in a retrospective look back fthrough the lens of offending, again eariy recognition and treatment may reduce the no of these people going to prison. Research is needed.

Research in the area of trauma needs evaluation of psychological therapies including EMDR

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
Education – Curriculum for Excellence embracing mental health and encouraging respect. Tackling cyberbullying. Support from PMHW to deliver programmes of health promotion and prevention including resilience building etc. Needs to start in primary school.
Shift in cultural attitudes supported through media etc (ongoing)

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
Our organisations do not act as good role models for our behaviour here.
Acknowledge and accept. Education especially delivered in schools. Use of social media and networks to demystify
Improve public awareness – start with professionals we work with eg in partner agencies, teachers, social workers etc

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
Make it more visible. Ask our service users, ex service users to help. Actively support carers' organisations especially those for parents of children with 'problems'. Alongside condition-specific groups develop networks which have less need for diagnostic label.
An inherent paradox in systems that exist now, in social welfare, DLAa, Educational need profiling is the need for stigma! ie a label. This is not good and we must do more to celebrate the diversity of the human condition and acknowledge that we all have stress, that family life is stressful, that children need respect and boundaries. They do not all need labels.

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

Comments

As Q5. Encouraging responsible citizenship for example, a tenet of our education systeh. Make it more meaningful. Respect for diversity and supporting everyone to make a positive contribution. An irony that most of society's volunteers are those with health, including mental health, problems. Volunteering does help fulfilment and confidence etc but can also be stigmatising. Fostering the concept of neighbourhood and neighbouriiness etc

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

Remove barriers to access. The new ways systems eg CAPA should foster a sort of access that allows signposting. Stop having too many rules about who should be seen. Allow self-referrals. (We could develop links from school It sytems etc for pupils to access our information and how to contact us directly) Do not get hung up on rereferral rates (one of the Balanced Scorecard indicators of Failure). Families can work on a problem to some

extent at any one time but may not have the capacity for change that professionals want them to. Acknowledge this, set goals with them, at their pace, allow them to go away and come back when they are ready to do more.
PMHW have made a huge difference to the gatekeeping of specialist services in D&G.
Skillmix is important as are competencies. A skilled workforce is needed but this must be a flexible workforce with eg some practitioners with capacity to home vist, support mealtimes, socialisation etc. the answer is to have a range of professionals whose complementary skills and attributes are used effectively. To do this it is important that there are clear pathways set out which act as a framework for the delivery of individually tailored careplans.

This should not be used as an excuse for the 'dumbing down' of CAMHS. Experience and skill should be valued and the complexity of the presentation of some children will require that they have exacting assessments which take time, and time for reflection. The roles of different professions are all to be valued and I would make a special plea for the recruitment and retention of psychiatrists to be given prominence especially as we are in the midst of increasing demand for ADHD and ASD assessments, and the appropriate administration of medication

Access to CAMHS must not be at the expense of quality, and the current way of measuring our performance leads to a 'bums on seats' mindset, rather than an acknowledgement of frequency and range of therapeutic interventions that should in many cases be delivered side by side. The time CAMHS professionals take to attend CP conferences LAAC reviews, Children's hearings, school meetings etc to deliver training and supervision, consultation and prepare complex reports is not reflected in our Key Performance Indicators to date.

One in particular – adolescents on adult wards has been applied too rigidly. A short local admission under the care of the clinical team who knows a YP and family very well and does not remove him/her from their family and friends and local context, could serve recovery better than an admission to a distant specialist IP unit

Access should not always be interpreted literally. Supporting partner agencies to manage a child in an educational or care setting is often as important a contribution to that child's mental health and welfare than direct contact.

We found that in this part of the document there was not sufficient emphasis of family. Family members are our cotherapists and our patients. Relationships are crucial and should be protected. The choices of our patients and their families should be respected. They should be listened to and we should work with them as openly and collaboratively as we can, and use other means to protect the child when we cannot. GIRFEC principles are central to this approach

Children of parents with substance misuse and children of parents with mental health problems are particulariy vulnerable and the thread of this connectedness of family members needs to be woven throughout the

Strategy. Input to help build resilience in these young people is vital

We could find no mention of the Substance misuse HEAT target which also applies to children. Access for this group is crucial

We are pleased that work is progressing on mental health indicators which is not highlighted. These have to make sense and be measureable

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

Comments
Give a national steer on CAMHS finance. Having been given £63k as our share of implementation money we are having to save £30k per year as part of CRES. This makes no sense

Training to ensure that those meeting child and family at first contact are able to be clear about task.

Unfortunately the progressive cutbacks in other services mean that there are fewer services to signpost to. There is a danger that the implementation of the HEAT target will be compromised by the dearth of other supports in the community.

To repeat an earlier point we have been very challenged by the lack of suitable information systems to support the reporting of HEAT data. This lack of IT infrastructure also impacts on record keeping, the capacity to audit, evaluate etc

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
Encourage this early through education in schools, signpost to internet sites, encourage support groups etc

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

Comments

Remove the barriers (as detailed in prev questions). Direct access, early appointment – have the conversation eariy rather than after months on a waiting list. Consider different clinic hours, self booking etc

Accessible clinics near the patient's home. User friendly accomrhodatiori. A nice, child-friendly place to come

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

Educate bur partners. ADHD for example is still 'not believed in' by many teachers. Offer consultation to partners so that they can discuss children and young people they are in contact with. Improve their awareness of Mh difficulties

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
Create pathways and systems which avoid duplication. IT support. For the patient consider their journey and try to avoid tem having to tell the same story over and over.

Personally I find the defensive practice of NHS Board means that I have to spend a lot of time writing and rewriting risk registers, efficiency and savings plans, demonstrating that we are implementing, Respect policy diversity policy, Hygiene policy, the list is endless. This is not a good way for an experience CAMHS clinician to be spending time

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

Comments

Working in a regional network has allowed the sharing of pathway development etc. crucial if inequalities in access and standard of care to be obviated.
Once more measuring variance and fidelity to model would be possible with supporting IT infrastructure

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

Access existing groups. Build on use of existing mechanisms eg use pf Experience of Service Questionnaire
For CAMhs, community education projects are willing to act as service evaluators, voice of youth.
We need to build on this with local focus groups etc. we encourage

feedback and input and are responsive to this

We do find that if a YP has had a particularly difficult period eg with severe eating disorder, once this is behind them they do not want to engage to help improve service

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

Comments
Engagement, empathy non-judgemental etc. this can be part of Psychological TX training

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches tp prbyidirig care in mental health settings?

Comments

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

Comments
Rights Relationships and Recovery all relevant to CAMHS. Locally training on 10 Esc modified for CAMHs. Important that Recovery model does not forget young people. Are you communicating directly with CAMHS about Recovery Indicator?

Question 18: How can the Scbttish Recoyery Network develop its effectiveness tp support embedding recovery approaches acrpss different professional groups?

Comments
ditto

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

Implicit in the work in CAMHS. BUT transition often presents a challenge for this reason. Respecting confidentiality is still possible while including and supporting family and in particular giving psychoeducaton. The approach in adult services is often so different that family feels left behind and isolated compared to CAMHS experience.

Listen to them

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
Again we would like to raise transition to adult services as a huge issue. Threshold for other services are different. Could support be given nationally to rethink responsibilities at different points in the lifecycle

Local knowledge of organisations that offer carer support and advocacy is vital. Acces to resources could be streamlined through online directories etc. Good relationships with partner agencies underpin supportive and inclusive approach to 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

In the West of Scotland CAMHS network regional learning events three times a year have offered presentations from redesigned services and also had topic presentations alongwith workshopping and networking opportunities with a sharing of and/or joint development of pathways etc Sharing good pracatice

CAMHS chatroom (formeriy QINMAc) also available for info tp be shared, questions to be asked, good ideas or models to be discussed.

We would like to set up a forum like this in the West of Scotland but resourcing it is a challenge

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

National or regional networks

Question 23: How do we disseminate learning about what is important to make serviees accessibie?

Comments
ditto

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

Comments
Little mention in the document of substance misuse (see next point) . Need to create or preserve dual diagnosis service for Yp with problematic substance misuse or comorbidity, and children affected by parental substance misuse, and/or with severe dev problems as a result of this (FASD and others) Infant Mental Health despite publicity is poorly developed Forensic CAMHs is poorly developed. Local teams should be working closely with Youth Justice. There should be consultation around the need for an adolescent IPCU or forensic IP facility

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
NHS D&G continues to instruct CAMHS only to see Out of Region LAAC in residential care in an emergency. These are the most vulnerable young people and should not be denied CAMHS access. No other service users are denied access. We must do more than simply 'see' more disadvantaged groups we must also develop more specialist services for them Nationally a clear steer on the Equality ACT and non-discrlminatory practice would help

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

CAMHS should be more connected to the Strategy for Autism . There should be a clear acknowledgement through a reflection in funding from Autism Strategy monies that it is very much a part of the work of any mental health service. Diagnostic services are still challenged and post diagnostic work with parents and carers should be a priority

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

Ensure that staff can be released for training, and that CAMHS Competency Framework becomes meaningful and is not overlooked in climate of austerity
Support regional learning networks and pathway development underpinned by Quality Strategy

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?

Comments
Recruitment and retention in Child and adolescent psychiatry remains a challenge. Increased training numbers and support and recognition of the specialist skills is important. Less rivalry between Psychologists and psychiatrists . respect complementary functions.
Ensure that workforce is equipped to deliver home-based service and also that skillmix does not become confused with a cheaper workforce.
Development of B5s to be commended but not at expense of other gradings and a mix of disciplines

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

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

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

Comments
Make the Balanced Scorecard for CAMHS more relevant. For example re-referral should not be seen negatively, numbers are not everything, rememeber to count the training, consultation, supervision etc and the non-direct work too. And finally do not make the collection of the information so time consuming that it stops us doing our clinical task.

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

Comments
IT infrastructure including eMREC

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
Continue to invest in leadership. Encourage NHS Boards to recognise the time is required both for professional development and for the tasks that befall a leader

Build evidence base

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

Comments

Leadership and engagement

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
Training, mentoring, supervision, respect