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Dear Ms Christie

Re: Mental Health Strategy for Scotland 2011 – 15

On behalf of NHS Greater Glasgow and Clyde thank you for the opportunity to comment on the consultation document "Mental Health Strategy for Scotland 2011 – 15". The Strategy is all-inclusive; as a result the policy goals driving priorities should be explicitly confirmed. This will help progress in making the change from the general points being made to service action and implementation.

As a result our response is set out initially highlighting key overarching points and then goes on to emphasise issues which have been additionally highlighted through our local engagement.

There are significant repercussions for the West of Scotland as a result of deprivation. Economic measures indicate that the initial impact of the recession has been cushioned by people changing their work patterns (for example accepting a cut in hours rather than unemployment), and that the fall in interest rates meant that repossessions were kept to a minimum. These are reported to be short term protections. If the recession continues, economic changes will lead to cuts in real income and this is considered by some (May 2011 the Institute of Fiscal Studies 2011) to be already happening.

The impact of welfare reforms will also reduce the incomes of people on benefits over the next 3 years which will exacerbate existing levels of poverty. An uneven geographic impact of welfare is predicted and an adverse impact across NHS Greater Glasgow and Clyde is anticipated (e.g. an anticipated 5% reduction for Glasgow would mean incapacity numbers would be cut by more than 22,000, of whom more than 12,000 will be denied benefit entirely).

These factors will have a damaging cumulative effect on people with mental health problems, including suicide trends.

It will therefore be key for the Government to be consistent in prioritising suicide and mental health across the full range of national and community planning mechanisms. The Strategy is one opportunity to reinforce recognition of societal issues, including isolation across the age ranges, and the role employment and poverty can play in ameliorating the detrimental impact on health and the impact all sectors, groups and individuals can have. As an NHS Board the focus of the Strategy on the NHS is welcome and needs to be balanced with recognising mental health is not just the business of the NHS or just of local authorities.

Following local engagement we also wish to emphasise the following:

Benchmarking, Evidence Based Practice and Clinical Outcome Measures

For benchmarking the Government can sponsor and progress further work in a number of areas. The impact of recession requires to be recognised. It is important to monitor economic indicators as well as changes in health service use and potential adverse health outcomes over the period.

Monitoring the use of primary care, mental health and hospital services, trends in suicide, prevalence of mental distress, health behaviours & overall mortality, and potential secondary effects such as levels of violence and child abuse all need further progress at a national level.

Health indicators are more likely to show long term effects of unemployment and increased inequality. As expected current trends are not yet showing any real impact from the early stages of recession. However the most sensitive indicators to early effects of the recession are likely to be in mental health services. Psychiatric morbidity is found in anticipation of unemployment. The threat of redundancy adversely affects mental well-being. In addition, a year after closure of a workplace the odds are reported to be of higher morbidity for men who are unemployed compared with those who were employed. Re-employment improves this result. There is public health concern of increasing evidence of a reversal in downward suicide trends across Europe as a result of the fear caused by the recession.

The impact of the financial position will aggravate pre-existing inequality so national strategy needs to clarify:

- what action is evidence based in closing the health gap;
- what evidence shows is most effective in how resources can more efficiently tackle inequality;
- what evidence shows are the most effective responses to the recession;
- what evidence shows works best in extending employment and mental health links (including training for users and the potential for payment to users and carers to engage in planning of future services/strategies);
- how the next Health and Well-being Survey and the 2011 Census can be used as indicators to give more information on people's current financial concerns and current health status.

Development of specific national benchmarking of the balance of community and crisis services to hospital inpatient care (based on needs analysis) needs to take account of activity in the NHS and its partners.

National work also needs to be progressed to benchmark the balance of care resource between physical health care and mental health care and not just the balance of care between mental health services in different geographical areas and age ranges. At present benchmarking nationally appears only to be at an "all mental health service level" (any comparisons of adult or older people's services have to be generated locally). National benchmarking also has to develop to be weighted on an agreed consistent basis (e.g. Mental Illness Needs Index (MINI) weighting).

National benchmarking development should also work to take account of relevant population comparisons and not just benchmarked comparisons within and across Scotland (e.g. for Greater Glasgow & Clyde places like Manchester and Liverpool because other areas in Scotland aren't of similar demography, deprivation or size to NHS GG&C).

National benchmarking also needs to develop identifying key dependencies on an interagency basis. The only measure across health and social care organisations appears at present to be the delayed discharge measure. National development of the balance of care between mental health specialties and between community mental health and in-patient health care needs to take account of the development of benchmarking for social care and third sector mental health provision. (This should include identifying independent/private sector benchmarking measures for service delivery and usage).

There are a range of initiatives/mechanisms continuing to develop which are offering techniques and evidence bases, proxy measures, standards, care pathways, outcome measures and other tools relating to services and provision. These include QuEST, Scottish In-patient Safety Programme, Demand Capacity Activity Queue, balanced score cards, Plan Do Study Act, Triangle of Care, Wellness Recovery Action Plan model, and Core Net. Nationally sponsored work to co-ordinate and to provide a recommendation of standardised usage would be welcomed. Identifying an operationally pragmatic preferred national outcome measure, (whilst acknowledging other validated outcome measures) would be welcomed. National procurement of a preferred outcome measure such as CORE Net could be a preferred way forward. This would provide further impetus and coherence to explicit consideration by every of effectiye evidence based approaches and that service staff are competent to deliver them.

Care Pathway

Currently many mental health services are organised as acute wards and specialist community mental health teams to target people with severe and enduring mental health services, whilst primary care and primary care mental health services target lower intensity responses. Rather than establish criteria for accessing a team, the application of a standardised clinical/social pathway would be beneficial in refocusing care whilst allowing local services flexibility regarding how they are organised. The clinical/social pathway can deal with people with the same problems but in accordance to their response to care and treatment.

e.g.

- people who have not responded to two evidence based treatments in a primary care setting or
- people who have not responded to one evidence based treatment and their accommodation or employment are at risk because of their mental health or
- people who have not responded to one evidence based treatment for their mental health and their long terms physical health is affected by their mental health issue will be moved along to the next stage of the care path irrespective of how local services are constructed overall.

Services in the local system will know that after someone has not responded to a specified care response they are moved to the next step in the pathway. This is irrespective of whether or not the same member of staff in the same team continues to deal with them or if another colleague in another team will deliver the next part of the care. The development of a measure for the application of care pathways would be beneficial in standardising care responses.

Health Promotion, ill health prevention, anti-stigma and anti-discrimination

Greater use of inequalities sensitive practice, meeting communication needs of patients and making services accessible for all patient groups is supported. The focus on NHS specialist community services is welcomed, although the deployment of early intervention approaches at an earlier stage than at the point at which specialist NHS mental health services would deploy is also key and this should include links to schools and early life.

In prioritising wider promotion and prevention, de-stigmatization and anti-discrimination the adverse impact of changes to incapacity benefit and income support were outlined previously. Nationally employability and skills interventions will need to impact materially on peoples income if there isn't to be a detrimental impact on mental health. Further support of this nationally would be welcomed.

Some of the Strategy consultation outcomes are wider public health issues, although the related questions are narrow and focus on mental ill health. The existing evidence base in relation to community development and its impact on individual and community mental health and well-being needs to be reviewed. This should include reviewing the growing evidence base for asset based approaches, building individual & community resilience, and active input by the people who use services (the skills, expertise and mutual support that service users can contribute to effective public services).

The See Me Campaign has been welcomed and national support of further positive role models including celebrities should be explored.

Providing services across organisational boundaries

Providing services across organisational boundaries is a priority for the Mental Health Strategy as well as within the Government's response to the Christie Commission Report. National recognition and reinforcement of the ingredients of success in developing partnerships is required and are reported to include agreeing at an organisational level the:

- non-negotiable issues straight away, including creating acceptance of varied terms and conditions of service for staff;
- key handover points and dependencies,
- areas of demarcation;
- setting out each organisations statutory duties and powers surrounding their delivery of services; and
- impact on contractual and overall service delivery.

All parties will need to ensure risk lies where it best falls, even though the key objective will be that none of the organisational boundaries are evident to a service user. Integrating services should produce pooled budgets subject to recognition of the ingredients of success above. Appointment of a joint general manager and joint managers at the lowest possible level of supervision can only work if the existing structures they are meant to replace are dismantled. The importance of benchmarking and care pathways which span organisational boundaries and which are inclusive of users and carers and third and independent sector care as outlined earlier requires to be recognised and developed as part of nationally sponsored work.

Equally identification nationally of the evidence of the components of successful collaborative working between services provided within a single organisation for people with dual diagnoses of mental health and/or addictions and/or physical health issues should be progressed.

Training

A further area for national guidance is the level of proficiency required for post training supervision and accreditation. The expansion of training opportunities for staff is supported and in keeping with such developments greater clarity around a set of nationally recognised requirements for service supported supervision requirements would be welcomed, e.g. supervision standards for the range of psychological therapy training.

Training nationally would be necessary for any national sponsored/recognised benchmark or outcome measure including for any National procurement of a preferred outcome measure such as CORE Net.

Training support nationally would also be welcomed for initiatives such as the Scottish Recovery Network. Further national support of training on routine sharing of information with users and carers and care partners is supported. National training support for specific dual diagnosis areas as well as for transition care for children to adults and for transition care for adults as they get older would also be welcomed.

A review of mental health content (across the full age range) on national undergraduate and post-graduate medical, nursing, psychology, social work and G.P. training course would be an opportunity for further modernisation. This should also include consideration nationally of a brief training protocol for GP's on mental health enhanced by case by case consultation, ongoing feedback and joint work with primary care mental health service responses.

National training priorities and support should be targeted and linked to development of national recognition of preferred evidence based care. National consideration should be given to clarifying the interaction between key legislation (Mental Health Scotland Act 2003, Adults with Incapacity Scotland Act 2000 and Adult Support and Protection Scotland Act 2007).

User and carer input is a recognised key component of care and care/service planning. National consideration of specific training for users, carers and staff engaging with each other both for treatment and separately for service planning would be welcomed.

Forensic Psychiatry Estate Review
Specific to Forensic services, with the re-provisibn of The State Hospital and the impending completion of the third and final medium secure service for the North of Scotland, the time is right to review the numbers, configuration and function of the forensic estate tp ensure that effective patient flow is facilitated in the years ahead.

Other oriorities
The Strategy referenced a number of existing plans, standards, indicators and policy initiatives, and recognition of "Shaping Bereavement Care – a framework for action" would add to the comprehensiveness of those listed.

Areas which were also highlighted locally as benefiting from clearer relative prioritisation included autistic spectrum disorder for people who do not have a generalised learning disability, interagency working for people with personality disorder, attention deficit hyperactive disorder, people with dual diagnosis and long term conditions (including raised risks for people with stroke, myocardial infarction, cancer, any brain injury and people with hearing impairment), and mental health screening for older people.

Yours sincerely

[redacted]

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