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.

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.

Implement a change/breakdown of "attitudinal" issues across Mental Health services via a national drive/Policy that will help to focus/change staff/individuals perceived perceptions, attitudes, labelling, inappropriate language and collusion.

Specifically with the re-structuring of mental health services into more community based services, there is an opportunity to join up with other partners in identifying and responding to the needs of those people diagnosed with a mental health problems.

Early education and prevention such as the Citizenship module within schools would support skills development, address stigma and discrimination and also address what is a recognised differential in the way in which males and females communicate or facilitate supports available to help address any issues that they may be facing. This would help facilitate a fundamental culture change in opening up discussion and communication, self-awareness and awareness of when

peers may themselves be experiencing distress

Joint working, training, shadowing at operational service provision level, this would include services who share clients, as the issues cut across service provision.

Local network seminars where information, experience and skills can be shared alongside netwprk opportunities.

A holistic response including universal services that may be crucial in early identification, and in supporting or maintaining structure and routine.

Use of person-centred models in planning to ensure, where possible, empowerment is maintained even during times of intense illness, and that each part of the 'service provision continuum' is aware of their roles and responsibilities and where services can compliment rather than duplicate effort. This would offer a cost effective response, as developing community networks locally could be done effectively within existing resources and would heighten understanding that all services are responsible for recovery, with joint working and communication providing a powerful platform for support and recovery.

Any proposed action needs to be reflective of what works well and importantly, supported where required, via ringfenced resources to ensure effective local delivery and successful outcomes for individuals.

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.

Review and implement services which are outcome-focused and offer choice, control and flexibility to individuals.

Services should lean towards a recovery-focussed agenda and work in partnership with other services/agencies including housing to ensure/remain responsive to all local needs.

Additional supports such as Care Management and the resources needed to support this function must be made available.

Potential to join up strategic partnerships and share outcomes i.e. Alcohol and Drug Partnerships and Mental Health Partnerships. This would give strategic direction to the operational cross-boundary working identified above.

Engagement and commitment with housing partners re a recognised lack of emergency accommodation for these individuals.

Emphasis of the powers under the new Equality Act 2010: individuals suffering from depression are identified as having a 'protected characteristic' and as such there is legislative support against discrimination within this.

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?

There needs to be a much closer alignment between clinical activity within adult mental health and multi-agency intervention led by local authorities under Adult Support & Protection. The Scottish Government report 'Responding to Self Harm in Scotland' made no mention of the need for all professionals to consider intervention under ASPA where there is a risk of self harm and someone has a mental disorder. Notwithstanding the limited powers available under ASPA the whole range of potential interventions – including those under Adults with Incapacity which can determine for example where and with whom someone resides – should be formally considered within a multi-disciplinary meeting given the limitations of all statutes including the Mental Health Act where someone does not have a 'treatable' condition and the variations in the use of and effectiveness of the Care Programme Approach.

Possible introduction of national campaigns (tv ads/local papers etc) at specific times of year i.e. Xmas to help raise awareness and highlight/offer national and local support networks available.

Introduce mandatory training (Assist/Safetalk) across Education/SW/Health/Vol Orgs as an aid to raise overall awareness and provide a skill base/ level of expertise in this challenging area.

Provide access to all local leisure activities with reduced rates/free of charge entry, thus negating any such current barriers.

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

Make better reference to: social capital, social networking and a "more inclusive society by continually highlighting/ promoting, at national and local levels – fronted where/if possible by prominent individuals who themselves have suffered from mental health difficulties as this can make it easier to understand/accept. It s important that influence is brought to bear on all sections of the media. The importance of the national See Me campaign should be emphasised.

Ensure that from an early age, good Mental Health is inextricably linked into the education curriculum and is supplemented via a variety of information, support networks etc. We should also adopt an inter-generational approach to communicating accurate messages to reduce stigma

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?

Continue to reinforce the anti-stigma message across all sectors. This can be done via
- Local annual events to re-inforce/learn/engage
- Mandatory training for all relevant staff
- Commissioned Services – core clauses/Performance indicators - measure actions taken to reduce discrimination
- identification of MH champions at political, organisational and community levels.
- Engagement of service users as positive role models of recovery in campaigns and publicity
- Engagement of service users in strategic planning partnerships.
- Engagement of high profile figures who have disclosed their own experiences of mental ill health and how they overcame this.

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

The action research carried out by IRISS in conjunction with East Dunbartonshire Council during 2011 provides a model to be built on here and elsewhere. It emphasises the 'community assets' approach to participate with service users in highlighting resources within a community to promote mental well-being and assist in recovery. This resource is then available to all residents including use as a preventative or early intervention tool. Other actions include: greater usage of Social Media (Twitter, Facebook, web sites/Text messaging) – Championing Recovery, the inclusion of mental health as a priority across cross cutting strategic groups ; joining up of strategic aims and outcomes ; reduction of barriers and boundaries in current practice ; positive imagery of recovery and self-management, capitalise on the gains which 'see me' made in a very high profile way ; normalising of issue. Given prevalence, many people will either experience or be affected by i.e. a family member, friend's mental ill health at some point. Inclusion of a holistic approach at cultural, community and institutional levels. Rounded message that professionals, families and communities need to work together to assume personal and collective responsibility with responses in kind.

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?

Learn the lessons from previous child death enquiries and work to GIRFEC principles; ensuring all staff know it is their job "to make sure children are alright". We need to improve interagency training, assessment and care planning: too many young people do not get a service or are diagnosed with a condition which health services will not treat. Young people who self harm or have been victims of abuse require a more co-ordinated support plan. Too many young people have been placed in a secure unit as they may present a danger to themselves but cannot be offered in-patient health services. They then are then exposed to criminality. Health staff need to be better engaged in and skilled at skilled at risk assessment and management.

There is currently a significant difficulty in accessing a CAMHS service for young people including the very vulnerable young people who are accommodated. Waiting timescales are lengthy.

There requires to be more integrated working to ensure maximising of resources and using key staff to support assessment and interventions across agencies rather than waiting for a one-off appointment.

The issues of mental health requires to be seen in a wider context and responses aimed to reflect the need rather than applying a limited interpretation of a diagnosable/treatable illness before CAMHS staff engage in direct work. Factors such as obvious ongoing distress and chaotic self-destructive self-harming behaviours need to acknowledged and addressed within the clinical frome and not relegated to the position of being control issues.

Quesfion 8: What additional national support do NHS Boards need to support implementatiph of the HEAT target on access to specialist 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.

Make local/national service more accessible/less bureaucratic.

Implement Self Directed Support as the basis of this. Ensure that this approach is truly outcome-focussed and places responsibility for individual budgets (if required) with the individual.

Clearly identify and communicate an individual's outcomes and pathways to treatment - recovery and put more emphasis on carers – ensure that sufficient support is available to and for them. We should also raise awareness of positive mental health and well being in order to maintain non-medicalised approaches to support, such as peer and family supports

Provide better, more visible easy access to a range of easily understood self help approaches, which include non-clinical and clinical approaches that do not just focus on illness, but the wider needs of the individual. Asset-based approaches need developed and evaluated for effectiveness. Proactive effort should be made to understand why there are high drop out rates for some services. Further investigation should be undertaken of the barriers that affect service users taking action.

Development of Peer Support within Community Mental Health Teams. Development of their role to promote WRAPS planning, Advance and Personal Statements and taking this forward more consistently and systematically.

Future development of supported volunteer peer support workers.
Development of links with voluntary sector supports locally to make services more fluid and less boundary-defined.

Development of much more systematic links with service user groups both local ad national, advocacy services, Peers support projects and potentially bringing them much closer together, with closer links / sense of joined up support, and easier access to preventative / primary care assistance.

Development of self help / web based materials locally focussed and centred on localities with links to services specific to this area.

Use of technology more widely.

Publicity within local community, utilisation of varied approaches; press, post office, mail drops with council tax information, payslip, billboards....

Consideration of targeted approach towards specific groups of people who use Mental Health services. Across East Dunbartonshire Council area there are approximately 700 – 900 people involved with secondary mental health services, and potentially three to four times that number who receive help for mental health related problems or illness from their GPs. There needs to be clearer and more open access to a range of easily understood self help approaches, which include non-clinical and clinical approaches that do hot just focus on illness, but the wider needs of the individual.

Building upon the Asset Mapping and service user engagement with this process, developing a more comprehensive and consistent approach to ensure broad service user involvement in the mental health system locally.

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?

Easier access to Primary Care Mental Health Services and better use of existing health links. Enhanced opportunities for self referral and opt-in services. Current GP referral route can deter and ensure that people do not seek the help they need at an earlier stage. As dementia affects many older people identifying opportunities for cognitive screening within the patient's current health system is useful. For example using the 4 item abbreviated mental test when a patient is in contact with their District Nurse.

Stigma and discrimination remain fundamentally important challenges to tackle with regard to mental health and continue to be significant barriers for people to access the help they need when they need it. Medical model of treatment and referral accessed through GP can deter, and there remains a reluctance to seek help from formal medical route. Further development of preventative and less formalised treatment / support is required to ensure greater access to services which is focussed away from a formal medical diagnosis and treatment to ensure that it's not a position of last resort. The Community Dementia Advisory Clinics developed in East Dunbartonshire are one such example. For Mental Health generally, informal drop-in services, advice sessions, well-being centred approach, stress / anxiety / challenges of modern life, didactic group work as opposed to more diagnostically focussed approaches.

Continued focus on challenging attitudes / language which reinforce stigma surrounding mental ill-health, and ageist attitudes related to dementia which needs to be reinforced within mental health and related services; formal part of induction for new staff local authority / NHS.

Wider enhanced mental health diagnosis across adults aged over 65 is required to promote treatment and recovery within this group.

Enhanced multi agency protocols across statutory agencies, police / emergency services, housing, local authority. There are some good local models in East Dunbartonshire i.e. Housing / Mental Health Protocol.

Local services for black and minority ethnic people with mental health issues and dementia needs must also be available. East Dunbartonshire are currently developing such a service referred to as the BME Dementia Advisory clinic. This initiative works along with other health awareness campaigns such as heart disease and stroke to encourage attendance as part of a wider health initiative. Materials that meet the information needs of lesbian, gay and bisexual people especially older people are also being developed.

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?

There needs to be a strong focus on what works and this need to take account of long term recovery and wellbeing imperatives instead of the sterile approach that measures success

according to referral to and discharge from service. Direct engagement with the views and experiences of service users, both individually and collectively is vital if a truly 'evidence-based' approach is to be developed. An accurate and effective integrated resource framework should be developed enabling clear understanding of the disposition of resources across the tiers. A move to a more asset-based model will require that the way some resources are currently embedded within acute areas is examined and these resources made more flexible and transactable.

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

ICPs have been developed internally by the NHS and in addition to the delays in their full implementation locally the stated objective to create this as a cross-disciplinary approach has not materialised. This is in contrast to the Integrated Assessment Framework for working with children which was developed for use by health and social work practitioners. Although Single Shared Assessment is embedded locally within the joint team approaches to assessment and support management have otherwise increasingly diverged – with ICP retaining a fundamentally clinical leaning and Social Work reinventing itself around an outcome-focused and self-directed support focus.

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?

We need to ensure that all redesign processes have service user involvement built in as standard. This requires that effective standing processes be developed and that engagement is not simply on an 'as and when' basis. Capacity needs to be built into service user process. This means training and empowerment. Consideration should be given to paying service users to attend and represent that perspective in planning discussions

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

Effective planning processes must reflect the engagement of all key interests and stakeholders. Joined up planning processes should ensure that there is a seamless cross-care group focus that maximises engagement and impact. For example, there is a Carers Planning Group in East Dunbartonshire and there is a well established user-led Association for Mental Health. Forums such as these should be empowered to input to and influence service developments and priorities 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?

There needs to be greater emphasis placed on soliciting, recording and acting upon the views and experiences of service users. The development of outcome-focussed assessment practices is an important step. The tailoring of the Talking Points approach pioneered in Older People services should be considered. The promotion of the personalisation agenda, through greater uptake of self directed support is important.

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

Information about the indicator needs to be widely disseminated. A national programme of training to support the roll out should be considered. Strong understandable exemplars of recovery need to be promoted. This should involve service users witnessing their own recovery into events that promote awareness and understanding.

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

As above, the involvement and testimony of those who have recovered or are on the road to recovery is a key resource. There should be a link up with asset-based work to broaden the landscape within which recovery can be nurtured and supported. The involvement locally of user-led organisations is key. In this regard a common agenda should be developed across addictions and mental health service developments. In East Dunbartonshire a Community Allotment Project with a strong therapeutic recovery-focused service element is about to be commissioned. This will provide practical support to recovery across these client 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?

The starting point is for services to strive to engage with families and carers as equal partners in care. This includes completion of carer's assessments and response to needs.

Tensions remain in balancing right to confidentiality about illness and treatment and importance of carers and families and their involvement in the person's recovery, and this will remain an individual choice. Greater preparation and explicit planning with people known to services could make this much easier and clearer; greater preparation of Advanced statements, nomination of Named Persons, preparation of WRAP plans which explicitly set out who someone would want to be involved with their treatment and care could be valuable tools not just to ensure that the right people are included, but also to ensure that their role is respected and strengthened by greater explicit forward planning.

Often it is the Carer who spends the most time with the person needing care, they know a lot about the person's behavior and the ways the illness is affecting them.

At times the cared for person (service-user) may not always give a true representation of their illness or may even refuse treatment or support as they do not see themselves as having an illness. It is therefore vital that the Carer is given opportunity to comment and to share experiences or viewpoints.

Carers worry whether their support is helping or exacerbating the person's condition and/or the situation. Reassurance and understanding will reduce their worry and making it easier to help effectively. Such involvement of the Carer can be vital to the recovery of the service user.

Sometimes however, the Carer may not know how serious the illness is, what the symptoms are, and how serious the symptoms may be and consequently may not feel comfortable contacting professionals.

Having Carers involved can also help their own mental health and coping strategies which subsequently aids the recovery of the cared for.

Within East Dunbartonshire, there is a dedicated Peer Support and Advocacy Worker for Carers. Experience has shown that where there is close working relationships between all involved, there is a more positive outcome for the family.

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?

Basic training across mental ill health issues, raising awareness of locally available supports and suicide prevention should be included for all new local authority and NHS staff to enhance their confidence to be able to sign post families and carers towards.

Greater use of intranet and IT systems to ensure that locally available supports such as Carers Link, EDAMH, Connections are much more systematically advertised and flagged up to all EDC based staff. Use of occasional Email drops to all staff.

It is appreciated that confidentially is important however although professionals may not be able to give specific information about the person, they could give general advice that may help. This may be a potential training or discussion issue, or perhaps even simple guidelines could be given.

As mentioned previously, Carers can feel lost and isolated when they don't receive information and advice from the professionals to help them support the person they care for and to maintain their own mental health.

Staff may already be aware of the stress and strain that Carers are under, but possibly more awareness raising could highlight the impact caring for someone with a can have, and how a little bit of support/information can help dramatically.

We need to consider the times at which we deliver services. If community service are delivering largely 9-5 services, does this represent a barrier to working with some families and 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?

There needs to be consistent approaches to capturing and sharing clinical data and more recovery and wellbeing-focused performance information. Make best use of existing data sets such as HEAT target reporting and the 'Balanced Scorecard' currently in use across NHSGG&C.

There are existing networks/forums such including the National Crisis Network, the National Mental Health Improvement Network and the NHSGG&C Mental Health Improvement Network which are useful sources of knowledge and expertise as well as benchmarking opportunities.

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?

We need to ensure that there is consistent use of a core national data set that can be interrogated to inform redesign of services where access issues are identified. There needs to be clear pathways that can quickly and visibly be identified by those who might require supports (and their carers).Consistent Mental Health promotion and anti-stigma work must underpin any approaches. Particular focus is required on the mental health needs of the BME and migrant populations. Cultural and religious sensitivity should not be a barrier to making information about morbidity and services available. Again anti-stigma work is vital. Proactive, specific work should be undertaken to address the mental health needs of the LGBT population. As well as specialist services such as Sexual Health clinics, mainstream primary care and social work services have a key role.

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

As above there are existing professional and clinical networks that can be utilised to reach the workforce. Local partnerships should develop wider information and access strategies and processes that include mental health wellbeing and recovery information as standard

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

Alcohol Related Brain Damage (ARBD) does not feature very much in the strategy. Given the well documented concerns relating to the high levels of alcohol consumption impacting on the community's health (both physically & mentally).

There are gaps in respite care for a range of care groups.

There are no therapeutic community or day service approaches for people with personality disorders.

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?

There should be more reference within the strategy to collaborative, multi agency and stakeholder involvement (including service users and carers). This will have the added benefit of tackling stigma, reduce popular misconceptions about mental health and well being, and ultimately help improve services

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?

The particular needs and vulnerability of people with mental health problems – often with co-existing substance misuse – who become homeless as a result of a loss of a tenancy or relationship breakdown – have been highlighted locally. Although some people in this situation have a history of severe and enduring mental health problems there are a high proportion of individuals with chronic

depression/anxiety or personality disorder/trauma associated with alcohol and/or drug use who are either difficult to engage with or highly demanding of services and who may well exhibit self-harming or parasuicidal behaviour.

There are good examples locally of joint working between health, social work and housing — including protocols around mental health/homelessness and addiction/homelessness plus a Health Housing & Homeless lead for the NHS but much more needs to be done including a major gap in resources around longer-term supported accommodation for those who will be unable to take on or resume an independent tenancy.

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?

A co-ordinated approach to implementation is essential. Local responsibility is required to identify the sites that work with people who have dementia. In East Dunbartonshire the Dementia Network has taken responsibility for this work. Using Transforming Older People change fund monies the following priorities have been identified

1. Promote Diagnosis
2. Post Diagnostic Support
3. Facilitate co-ordinated, effective treatment and support
4. Promote culture change

Local areas should identify single points of contact for SSSC and NES liaison.
A baseline of how teams and organisations measure against the Dementia Standards should be established through local information and self audit.
Each area should identify a dementia champion.
These dementia champions should have a forum to meet to share their experiences.
SSSC advisors should meet with each organisation to assist in identifying which staff require to be up skilled and to what level
National materials to support this should be developed by NES and SSSC
Local areas should ensure that third sector organisations receive support to engage in this process.
Local areas should pool information resources and share across identified networks.
Dementia skills need to be acknowledged in the Knowledge and Skills Framework and PRTL plans.
Feedback should be sought from people with dementia and their carers.

However following all of the above local momentum is required to ensure local champions are knowledgeable, skilled and enthusiastic about their role. In East Dunbartonshire we are developing a dedicated web resource for this purpose as well as the ongoing work of the East Dunbartonshire Dementia Network.

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?

Effective processes that engage and record patient, service user carer and workforce experiences and perspectives should be a standard feature of local and regional service planning and development. There are certain areas where population-wide surveys such as those conducted by the Glasgow Centre for Population Health would be useful, especially in regard to wellbeing. Methodological robustness needs to be paramount.

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

There is a need to ensure that under graduate schemes of health and social care professional education are balanced enough to ensure we are producing practitioners who are fit for practice in a complex care environment.

The broader workforce needs to be considered in the context of a national Mental Health strategy. We need to consider not only the development needs of those working in mental health services, but those of others working for large employers, such as teachers, police etc. We need to think about improving the mental health literacy of the Scottish workforce in general.

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

This question misses ah important point. Any person can go along to a training course but it does mean they are proficient to deliver therapy. Post training supervision is crucial in ensuring our ability to build capacity in this area, and training is only one aspect of this process.

It would be helpful to be clear about the meaning of the word "psychological therapy"

We need to fully understand who in the service is trained in psychological therapies. This means having access to certificates of course completion. Some people may believe they are trained in a psychological therapy but their level of acquired training may not match this belief- this is a clinical/care governance issue that all services need to consider, within and outwith the NHS.

On a practical level, services need to consistently use service improvement methodologies to best understand the demand on services, and the capacity that they have to deliver.

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.

The availability of benchmarking data appears to be largely NHS-derived. There is reference in the consultation report to the development of benchmarking in social care services - it is assumed that this refers to the work of the Scottish Community Care Benchmarking Network, but this is not clear. It would be fair to say that the SCCBN outcomes framework is predominantly older-people-centric in terms of indicator development; it has not developed any substantive mental health-specific indicators within the framework to date. In addition, to consider benchmarking separately by organisation does not capture performance from a whole-systems perspective. It would be beneficial to fully review the mental health performance measurement landscape, and to take a whole-systems approach to performance measurement - to focus energies towards developing a coherent set of indicators that measure the quality of processes and outcomes that span the landscape of territorial input 'ownership'. In this respect, the national reshaping agenda for older people could provide a useful model, as it has generated a set of core performance measures that derive from the strategy, support its implementation and encourage joint accountability.

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

The response to question 31 has relevance here, however given the nature of mental illness and associated therapies, the generation of meaningful outcome information should be built upon

qualitative evaluation at an individual level. This would require the development of clear and consistent models of outcome-focused care and support planning, with individualised reviews and recording of outcome attainment. This represents good practice operationally, but presents challenges in terms of recording and subsequent data aggregation. However, very positive initiatives have been established in some local authorities, using the Talking Points (source: Joint Improvement Team) approach, allied to developments in Management Information Systems. In these areas, very productive and important outcome-focused data is now being produced which is derived directly from the patient/service-user experience, rather than from a clinical input/output perspective.

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?

An approach should be developed that makes mental health everybody's business. Mental health services must become more visible, de-stigmatized and mainstream.

The connections between mental health, addictions and homelessness must be fully explored and prioritised so that people are not excluded from services or, sometimes worse, 'pih-balled' from one service to another with no clear ownership or plan.

The current economic downturn is bound to increase anxieties and impact on the broad sense of wellbeing across the community. Primary care service and frontline social work, housing, benefits advice and debt advice services should be primed and prepared to identify and support.

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

It is vital that this consultation is as broad-based as can be achieved and that it is listened to, and impacts upon the final Mental Health Strategy.

There needs to be clarity around the positipn of Mental Health services, both for adults under 65 and for older people, within the arrangements being developed for integrated heath and social care partnerships.

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?

The consultation document is correct in its aspiration for an integrated legislative framework. Although the three statutes share common principles and do provide broadly complementary and alternative routes to protect individuals it can encourage separate pathways and processes. All three Acts place a duty on local authorities to investigate situations where an adult is thought to be at risk of harm and social workers are probably best placed to work across statutes to find the 'best fit' and are becoming increasingly skilled at doing so.

Health practitioners remain reluctant to report any concerns around a risk to someone with a mental disorder under section 5 of the Adult Support & Protection Act or of the duty of local authorities to investigate such matters either under section 33 of the Mental Health (Care &

Treatment) Act or section 10 of the Adults with Incapacity Act. The extremely low number of referrals locally from health staff under adult protection is mirrored nationally as evidenced by the data collated across Adult protection Committee biennial reports. Training delivered by the NHS to health staff does not appear to have had any significant impact on awareness of referral rates. It would appear that for most adult mental health clinicians the only significant decision continues to be around the applicability of compulsory measures for care and treatment under the Mental Health Act rather than a wider appreciation of the joint task of safeguarding adults at risk notwithstanding the limited powers for formal intervention.

National multi-agency guidance around adult protection and its relation to other legislation would be useful.