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

It is crucial that there is synergy and cohesion between mental health strategy and the *Road To Recovery* drugs strategy. This is vital as the effective delivery of both strategies requires that the needs of problem drug users with mental health problems are recognised and addressed effectively. There are other related strategies, including alcohol and housing which need to articulate with the mental health strategy in order to ensure delivery.

A number of reports have highlighted the need for more joined-up practice including *Mind The Gaps 2003 and Closing the Gaps - Making a Difference 2007. The 2007 report suggested that little had changed between 2003 and 2007 and our sense is that a similar situation applies now to the 2007 report.*

Seryice delivery to dual diagnosis / co-morbid clients continues to be challenging with pockets of good practice but significant areas where practice falls short of what shpuld be expected. A more proactive approach by Government to changing practice on the ground is required.

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.

Alcohol and Drug Partnerships (ADPs) could be charged specifically to explore the needs of dual diagnosis clients to ensure that their needs are being met effectively and where these needs are not being met, to ensure adequate service provision is developed.

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 heeded to identify exactly what heeds 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.

In the case of problem drug use, the link between problem drug use and mental health is well evidenced. As well as mental health being a cause of people becoming engaged in problem drug use, the lifestyle often associated with problem drug use can involve further trauma and alienation which can cause or complicate mental health problems.

Despite this understanding, mental health services continue to be routinely denied to drug users. Assessment often fails to identify mental health issues and where mental health issues are identified, clients are often not referred to mental health services. When clients are referred, the service received is often unsatisfactory. The lack of joined up practice between drug treatment services and mental health services is problematic due to

- lack of functional protocols
- tack of staff training
- stigma
- unwillingness of some mental health services to work with problem drug users

Given these barriers, drug service staff are discouraged from identifying potential mental health issues or referring their clients.

This situation has a detrimental effect on the efficiency and effectiveness of both mental health and drug treatment services – as well as to the people affected, their friends, families and communities.

Improvements are clearly needed in joint working between drug and mental health services and staff, based in clear functional protocols with good staff understanding and relationships based on joint training.

Drug service clients should have advocacy support when engaging with

mental health services.

The document *Mental Health in Scotland closing the gaps – making a difference* (Scottish Government 2007) outlines how many of these issues could be addressed.

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?

Scottish Drugs Forum's research, undertaken with European partners and funded by the European Commission through the Executive Agency for Health and Consumers, provides evidence of the needs of older drug users.

A clear picture emerges of a subgroup of older drug users who are traumatised; socially isolated; frequently ambivalent about whether they live or die; semi engaged, if engaged at all, with services; with varying levels of mental health problems.

The risk of drug-related death among this group is high. While intention is difficult to determine some overdose deaths among this group are likely to be suicides whether they are counted in these figures or not.

A service focus on this group's mental health and other support needs is long overdue. Nationally this group should be prioritised and Alcohol and Drug Partnerships should be asked to report on the size of the over 35 problem drug using population, its needs and how these are being addressed particularly with regard to their mental health.

National Confidential inquiry into Suicide and Homicide by People with a Mental Health Problem - Lessons for mental health care in Scotland commissioned by the Scottish Government in 2008 recommended that "specialist community mental health teams providing an outreach service for patients who are at risk of losing contact with care" – this is a good place to start suicide and self harm amongst people who are known to care services.

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

The action to reduce stigma in mental health through the 'See Me' campaign is to be applauded. Seeing beyond diagnosis labels of schizophrenic, depressive etc is an innovative approach. This could be extended to the term 'addict'.

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?

Stigma is a complex issue and it is inappropriate to ask services to develop means to address stigma without providing adequate support to do so. There can be unintended consequences of poorly developed initiatives around stigma. For example attempts to reduce the stigma on one group of drug users (those in stable recovery) may inadvertently further stigmatise 'chaotic' drug users in ways which may make them less likely to engage with treatment services.

Services themselves reflect the attitudes and values of the society in which they develop and of the community which they serve. Problem drug users frequently refer to the stigma they face from services including mental health seryices. Services are themselves stigmatised within their sectors and within their communities. This should be acknowledged and addressed.

Question 6: What other actions should we be taking to support promotion of mental wellbeing for ihdividuals and withih cdmmunities?

Comments

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?

Dual diagnosis within families is sadly not restricted to one generation. In many cases problems become more entrenched with each generation. Therefore early intervention is crucial for children of parents with drug or alcohol problems. A proportion of these children will have mental health problems and therefore should be the target and focus for CAMHS.

There are specific barriers to this population accessing CAMHS and that in the absence of active parental support in engaging with CAMHS these children should be adequately supported to attend.

National Confidential Inquiry Into Suicide and Homicide by People with a Mental Health Problem - Lessons for mental health care in Scotland commissioned by the Scottish Government in 2008 recommended that there should be "improved mental health services for young people,

providing better access and early intervention" – this remains an aspiration.

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

The HEAT target of 26 weeks needs to be reduced. In addition work needs to be undertaken to identify whether children affected by parental drug use with mental health problems are being have adequate 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.

Question 9: What further aetion do we need to take to enable people to take actions themselyes tp maintain and improve their mental health?

This question is apposite to -

- drug users

  Whether mental health issues are a cause or a consequence of problem drug use, the extent to which mental health issues can be addressed affects the extent and nature of people's drug use. While an obvious vicious cycle is possible a virtuous cycle can also be set in place.

- drug users in recovery

  The addiction and relapse model can mask the extent to which mental health issues cause relapse in drug users. in recovery. Hqwever the connection is an obvious one. Engagement with positive and high quality mental health services can support recovery in drug users.

- those affected by their drug use including partners, family and friends.

  In their role as supporters, advocates and /or carers the good mental health of these people is important to drug users as well as to the individuals.

Measures to monitor and maintain good mental health are hard for people in these groups to prioritise in face of more immediate needs. It is likely that significant intervention and prompting will be required. This is most likely to be effective where it comes through services with which people are engaged – GP health services, social work etc. Prompts, awareness-raising and training to take such actions should therefore be based in generic services.

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

While the characteristics and needs of these groups may be very different, it will be a significant challenge to ensure that they seek help when necessary and that that help is available. The best encouragement we could have to engagement with services would be to have accessible high quality appropriate services that welcome and support people who are problem drug users the purpose and suitability of which was self-evident to potential users.

As regards the groups identified in question 9 - drug users, drug users in recovery those affected by drug use including partners, family and friends, mental health services should be explicitly described and offered to these groups. This is most likely to be achieved through the marketing of services, through signposting and through services with which people are already engaged and with whom they have a good relationship – possibly drug treatment and care services, GPs, family support groups for example

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?

For drug users this is the fundamental question. As a society we have a high rate of engagement in drug services amongst problem drug users. However, given the mental health profile of this group engagement with mental health services or co-morbidity services is relatively low. This means that mental health needs are not being met. If we are to have whole-person approach to treatment it must include access mental health specialists. This situation has a detrimental effect on the efficiency and effectiveness of both mental health and drug treatment services – as well as to the people affected, their friends, families and communities.

Improvements are clearly needed in joint working between drug and mental health services and staff, based in clear functional protocols where good staff understanding and relationships based on joint training. Drug service clients should have advocacy when engaging with mental health services.

User involvement in the design and delivery of services for drug users with mental health problems should inform the design pf local protocols for joint working or the development of joint co-morbidity services.

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?

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

The Integrated Care Pathways for schizophrenia, depression, BPD, dementia and bipolar disorder are well-defined. A similar ICP for co-morbid mental health and substance misuse patients could be developed. Putting this into practice would be assisted by specific outcome indicators regarding the engagement, retention and outcomes for co-morbid, dual diagnosis patients were compared with those for 'single diagnosis' patients.

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 csre provided?

Scottish Drugs Forum welcomes the statement of intent regarding service user involvement in service design and delivery and in care provided. Unfortunately in a mental health context drug users are likely to be excluded from attempts to involve service users as there is a perception that they will be difficult to engage in user involvement activity.

SDF has a track record of effective user involvement using a variety of methods. Peer-to-peer interviewing formed part of the field work for our research on older drug users and their needs including mental health needs. SDF would be happy to share this research and to contribute further to the understanding around the mental health service needs of problem drug users.

SDF's National Quality Development Team involves service users in the development of drug services and is interested in exploring user perceptions and experiences of the interfaces with mental health services and how these may be improved.

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

Mutually beneficial partnerships are most likely where there is a clear understanding of the benefits to be derived from partnerships by each stakeholder and where all partners feel their contribution is valued and beneficial.

The monitoring of mental health and the feedback to partners when there is a change is an obvious role for all partners a conduit for doing this and agreed actions and roles for each partner as part of a mutually agreed action plan will ease dealing with transitions in mental health.

For drug using service users these partnerships can become difficult for all partners but especially staff. A lack of resources for co-morbidity and under-developed protocols to deliver quality services mean that such service users are left engaging with drug services that are unable to identify and address mental health problems nor to make a satisfactory referral to those who could.

The development of protocols which would allow drug service users to receive appropriate mental health services should be prioritised – this would involve a means by which service users, families, carers and staff could monitor changes in mental health and drug use and communicate these effectively allowing a pre-prepared action plan to be implemented. Of course this could only be done with consent.

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?

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

There needs to be synergy between indicators of mental health recovery and those for people with drug or alcohol problems as has been described there is considerable overlap with these populations.

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

SDF will continue working with Scottish Recbvery Network in exploring how this is done. Joint work is being undertaken in the area of developing peer

work roles.

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?

Whatever means are developed for the involvement of families and carers in care and treatment should be compatible with the involvement of the families and carers of problem drug users in their mental health care and treatment. There is a potential issue with all service users as to the appropriateness of family and carer involvement and issues of confidentiality but this has to be assessed on a case by case basis and not on the basis of ideology or a 'rights' basis.

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?

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?

Such definitions of what 'works' are difficult. Any attempt at such definition should involve service users and people affected by mental health issues including problem drug users.

Any such picture must include the perceptions, opinions and experiences people affected by mental health issues and not only users of the services mentioned. Otherwise there is a real danger that those who have benefitted from these services are the only voices heard. It is important to hear those who could have but did not use services.

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?

Access to mental health services by people who are problem drug users and the experiences of such people in using these services are long term issues which have not been satisfactorily resolved.

SDF's own research on older drug users' needs confirm that there are people with longstanding drug and mental health issues who have not received treatment or even proper assessment who are self-medicating with street drugs. These socially isolated older drug users are in poor mental and physical health and at high risk of death, particularly through overdose.

An audit of statutory sector drug service clients to determine the number actively involved with mental health services would be a good benchmark for how much the reach of mental health services could be extended.

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?

Service for problem drug users with mental health problems is a glaring gap in provision and impacts on the effectiveness of drug treatment services. Working practices that excluded drug users from mental health assessment and treatment have been breached but this barrier is largely intact. Problem drug use is strongly linked to having a mental health problem. Poor mental health can cause problem drug use and problem drug use and the stigma and lifestyle that often accompanies it can complicate or cause mental health problems.

A recent report (*Mental health substance misuse and suicide prevention research* – NHS Greater Glasgow and Clyde and Renfrewshire ADP) offers an insight into some of the barriers.

- Poor staff attitudes
- Poor accessibility

- Staff ignorance of the care pathway available to this client group
- Mental health service criteria strictly applied explicitly excluding drug users with mental health problems
- Refusal to carry out regular assessment means that changes in clients' capacity go unrecorded. This affects access to supports
- Rigid funding regimes mean that funding does not follow client and some supports remain unavailable to the client.
- Voluntary sector ability to lead or call a case conference (or even participate in one) is limited in some areas due to statutory sector attitudes
- Although single shared assessments have been developed the sharing of these and the extent to which they are accepted is very limited in some areas and in some areas they are not used at all.
- Clients' chaotic lifestyle means that they cannot maintain regular contact with mental health services and consequently staff regard them as uncommitted to addressing their mental health.

The report describes problems with the Care Pathway for such patients.

- The vbluntary sector services are sometimes excluded by other agencies who will not refer to them or prefer not to refer to a voluntary sector partner.
- Follow-oh protocols not in place for example at A&E services.
- Mental health services give drug users a 'excluding' diagnosis which means that they have no service to offer and can sever links with the patient. (Bi polar disorder is given as an example of such a diagnosis).
- Lack of a place of safety in emergency- easy access homeless accommodation has been closed in many areas in meeting 2012 homelessness targets
- There is a reluctance by mental health staff to accept referrals of clients with drug issues. Clients are routinely referred back with no mental health assessment having been undertaken.
- A patchwork of service delivery standards and practice dependent on geographical area meahs that A&E acute and community health services deliver a non-standardised service across Glasgow never mind Scotland! This is hard to justify on the basis of evidence-based practice or even resource availability but seems to be based on historic work practices and systems of work.

All of this represents a significant gap in provision and this addressing this should be a focus for the strategy.

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?

Alcohol and Drug Partnerships should have the effectiveness of joint work with mental health services and the delivery of quality mental health services to problem drug users as a measurement of their work on which they should be required to report to Government

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 pf providing an integrated apprpach to mental health service delivery?

Mental health services for problem drug users should be a national priority. The aspiration to integrate services but substance misuse services are, generally speaking, a long way from being integrated with mental health services either through joint

A recent report (*Mental health substance misuse and suicide prevention research* – NHS Greater Glasgow and Clyde and Renfrewshire ADP) offers an insight into some of the barriers and is worth reading in this context.

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?

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?

Surveying those drug services who provide mental health interventions as described in the Directory of Drug Services in Scotland as regards their training and info needs would be a useful exercise

A survey should be conducted as to drug service user experiences of

- Assessment in drug services (as regards mental health)
- Referral to mental health services
- Engagement with mental health services

A survey of ADP membership strategy and action plan documents to see the extent to which they have accounted for partnership with mental health services and a mirroring survey of staff and service users experience in this

regard would be useful.

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

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.

An audit of statutory sector drug service clients to determine the number actively involved with mental health services would be a good benchmark for the reach of mental health services could be extended.

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

Comments

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?

The development of co-morbidity services and improved interface between drug and mental health services.

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

The Government should lead on the emphasis to Alcohol and Drug Partnerships on the prioritising of mental health and the provision of adequate services and ADP's should report on the effectiveness of local services in this regard.

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?