

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

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.

Comments

I agree that these challenges and issues are very important. These issues are faced with boundaries between Social Care, Education, Health, the Third and Private sectors in my field of mental health for children and young people with Learning Disabilities. Here Health Services should provide assessment and treatment (in it's broadest sense) of Mental Health problems, including where appropriate, 'Challenging Behaviour'. Social Care should provide support for children, young people and their families to enable social inclusion and development opportunities for the individuals and respite for families. Education is crucial in the child/young person's learning and development. Both the Social Care and Education input also of course have a therapeutic aspect from the Mental Health perspective and these 3 cannot be easily separated in reality. Community Child Health

Services also play a key role.

For these young people, I don't think it is so much redesigning the boundaries of who does what on the ground, although there are clearly significant overlaps in the roles of different agencies (e.g. in the provision of 'Tier 2' mental health input to which all contribute as well as giving support and information to families). It is rather important to recognise the impact of services or lack of services from one of these agencies on another. The separate planning and budgets for Health Education and Social Care locally and nationally can effectively hide gaps in services and prevent needs being met in the most helpful way for children/young people and their families and in the most cost-effective way for the overall public purse.

For example, it is now being recognised that mental health services for children and young people with Learning Disabilities are very patchy and poorly developed in Scotland and there are significant access difficulties for this group across the Tiers. The outcome of unmet mental health needs rarely impacts on local CAMHS services, who may either exclude these children overtly or effectively (through lack of expertise/appropriate services). Children with highly complex and severe mental health needs may be expected to be managed by Paediatricians who do not have the training or multidisciplinary resources to properly meet their needs. This risks lack of recognition/appropriate diagnosis and in some cases inappropriate prescribing of psychotropic medication.

Escalating behaviour problems are often 'contained' by increasingly restrictive and expensive care packages and educational placements, including out of area residential schools. Even these may not have access to specialist LD CAMHS services so children/young people may reach and remain in these services without access to appropriate mental health assessment and treatment. In addition to the obvious negative impact on the children/young people and their families, the financial impact is felt mostly by Social Care and Education budgets. There is little financial incentive therefore within current funding arrangements for NHS Boards for investment in mental health services for this group of children, as the gain is likely to be most felt in Council budgets. Improving Child and Adolescent Mental Health Services for those with Learning Disability should also lead to a saving to Health Budgets for Adult LD services, or at the very least provide better, more local provision and a better quality of life for people at the same cost. However, even this degree of joined up thinking and planning between Children and Adult services within Health Boards is lacking.

The Government could help in a number of ways. Firstly, some clear thinking at a strategic level about what is Health and what is Social Care and what is Education, prior to simply going ahead and merging budgets/management. Some elements will cut across boundaries, such as early intervention with parenting (including behaviour and sleep management). A Health element is crucial to this group, even at this basic level due to the high levels of complexity and physical and mental health co-morbidities. Once problems have reached Tier 3-4 level, specialist and skilled mental health assessment and intervention can delineate the problem clearly, treat the medically treatable elements and advise on

behavioural, communication, sensory, and environmental strategies. There is some audit-level evidence available as to the impact of service models (for example the Leicester LD CAMHS Intensive Outreach Service preventing out of area placements). This type of evidence needs to be sought and collated nationally in Scotland and pilots of such innovative service models supported and outcomes measured. Allowing for local variation based on geography and demographics, a small country like Scotland should be able to share experiences and develop services in a co-ordinated and planned way without different areas having to constantly 'reinvent the wheel'. In my experience, professionals too often use 'local cultural & demographic differences/regional variation' as an excuse for poor services or to deny the need to make changes to the way things have always been done. Many services have developed the way they have for historic reasons based on local service provision or interests or views of particular clinicians, leading to vastly different services across what is a small country. Health service research, including the development and use of appropriate outcomes measures needs to be commissioned and supported at a national level. As outlined above, outcomes of mental health services are seen across agencies and this must be taken into account.

Children with Learning Disability are an ideal group to look at in terms of piloting new ways of interagency working. They have high levels of inter-related physical and mental health needs as well as educational and social care needs. There is a high cost of doing nothing to whole public purse as well as to the children and families concerned. As mental health services are so under-developed for this group nationally, there is an opportunity for strategic national thinking so that service development is thought through and (as much as possible) evidence-based from the start.

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

I would like to see the mental health needs of children and young people with Learning Disabilities being another priority area here due to the recognition of the gap in existing provision for this group. I am not sure whether this group is already considered to be included in the 'developmental disorders' group mentioned above.

In my view, in order to understand better what changes are required for

delivering better outcomes for people developmental disorders and Learning Disability, there is a need to look across age and service boundaries. We need to think logically and developmentally and systematically map likely needs and journeys across the lifespan. We need to start with the needs of the children and families with conditions like ADHD +/- Autism +/- Learning Disability +/- other developmental disorders. We need to think and track these systematically through childhood and across the lifespan (not starting with what services are there and looking for gaps). This is likely to produce a map starting with early recognition and diagnosis and moving through a number of issues/interventions/agencies, including post-diagnostic support, early intervention, organised follow-up and monitoring, social care support and respite, appropriate educational support, improving knowledge of signs of physical and mental health co-morbidities, improved access to mental and physical health services, transition planning, adult occupation/employment, improved recognition and support within the criminal justice system, etc. We should then move on to look at who currently has skills/capacity from across agencies to provide what's needed and systematically plan so that gaps can be efficiently filled and duplication avoided. An agreed, joined up map of likely needs will by definition be interagency and include early years and preventative work. Linking this with more specialist and intensive needs across the lifespan will allow for proper evaluation of interventions – whose impact may be felt at a different age and by a different agency from that which provided the intervention. For example, the impact of early mental health interventions on later need for high cost out of area education/social care placements, or the impact of specialist communication and sensory interventions on mental health and behaviour.

Any work looking at the mental health needs of people with developmental disorders (including Learning Disability) needs to include from early stages the skills and role of Community Paediatricians with these children. They have a vital role in the recognition and diagnosis of many developmental disorders. Paediatricians have variable knowledge and skills in treating these disorders and recognising co-morbidities. In many areas they have been 'holding the fort' where there is a lack of mental health services, particularly where CAMHS has not seen children with Learning Disabilities or have not taken an interest in children with (e.g.) ADHD and Autism. Changes in Child Health services, particularly with a national reduction in the Community Paediatric workforce therefore has an impact on children with Learning Disability and other developmental disorders. Reduction in routine health surveillance, particularly for non-verbal and Autistic children can also lead to undiagnosed physical problems (e.g. constipation, infections, GI reflux, epilepsy) presenting to mental health services as distress and behavioural disturbance.

There therefore needs to be a joining up at a national level of reviews of Child Health Services and Children's Mental Health services. These have felt in the main separate to date. Another example is of the potential impact for Mental Health Services of the introduction of 2 year old health checks in Child Health services. These checks are very welcome as I believe that the impact of Hall 4 on reducing developmental screening was detrimental to children with developmental disability. However, services need to be in place to respond to difficulties which are identified. I understand that 2 year

checks will look for language delay. This is known to be strongly associated with a number of developmental/mental health co-morbidities at age 7 (LD, ASD, ADHD). Skilled clinicians from Child Health and Mental Health need to be available via clear and co-ordinated services to monitor, assess and treat the children who will be identified with language delay in a timely manner.

Transitions from child to adult services are another key area. We need to understand why they are difficult before taking realistic and appropriate action. In my opinion they are often difficult because services were originally set up for different reasons, with different foci and with different ways of working. E.g. CAMHS focus in some areas on 'family work', psychotherapeutic approaches, or sometimes developmental disorders. Adult mental health focus tends to be on major mental illness. As outlined above for developmental disorders, we need to map what the mental health needs are of children, young people, adults, older people, i.e. across the lifespan and then plan how services should respond. Developmental disorders like Aspergers and ADHD obviously continue into adulthood in many cases, but adult mental health services have not traditionally recognised or worked with people with these problems. Psychosis may be less familiar to CAMHS clinicians, particularly when they only work with under 16s. When changes are made to service boundaries, e.g. CAMHS changed to see up to 18's (and therefore a much increased level of psychosis), or to see children and young people with LD, the skills and resources must be identified so that this work can be skilfully and safely carried out.

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

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

The emphasis on emotional wellbeing within schools is welcome. Perhaps sensitively introducing more information about mental illness and ill-health into schools would be helpful. But any new anti-stigma projects need to be carefully trialled to ensure they are not counterproductive.

Care needs to be taken that trying to 'normalise' conditions with the best intentions do not inadvertently lead to a lack of recognition and services for groups. For example, in many areas, Education and Social Work are keen to avoid diagnostic labels such as 'Learning Disability' or 'ADHD' in the belief that they are depersonalising and stigmatising. This can lead to the needs of the person not being properly recognised and limit their access to assessment and treatment. Stigma can be reinforced in this way. Dialogue needs to be encouraged at local and national level between those trying to reduce the stigma of mental illness or disability in different ways and with sometimes unintended consequences.

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

This could be linked into the work to improve the physical health care provided to those with mental illness (and learning disability). Discrimination by health care workers is one key element of the difficulties these people have in accessing services.

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

Comments

Supporting projects and initiatives that improve community cohesion and reduce isolation of individuals. This cuts across many government departments and non-government organisations. There is a real risk in the current economic climate that many local community projects will be affected by cut-backs and the knock-on effect on mental and physical health will be great. This needs to be monitored, and projects encouraged and supported in evidencing the positive effects that they have. This is particularly difficult for small organisations.

Improving physical health is very important in preventing mental ill health and well being.

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

Child Health services and CAMHS need to be more closely linked at a local level (clinically and in service planning) and at a national strategic level (see above).

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

Comments

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

Easy access to information. Education within schools and in health care settings. Encourage the availability of local community projects that reduce isolation, provide meaningful occupation (paid and unpaid) and encourage physical exercise and health.

For those who cannot understand their own mental health needs (due to e.g. severe learning disability or dementia), family and carers need education/access to information so that they can recognise signs of ill health in those they care for. 'Diagnostic overshadowing' is a real risk for these people, resulting in symptoms of physical or mental ill health being put down to their LD or dementia and treatable conditions missed.

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

Comments

This links with the anti-stigma work. But when people do approach professionals, the professionals must be receptive, supportive, and well-informed of mental illness and services available. If not, people can be further put off seeking help on for themselves or for those they care for.

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

Ensure that experienced clinicians are available to assess people quickly and to direct them to the most appropriate treatment. Clinicians need improved admin support so that they can make best use of their clinical skills and time. This is particularly important to encourage and enable them to collect outcome data so they can evaluate and improve their services. Within my practice, a lack of interagency care coordination and a lack of Tier 2 mental health services are huge barriers to the efficient use of specialist clinical time.

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

As per Question 11. Plus the need for service-related research to evaluate the outcomes and effectiveness of interventions and service models.

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

Comments

In my area of work, attempts to put into place ICPs and GIRFEC immediately highlight the gaps in service provision and lack of access of the children and young people to a range of services across the Tiers. Implementation then becomes very difficult as the services are simply not there and pathways just lead to dead ends.

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

For my group of patients, time and skilled use of total communication is required to meaningfully involve children in these aspects. Families as well as the children themselves can be considered 'service users' in the context of my work. Their views can be gathered, locally and nationally about service design and delivery.

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

Comments

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?

Comments

In my current experience, this is very difficult to provide for children and young people with Learning Disability given the major gaps in basic service provision.

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

Comments

Although I am aware of it's work, this has had little prominence within CAMHS work.

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

Comments

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

Within my work with children and young people with Learning Disabilities family and carer's roles are central and crucial. Most behavioural, communication, sensory and environmental interventions can only happen with their hands-on daily work. Unfortunately, many are too exhausted with the daily demands of caring, lack of sleep etc that they are unable to put in place interventions that will ultimately help. Many interventions increase their work and stress levels initially, before leading to improvements. We frequently find that families are already at breaking point and we therefore cannot expect them to implement interventions that may make things even worse in the short term. Families need respite and support so that they have the energy and resources to implement interventions. The current reduction in council budgets are leading to further reductions in respite and other support services so this situation is deteriorating. More families are likely to be unable to care for their children with severe and complex needs and result in more out-of-home expensive placements. This needs to be evaluated and monitored.

If mental health and education/social services were able to work together in a more collaborative and productive way around such scenarios, then respite care could be directed in a more thought-through way. At present in my area it seems to be given only as a last resort at times of extreme crisis for many. It would be better if it could be targeted, for example, to support families better at times when they are engaging in therapeutic work which ultimately could lead to an improvement in their child's mental health, well-being and behaviour.

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

Easy access to good quality, up to date, on-line information to give families and carers about diagnoses, treatment (including medication) and strategies to support them in their caring. In a specialist area like mine, individual clinicians often have to individually seek out such information which comes from a variety of sources. They then have to check it's suitability and adapt it to suit our patient group. This is time consuming and often not possible to fit into busy clinical jobs. It is also not a good use of senior clinician's time and NHS resources when this time is multiplied across the country. Government support in developing websites to facilitate more efficient use of time and to develop more high quality resources would be welcome. Some targeted funded time from clinicians would be helpful – particularly to keep information up to date.

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

For my patient group we would have to look at other areas of the UK to get an idea of an appropriate balance. Community services are under-developed and specialist inpatient services non-existent. Young people aged 12-16 with moderate to severe learning disability cannot access Psychiatry beds in Scotland. As commented above, as mental health services for this group need to be more or less started 'from scratch', this provides an opportunity to plan and develop well-balanced services linked in well with Child Health, Social care and Education, rather than having to redesign services at a later date.

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

I welcome the inclusion of access to CAMHS for children and young people with Learning Disability as a key performance indicator on the CAMHS Balanced Scorecard. I would assume that similar measures could be used for other minority and high risk groups. Measuring access to assessment needs to move on to measuring access to appropriate treatment, along with some type of outcome measures. There is little point in improving initial access to a service which is unable to provide appropriate treatment due to a lack of capacity or skilled specialist clinicians.

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

Comments

Evaluate 'did not attend' rates in different services and show which service models lead to better engagement.

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

Comments

Major gaps in services for children and young people with Learning Disabilities across the Tiers of mental health provision. This group shares many developmental co-morbidities. Gaps in IPCU provision for young people and gaps in forensic mental health services for young people.

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

While there has been significant progress in highlighting the mental health needs and service gaps for children and young people with Learning Disability, I think that consideration needs to be given to further supporting the work of the LD CAMHS Scotland Network. There is a relatively small pool of very busy clinicians who find it difficult to give time to the important work required to take forward a number of key actions. Government funding for admin/IT support or for clinicians to give backfilled sessions to take on pieces of work should be considered.

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

The work around acute hospital care should be broadened to include care for other vulnerable groups who also have communication difficulties, such as those with Learning Disability and Sensory Impairments. Much work has been done on improving the care received by adults with Learning Disabilities in acute hospitals in Scotland and the valuable role of Liaison Learning Disability Nurses recognised. The proposed work in acute hospitals around people with dementia should look at this work so that relevant lessons can be learned and unnecessary duplication avoided. The care received by children with Learning Disability in Paediatric wards also needs to be looked at. It can often be difficult for these children to access appropriate medical assessment and treatment.

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

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

There needs to be more centralised planning and support for training for specialist posts (linked to workforce planning and regional need), supported by professional organisations like the Royal College of Psychiatrists. For example, there is enthusiasm among trainees for LD CAMHS Psychiatry but those trained in it have all had to fight to get appropriate training on an individual basis. We have lost at least one fully dual trained Psychiatrist to England recently due to a lack of planning and availability of posts, despite there being an acknowledgement of a need. Others are currently being put off this career path due to uncertainty about availability of posts.

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

Need to look carefully at how outcomes are measured for particular groups – the outcomes may be felt at a point distant in time and in other agencies to the delivery of mental health services.

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

Comments

Better IT support and admin support to aid clinicians in collecting and analysing data.

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

A specific and honest look at the effect of service cuts/changes in one agency on the work of others. For example, the effect of not having LD CAMHS services on the budgets of Councils and the lives of individuals due to expensive out of area placements for children with undiagnosed/untreated mental health problems. Also the effects of cuts in social care on stress in families and their subsequent inability to put in place strategies to improve the mental health of their complex children.

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

Comments

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