Joint Assessment of the Western Isles Mental Health Service: a Mental Health Service in a Remote and Rural Setting

Commissioned by the Mental Health Partnership

May 2005

This assessment was commissioned by the WIMHP and considered necessary because:

- There was a major NHS redesign process ongoing in the Western Isles concerning all service provision.
- There was a need to review the status and progress of the Mental Health Service locally in the light of the published National Framework for Mental Health Services in Scotland (1997)
- There was perceived to be a need to prepare the service for the strategic work programme proposed by NHS Quality Improvement Scotland (October 2005)

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The National Service Framework

The Framework has been prepared in accordance with Government objectives and policies to provide clarity and a sense of direction.

The National Framework for Mental Health Services (1997) was created as a performance monitoring tool, to place emphasis on meeting the needs of service users and providers through process and service elements. These tools is used alongside commissioning within Health Boards in Scotland, General Practitioners and Local Authority Boards and Social Work Departments to measure performance and help to identify opportunities for development and enable service commissioners to establish to what extent they are encompassing these elements and thus are able to meet the identified needs. Staffs in health, social work and housing agencies are to develop a joint approach to the planning, commissioning and provision of integrated mental health services. Local agencies must work together to deliver comprehensive mental health services which meet the needs of their resident population.

The Framework is drawn from current best local practice and aims to build upon initiatives already in place. Its purpose is to:

- A general consensus over the key issues in a local mental health service;
- Provide a template against which the local commissioners and providers of mental health services, in consultation with the people who use these services and those who care for them, can agree priorities for action that are related to outcomes and to clinical and cost-effectiveness, and can assess progress;

and

- Establish a yardstick by which The Scottish Office can assess local strategies and action plans and monitor progress.

The Framework is in two parts:

- The Framework itself which sets out the essential features of a local mental health strategy; and

- A matrix summarising the elements a comprehensive service should provide in order to meet the needs of people with mental health problems, and examples of possible service responses. A further document is available which provides wider information and discussion of each element of the Framework. This "context" document is not part of the Framework and is provided to assist readers who would find it helpful to have background information on particular aspects of the Framework.

Introduction

The National Service Framework suggested that additional, new resources must articulate well with existing resources. The NHS Trust Chief has stated previously in the Mental Health National Service Framework: Workforce Planning, Education and Training Underpinning Programme: Adult Mental Health Services document that there are currently few well-tested service models of primary care mental health and indeed there may be several different ways to deliver better outcomes.

With this in mind, it is suggested action is needed in four domains in Health and Social Work:

- Organisation and management of services;
- Education and training;
- New staff;
- Proposals designed to improve the systems in place to support good quality services.

In more specific terms this relates to the following:

- Effective two-way communication throughout the service;
- Involvement of clinical and care staff, integration of primary care with secondary and tertiary services, and joint training across agencies;
- Effective involvement of those who receive services and of those who care for them;
- The installation of adequate and coherent management structures within organizations;
- The use of the system for audit and quality control;

Within this National Framework, actions have been highlighted which can be taken immediately, and those where change is likely to take longer. However, it is important to remember that improvements will take time, and change should only be approached when the appropriate groundwork has been done, and where it is clear that change will add value.

Essential Features of a Local Mental Health Strategy

According to the National Mental Health Framework 1997, developing an effective local mental health strategy requires:

- A clear understanding of national policy;
- Effective joint planning and working;
- Multi-agency agreement on local needs and the balance of care;
- An agreed service framework which meets the assessed need; and
- An accurate knowledge of the totality of resources available to provide the service.

STATUS DOCUMENT

The following assessment of Mental Health Services in the Western Isles has been commissioned by the Mental Health Partnership. Over the last 10 years, the Mental Health Partnership has attempted to change, in conjunction with other partnerships, the provision and expectations of Mental Health Services in the Western Isles.

The MHP promotes the development of relevant, good quality services and this is done through the operation of an integrated liaison system. This involves the setting up of:

- Joint case registers;
- Good practice protocols;
- Liaison audit of care;

The methods used in the assessment were a review of documents produced relating to the development of Mental Health Services in the Western Isles, interviews with the lead people on Mental Health and direct observation on the developments that are currently in process or which are to be further developed in the near future.

Assessments of progress have been carried out by the Mental Health and Well Being group from the Scottish Executive. This current assessment takes the elements of the National Framework for Mental Health Services, published by the Scottish Executive in September 1997 and examines the expected developments then compares the Western Isles position with these. Areas good practice has been highlighted and deficits /suggestions for change are noted.

1. **Process Elements**

1.1 <u>Interface between primary care, secondary care and social work</u>

The National Service Framework suggests that although there is lack agreement over the roles and responsibilities of primary and secondary care and of best methods of working at the interface, many practices have explored different ways to work more effectively. Communication is key and it is important to ensure that patients entering into primary care have their needs met. A link with the Community Mental Health Team is perhaps the most common means for primary care staff to obtain the help they need. In some places, a named link worker has been employed. Normally a sessional Community Psychiatric Nurse employed by the trust or the HA, this is someone with a specialised mental health training who provides some assessment and treatment, and works to facilitate clear lines of communication between primary and specialised services.

A key theme for all current health and social care policy is partnership working.The recently published consultation document in England '*A Quality Strategy for Social Care'*, published by the Department of Health, with suggestions for modernising Social Services agenda notes that `the current system is too fragmented, with too many organisational boundaries getting in the way of what should be our principal objective – seamless services where the needs of patients and users come first at all times.' It goes on to say that `in future, social services will therefore need to be routinely delivered in a variety of new settings, including GP surgeries. They will need to work alongside other professionals such as GPs, nurses, community health teams and housing agencies. Service teams will need to be closely integrated across local authorities and the NHS; budgets will be pooled together and care will be provided as part of a fully integrated and effective system.'

1.2 <u>National Development</u>

The proposals set out in the National Service Framework for mental health services are among the most radical proposals for change in the history of the health service. Community care teams will support the most vulnerable; Early Intervention teams will improve access for people in the critical early phase of psychosis and Crisis and home treatment teams will provide alternatives to hospital.

New investment is being delivered, and together with existing resources, it will make a difference in time. Ensuring that existing services and resources are managed well is also essential. In particular it is important to build on good partnership working, share good practice, build on the best of what the health service has to offer, and support staff.

National NHS Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08 envisage well integrated system, involving statutory as well as non statutory services, that is able to deliver:

- Faster access to effective treatments for people with common mental health problems;
- Support for primary care from specialised services provided through a re profiled Community mental health team;
- Faster access to help for people in crisis;
- Care and treatment close to home;
- A rapid response and early intervention in the first episode of psychosis;
- Better integration of the components of effective care, including welfare, housing, health and social care, and support from the voluntary sector;
- Support for minorities and groups with special needs, such as women, black and minority ethnic groups, people with sensory impairment and those with co-morbidity;

An integrated system of better quality care for people with severe mental illness, between primary care and specialised services for people to ensure:

Care co-ordination in primary care of those needing continuing support, rehabilitation and recovery;

- Organised care to attend for physical needs;
- Co-ordination of support for carers and attention to their own vulnerability to mental health problems;
- Links into assertive outreach, crisis/home treatment and early intervention in psychosis.

1.3 Local Development

The National Framework suggests that general adult psychiatry and specialist services must work with local GPs to define their roles in the care of psychiatric disorders. Clarity about which interventions should be delivered in primary or secondary care will aid this process. Effective communication between primary and secondary care is vital for ensuring the effective care and efficient use of resources.

There has also been debate regarding the nature of the role of primary care in mental health care. General practitioners are being urged to take a more proactive role. They are becoming responsible for the care of stable patients freeing up specialists to deal with the more immediate problems.

Although there is some evidence that neurotic disorders can be more cost-effectively treated in primary care, many general practitioners (GPs), and possibly some patients, prefer referral to community mental health teams and community psychiatric nurses, which are provided by the secondary health care services. Since the latter are provided with the intention of improving serious mental illness their involvement in the care of neurotic illness can lead to tensions between GPs, local health authorities and service providers.

Partnership working will be enhanced by the following:

- Protocols defining respective roles in the care of psychiatric disorders, with agreed pathways into and out of services.
- Services that give primary care rapid access to specialist mental health assessment and a point of contact.
- Joint education, training and audit
- Good relationships between teams from primary and secondary care.

The services elements which are suggested should be in place are:

- Primary care liaison workers
- Clear care/treatment pathways for a range of mental health problems.
- An urgent advice and assessment service.
- Assessment and Crisis Resolution available 24 hours.
- Primary care to be included in CPA planning,

The CMHT should be fully multi-disciplinary including medical, nursing, social work, psychology, occupational therapy with access to other professionals such as physiotherapy, pharmacy, dietetics, speech, language and art therapies as required.

The CMHT should:

- Have a clearly defined role and remit that is understood by all local agencies especially primary care;
- Work from a joint base with a shared operational policy and clearly defined priorities within a local strategic plan;
- Have good links with specialist services such as, substance misuse and forensic teams;
- Provide effective psychological treatment and social care;

1.3.1 The delivery of community care to people with MH problems by the PHCT to a suitable standard

The relationship and its effectiveness between primary, secondary health care and social work services are influenced by a number of factors:

- The appropriateness of referrals from primary care;
- Developing integrated aftercare and follow-up arrangements;
- The development of Primary Care Trusts (PHCTs) bringing new methods of provision, commissioning and contracting of health services which is not relevant here as this is done through the Community Health Partnership which deals with everything but acute care;
- The implications on quality of mental health care in general practice.

1.3.2 Input from MH Services

The CMHT divides into specialist teams and/or functions such as:

- Crisis intervention;
- Assertive outreach;
- Continuing care;
- Primary care liaison;
- Integration of most aspects of community mental health care within the primary mental health care team;
- Liaison workers operating between primary and community mental health services are crucial;

The JLIP Progress Report from September 2005 stated the current link of Mental Health with locally delivered joint plans. Service components are seen between Community Health Planning, Joint Futures Agenda and Regional Networking. The steering group is made up of individuals from various health sectors, Social Work and the voluntary sector.

1.3.3 Communication between Primary and Secondary Services

Within the MH Services itself the secondary care based community mental health teams (CMHTs) and primary care is involved with:

- Regular meetings around individual cases;
- An attached mental health professional working with primary care;
- Continuing Local Needs Assessment;

1.3.4 The PHCT and Social Work

This document consults on new or renewed ways of working that might have an affect on social workers taking account of the number of key policy/practice issues of relevance to social workers working with children such as the development of the role of lead professional and the need to safeguard children.

The interface with social services is developing rapidly, predominantly because of the development of PCTs and the appearance of Care Trusts. A single organisation providing both social care as well as health care allows for further development.

The establishment and continuation of the interface between care provisions is further secured with the consultation between multi-agencies including service providers and users. The Community Well Being Plan links directly to this as its Action Team includes: ADSAT, Mental Health Partnership, Local Health Plan, Children's Services Planning Group etc;

There has also been debate regarding the nature of the role of primary care in mental health care. General practitioners are being urged to take a more proactive role. They are becoming responsible for the care of stable patients freeing up specialists to deal with the more immediate problems.

Although there is some evidence that neurotic disorders can be more cost-effectively treated in primary care, many general practitioners (GPs), and possibly some patients, prefer referral to community mental health teams and community psychiatric nurses, which are provided by the secondary health care services. Since the latter are provided with the intention of improving serious mental illness their involvement in the care of neurotic illness can lead to tensions between GPs, local health authorities and service providers.

1.3.5 Areas for consideration

Should referrals to secondary care should be limited to those most in need of this level of expertise;

Would this mean GP management skills would improve, so leading to better quality of care for patients who are not referred;

What is the nature of their role?

What is the role currently being adopted by general practitioners in the care of their patients with mental health problems?

1.4 Involving people who receive services and those who care for them

New emphasis on the place for service users at all levels is provided in the National Framework. It states clearly that patients need an identifiable person they can turn to if they have a problem, or if they need information whilst using NHS services. By 2002 an NHS-wide Patient Advocacy and Liaison Service (PALS) was to be established in every trust. Patient Advocates were to act as an independent facilitator to handle patient and family concerns, with direct access to the Chief Executive and the power to negotiate immediate solutions. They will be able to steer people towards the complaints system, where necessary. These developments will also challenge primary care mental health services and they provide an opportunity to strengthen the provision of high quality mental health treatment and care.

1.4.1 National Action

Clearly, when considering the issues around workforce, education and training it is important not simply to focus just on the statutory sector. Whilst they may be the major players in terms of size and finances, they are not the only ones providing services. Users welcome the innovation and flexibility that the voluntary sector can provide and if the wishes of service users are to be met, a more corporate approach to workforce, education and training is required that will fully bring on board the needs and wishes of the voluntary sector. In undertaking their workforce planning, the statutory agencies should take account of the level and type of services provided by the voluntary sector either independently or by commission, both currently and in the future to see how this fits in with their future commissioning arrangements and service provision. In parallel, the voluntary sector should plan their workforce needs taking account of their forward business plans and likely future commissions for the delivery of services. This two pronged approach, particularly if undertaken to a similar planning cycle which also matches the service planning cycle, will enable a more informed two-way dialogue to take place not only in terms of numbers of staff required but also their skills, knowledge and aptitude including their education and training needs.

This, in turn, will enable a process to be put in place whereby a more informed, joint education and training strategy can be implemented across both sectors. As a minimum, the aim must be to allow and encourage staff from the voluntary sector to take part in education and training provision leading, in due course to an expectation of their regular participation if this is not already happening. Indeed, service users expect that the location or provider of a service should not be the determinant of the level and/or quality of what is on offer and in some forms of care such as day centres for example, these can be found in both sectors. The introduction of an open and transparent workforce, education and training strategy and policy across both sectors, available to all, will not only reinforce joint working but should also help to iron out any differences of quality or lack of appropriate qualifications wherever these may be found.

Similarly, both sectors use volunteers in a variety of tasks to supplement the workforce and it is important not only to tap into their experience but also to consider what education and training needs they might have. The other side of the coin is that usually, they will have a lot to offer around what might be called "life skills" which might be useful in the delivery of education to professional and other staff. This could be particularly true if the volunteer is or has been a service user.

1.4.2 Local Action

The voluntary sector is becoming increasingly important in the delivery of services. An informed, joint education and training strategy across sectors is important and workforce development in the non-statutory sector needs to be supported and funded.

1.4.3 Involvement of People who Receive Services and those who care for them

One of the main policies of Mental Health Development and Promotion in the Western Isles is to ensure the inclusion of Service users and other public representatives to ensure they are fully involved in the initiatives being developed.

Allies for change

Representatives from user groups/Training Courses

Planning and Project Activity through I Reach

1.4.4 Health Promotion

NHS staff working with WIAMH to promote good practice. Included a 2 day workshop with an experienced facilitator and a wide cross section of service users and providers to develop a MH&WB action plan.

A series of Networking events have been held in Stornoway and Benbecula to discuss issues re MH&WB.

1.4.5 Invitation to act in Western Isles Course 2003

This course was run back in 2003, with the aim of involving service users and participants to clarify their position within the local action plans and go on to identify changes for further strategies. The outcome was to increase networking and thus work towards a shared vision. The issue was raised that more service users and carers needed to be engaged in this work, and this has been tackled through the JLIP.

1.4.6 Health Forums and re-design

This has been tackled through I Reach and WIAMH. Service Users and Carers were to be invited to share their experiences.

1.4.7 Close links with other agencies and groups for example dementia etc

Mental Health and Well Being Network to be further established through workshops held i.e." Evidence into Practice" and further develop this through feedback form training questionnaire. This is to be further developed to include Barra and Uist and then to be linked back to the MHP.

1.4.8 Advocacy services

There is a well-developed advocacy service in place in the Western Isles, with the aim of working in collaboration with the service user group to develop collective services. As regards involving service users and carers, the advocacy service has encouraged ordinary citizens to become involved in the decisions made about services provided, with an example of the work of the Advocacy service being The Western Isles Carers Users and Supporters Network

1.4.9 Community well-being forum/Community planning partnership

1.4.10 Patient information project

Worked through I Reach with the aim of including mental health users on the committee.

1.4.11 Health Promotion link to workforce initiatives

Training questionnaires were developed to identify training needs and focus groups to help promote understanding and people's confidence.

1.4.12 Problems relating to stigma etc

One problem which is unclear as to its position is the approach of the Mental Health bodies to stigma, remoteness and isolation from social networks and support services. Needs to be clarified.

1.4.13 Areas for Consideration

Services provided by the voluntary sector have the advantage of being able to be more responsive to the needs, and wishes of users. They have the reputation for being more innovative, creative and flexible than statutory services. Given the current climate in health and social care, it seems likely that voluntary organisations will continue to expand and develop their role as providers of services for people with mental health problems.

Currently, these voluntary services are not replacing statutory health and social services, but are complementary to them, filling gaps that would not otherwise be filled. Providing practical, emotional and social support to people with mental health problems may relieve the demand on other services for these types of activity, resulting in a more appropriate use of professional staff's time.

Voluntary services should invest time in regular liaison with potential referrers, explaining the referral criteria and the service to be offered, and providing updates on progress. This should include liaison with hospital and community mental health services, social work staff and general practitioners, and should be an ongoing process, continuing after the service is well established;

Working with the voluntary sector is not just about contracting for a service but commissioning services. This process should provide opportunities for all agencies to learn from one another and to respect each other's contribution. Crucially, clarity regarding the nature and quantity of referrals by all agencies involved is needed.

1.5 Joint commissioning

1.5.1 National Action

Joint agency standards can be used to assess and to commission mental health services by primary care organisations. They include the need to demonstrate a commitment to partnership working, innovation and modernization, and to having a commissioning system that is backed by adequate resources and appropriately trained staff.

Within the National Framework document, particularly the matrix section, issues that have been considered are:

- the importance of members of the team understanding of structure, the nature of leadership, the reporting mechanism, the role and function of the strategic overview group, and the financial limits within which services will have to be delivered;

- the team members need to understand the importance of reaching agreement, that no group, professional or lay, has the right of veto over the process or decisions made. The team needs to be sensible of, and sensitive to, local feelings and the need to take a proactive approach;

- The team will have to work out a communication strategy to ensure that all key stakeholders, including elected members, are kept in touch with its deliberations and decisions;

- A timetable will be established for milestones towards completion of the strategy, any consultation process, and implementation;

- The team should agree on a policy of appropriate access to each agency's individual records, and of compliance with national legislation and guidance on access to their records for people receiving services;

- The team should contribute to an assessment of local need and the development of a profile of existing accommodation and services. This will include the current spend, the current activity, the current layout of services, and will examine gaps and overlap in provision;

1.5.2 Local Action

On the basis of this process, the local joint commissioning team should consider what need it will have for a common set of data, to inform future planning. Audit of individual care plans and the care planning process will probably show up certain needs identified for individual groups of people who receive services which have not been met.

Service delivery is required to address the tensions that have arisen following changes in government policy. Policy initiatives increasingly emphasize the importance of breaking down organizational and professional barriers in order to achieve the delivery of effective mental health services. In this context, joint commissioning is seen as providing a way forward, and GPs are now identified as having a key role to play, alongside other professionals and agencies.

Local demographic data, including the existence of areas of deprivation, or where services are lacking, must be identified. In the local setting it is important to note that arrangements have been made by the joint commissioning team to help clarify issues such as prioritisation, protocols for admission and discharge, compliance with mental health legislation, care management, the care programme approach, and Community Care Orders, measures of the quality of the process, expected outcomes, and staff development.

A main area of the work is known as the Joint Future Agenda. This is an initiative from the Scottish Parliament. It encourages the organisations within the public sector, to work together, to provide better care and treatment for service users.

The local services being worked on and developed within the joint services include:

- Mental Health Services
- Learning Disability Services
- Services for people with Physical Disabilities and/or Sensory Impairments
- Services for Older People
- Services for people with Drug and Alcohol Problems
- Services for Children

This joint team also leads on the development of the Health and Community Care Plan. The plan has several guiding principles, and includes the aim to provide as much health and social care, within peoples own homes and communities, as possible.The task of implementation measures its effectiveness include:

- Publication and wide circulation of a local mental health strategy, leading through structured consultation to the definitive document;

- A robust, timetabled, implementation plan taking account of resources, and priorities, with flexibility to deal with unforeseen circumstances.

A number of policies have been introduced relating to joint commissioning including:

- Joint Funding
- Single Shared Assessment

However, there is evidence that joint commissioning is not yet well established, and a number of barriers to its development have been identified including Financial Accountability and the link between operational and strategic aspects of commissioning.

1.6 Effective leadership and management

Leadership is discussed in the national framework in terms of:

- Providing effective organisational and system leadership;
- Managers/professional staff at all levels visible and accessible to all staff as appropriate;
- Leaders at all levels demonstrating support for their staff;
- Leaders personally practising and seen to be practising good HR policies.

1.6.1 National Action

The structural approach to the Framework has been to define a vision, guiding principles and strategies. The vision is the direction in which national health workforce effort should be focused, the principles are the underlying fundamentals that will guide health workforce strategic action in achieving the vision; and the strategies are the planned actions that will deliver the vision and this is more so important in an area where the service is dispersed geographically.

Staffs are the principal resource in delivering high quality services to users. All employers must have in place therefore a framework for the delivery and monitoring of supervision, supportive mentoring and appraisal.

Mental health services need effective leadership within each organisation and across organisations. Mental health leaders need both to manage their organisations and work with networks in partnership, often operating across organisational boundaries. They should be able to build organisations which work with service users and carers, and which have the confidence of local communities. Staff need to be inspired, motivated and supported.

1.6.2 Local Action

The standards referred to above should be incorporated into local service models, governance arrangements and service agreements. The altered professional, social and organisational context in which mental health care is being provided reinforces the necessity for effective and ongoing support to be provided for staff to ensure their practice is relevant and up to date. Systems need to be put in place, where they are not already, to ensure this is readily available. Mistakes and 'near misses' should be recognised early, and implications for professional and organisational learning are identified and actioned.

The Boards of NHS organisations should, given the acknowledged recruitment and retention difficulties in many mental health services, consider requesting early evidence of action being taken relevant to the 'Improving Working Lives' standard for their mental health workforce.

1.6.3 Clear Vision and Inspiration leadership

The MHP has had increased and steady membership since it was introduced in 1997. Key areas for its effective management have been service redesign and clinical leadership, alongside joint training;

A number of key projects and reports have been compiled as regards the leadership and management of Mental Health Services. As the services offered are dispersed geographically there is an efficient service of communication with the Southern Isles:

MH&WB Report "Getting it done"
Integrated Care Scheme;

A number of services also run complementary to the services offered within the health board and Social Work mental health services including counselling agencies.

1.7 Quality Assurance

The aim of all National Service Frameworks is to drive up quality, tackle variations in access to care, increase the effectiveness of care and enhance user and carer experience by ensuring changes are systematic and sustainable. Changes must:

- Be measurable and make a difference to the quality of services received by service users
- Set standards that are ambitious but achievable
- Ensure all the partner agencies work together at local and national level to secure change.

Progress will be measured by a number of performance indicators within the performance assessment frameworks of health and social services as well as by specific performance targets set within this National Service Framework. This framework provides 44 key actions, each setting out the timescale and identifying the organisation responsible for implementation. Performance targets are set and the necessary monitoring information required is identified.

Every local health board (LHB) /unitary authority area should have a Local Mental Health Strategic Planning Group to co-ordinate commissioning and each will be expected to include plans to prioritise and improve local mental health services as part of its wider improvement plans. This group should include representation from voluntary/independent sector service providers. On the wider front, Local Health Alliances and initiatives such as Communities First should also reflect the inclusive model.

1.7.1 National Action

This highlights the importance of developing a good map of local training needs, a framework for mental health clinical governance, systems for the evaluation of the changes proposed, and clear measures of the outcomes for patients and service users.

Development is needed to improve the integration of services and communication between them; to promote new service models, and new ways of working. The service would be greatly strengthened by the establishment of a multidisciplinary primary care mental health team. During the coming year, mental health services will be reviewed systematically to examine progress on NHS Planning and Implementation. The extent to which services operate as an integrated whole will be a defining characteristic of their quality.

1.7.2 Local Action

A quality standard in terms of local response is measured across core activities, including organisational arrangements; planning process, implementation, performance monitoring, and communication with stakeholders have been applied.

In the treatment field the key indicators include number of clients, waiting times, new referrals, treatment completion/planned discharge rates, and unit costs. In addition to these quantitative measures, a range of qualitative measures are being developed, referring to the appropriateness of the treatment:

- the establishment of monitoring, and audit structures, with verifiable checkpoints, to measure standards of service delivery and outcomes (including those defined by people who receive services)
- a continued cross reference against the implementation timetable set out in the Framework document
- internal cross referencing with health, social work, and housing procedures; and
- a process of self-evaluation using criteria;

1.7.3 Benchmarking

This project seeks to show how the Western Isles Mental Health Services is performing in comparison to other providers in Scotland with regards to such issues as the success of local action plans in meeting national standards, provision of services in local areas with regards to future needs and service use.

1.7.4 Research and Development

Best Practice – MHA

1.7.5 Focus on process

Implementation of Service redesigns Project Board;
To overlook any decisions made and to ensure that they are effective and coordinated correctly;

1.7.6 Continuous Improvement

Service Redesign Committee;
Meet quarterly to provide overview and supervision;

1.7.7 Partnership

Reviewing joint documentation and protocols involving key agencies;
Mental Health Partnership

1.7.8 Outside Consultant

There have been a number of internal and external assessments regarding mental health provision as noted below:

Feedback from Mental Welfare Commission re specific cases

1.7.9 External Assessment of ADSAT – Workshop to organize leadership

The aim of this assessment was to identify the topics that will form the basis of a leadership programme, based on the ADSAT members' assessment of the current effectiveness of the ADSAT;

The group believed they were performing well within their aims and in particular the areas they felt they were progressing well in were implementing policies and change, communication between multi-disciplinary agencies and communication with the public.

The areas which were to be worked on were:

- Membership - level, representation
- Role of individuals and expectations
- Involvement - attendance at meetings, interest, contribution outside meetings,
- Member training
- More links with all members and the sub group
- Dissemination of information / feedback from the training programme
- And Culture change on alcohol – locally – how can we have an input /implement;

As such this group raised a number of issues regarding monitoring of services and proactive commissioning;

1.7.10 <u>One Provider Unit – One system</u>

The services provided currently within the Mental Health Framework have a high degree of uniformity, with all levels of organization involved in decision making and appropriate response.

1.7.11 <u>Areas for Consideration:</u>

A systematic arrangement for assessing the health and social needs of people accepted into the specialist mental health services could be one area for development. Authorities will need to ensure a fully integrated approach to the CPA and the health and social services unified approach to assessing and managing care.

1.8 Information Systems

1.8.1 National Development:

Communication within and between services must be robust. There should also be effective protocols in place for communication of risk and sharing information both to the individual and to others including those providing services. The term 'information' is used here in the broad sense, referring to the 'management intelligence' required to effectively plan, resource, manage and deliver mental health services in a way that best meets community needs. It therefore refers to both the collection and use of information.

This broader view of the information concept recognises that the need for quality information exists at all levels of the health system:

- At the service delivery level, clinicians need to have access to a core set of information to conduct a needs assessment, formulate an individual care plan, monitor progress and evaluate outcome. Consumers and carers also need access to information to evaluate the value of the treatments they receive;

- At the service management level, access to specific data is necessary to manage resources, monitor workflows, conduct clinical audits, and monitor the overall efficiency and effectiveness of the service;

- At the policy level, information is necessary to assess the population needs for mental health care, plan and pay for services, determine priorities and systems for the allocation of resources and monitor the achievement of outcomes set by government;

1.8.2 Local Action

Together, the local aim is to build and apply an information base that:

- Strengthens the focus on consumer outcomes;

- Supports improvements in service quality;

- Shifts the focus of concern from cost to value for money; and

- Improves our understanding of population needs.

1.8.3 Communication to the support of care/Clinical decision making support

Information sharing protocols in place.

There are currently 22 documents in place regarding mental health in the Western Isles which have been co-written and implemented by a number of differing agencies, with the aim of creating a common information pool and a common protocol to follow;

Single Shared Assessment;
Introduced to improve early intervention and periodic review;

Caldecott Guardian;

Recording of Activity
A database of all who have attended MH&WB training is maintained

Basic Admin Support
Information sharing systems have been in place through the JLIP Mental Health Services Manual;

Confidentiality
Agreed protocols are in place regarding the collection, use and passing on of information;

1.8.4 Areas for Consideration

The following aspects of mental health information could be considered:

- systems for the routine collection of patient-level and service utilisation data by mental health service providers;
- the development and use of national collections built from routine service delivery data reported by mental health service providers; and
- the development and use of other data collections to inform about the population's need for mental health care, its use of services, the quality of those services and the outcomes achieved.

There should be agreed mechanisms in place to ensure that people cannot, for example, fall through the services 'net' between general and specialist services for drug and alcohol, criminal justice/forensic mental health, child and adolescent mental health, learning disability services and mental health services for older people.

Specific jointly agreed protocols must be in place to ensure effective and seamless transitional arrangements for individuals (for example on transfer of care or discharge to the CMHT and the GP). Shared care arrangements should be in place for individuals who have long term needs.

1.9 Staff supervision, development and training

In commissioning the provision of services from the voluntary sector, the statutory sector needs to satisfy itself that the staff are properly trained to carry out the appropriate service functions effectively. A joint training strategy will help to ensure this happens.

By having such an underpinning set of joint strategies, the opportunities may allow for a more innovative use of staff whereby they could have the opportunity to work across both sectors, helping either party to close short term gaps in skills and experience or vacancies for example. This will provide staff with a greater depth of knowledge and experience, the opportunity for career and personal development as well as giving them a wider portfolio of skills which, in turn, may help to retain their interest and motivation.

1.9.1 National Development

Mental health service providers face a number of challenges as they try to recruit and retain adequate numbers of qualified staff. Sustained local action is going to be essential within the health improvement programme, using local mechanisms for workforce planning, and for education and training, including continuing professional development and lifelong learning.

National standards and service models will require additional staff, properly trained and supported, to provide modern mental health care. More staff across all groups, including care support workers, will be needed. Skill mix issues will have to be addressed.

The Department of Health, working with local employers, education consortia and their higher education partners, and the national training organisations, has commissioned an action plan that will clarify and endorse:

- key principles for the creation of a sufficient, skilled and supported mental health workforce;
- key skills and competencies required throughout mental health services to ensure services which are non-discriminatory, and sensitive to the needs of all service users and carers regardless of age, gender, race, culture, religion, disability, or sexual orientation;

1.9.2 Local Devlopment:

There are targets in the workforce plan to meet identified gaps in roles i.e. Consultant Psychiatrists and Allied Health Professionals including Social Care Workers.

A key priority is to become more focused on service user need. This will be achieved by developing a workforce plan from service plans and objectives by an integrated approach to workforce planning, introducing new roles, establishing close links with colleges and the smooth introduction of the Agenda for Change national job evaluation framework.

1.9.3 Examples of Local Practice

-ongoing staff training;

Service redesign – training requirements were to be assessed; added details on the workforce, retention etc and development of requirements;

Health promotion of work initiatives i.e. SHAW, multi agency training etc;

Relating to new Mental Health Act, change in functions of staff relating to key roles in detention, treatment orders and interaction etc;- training undertaken to ensure this is achieved;

Training sessions for Advocacy staff;

Training questionnaire identified for training need, experience and focus groups;

Mental Health First Aid for NHS Staff;

Psychological Therapies – CBT?

1.10 Measurement of Outcomes

Outcome indicators are defined as 'indicators of changes in health status specific to each priority group. This definition can also include indicators of the changes in risk and protective factors for individuals, populations, communities, organisations and environments. In addition to consensus about the definition of terms, it is also essential to develop validity around outcomes and indicators:

Outcomes should be congruent with the evidence - This criterion makes explicit the need to ensure that outcomes are consistent with empirical evidence relating to the causes of and interventions for mental health disorders and problems.

The relevance of the outcomes for the level of action should be considered - For example, the outcomes will vary in relation to whether action is to take place at the national level, the strategic sector level or the local level. It is not always possible to develop outcomes that are relevant at all levels of action, rather what is useful is if the information collected at say the local level can inform both local and national action, and vice versa.

Outcomes should be stated clearly and concisely and have face validity to funders, project implementers, evaluators and consumers - It is vital that outcomes are stated clearly and concisely, because they guide action at national, strategic sector and local levels. It is therefore best to reduce ambiguity by stating clearly what is to be achieved.

1.10.1 Local Action

Thus as regards measuring local mental health outcomes the following are key areas for monitoring:

- Reduction of mental health problems and symptoms as these relate to a range of symptomatic presentations and disorders, including anxiety, depression, postnatal depression, substance misuse, conduct disorder and behavioural disorders, suicide and self-harming behaviours, eating disorders, psychosis, and dementia;

- Increased mental health, wellbeing, quality of life and resilience.

- Increased mental health literacy.
- Further social support and community connectedness.
- Increased investment in evidence-based programs relevant to promoting mental health and preventing and reducing mental health problems and mental disorders by governments and non-government agencies;

1.10.2 Local Initiatives

A reliable set of perspectives through which to assess outcomes

QIS is responsible for most of the monitoring and evaluating which has been done but this tends to be conditioned orientated;

Standards of Schizophrenia and Choose life are regularly reported back;

Inter-agency monitoring, evaluation and quality assurance and developing plans that arise from this;

Monitoring development and impact of Mental Health in relation to Joint Futures Agenda etc;

Clinical and Functional Outcomes;

ICP's

1.10.3 Existing Outcome Indicators

Evaluation into practice training to encourage and support a better understanding and a use of evaluation issues. Evaluation of all training and workshops delivered.

Admission and re-admission rates – re-admission rates are quite high;

Follow up; lag times to specialist services etc

Bed-occupancy;

Suicide mortality rates

1.10.4 Areas which should have a priority for outcome assessment

Best practice statements in regards to the five areas where outcomes are:

- Day care
- Community Mental Health Teams
- Alcohol/Drugs
- Community Psychiatric Nurses
- Psych therapy/Counselling

1.10.5 Areas for consideration:

Monitoring could be measured against the following:

For **outcomes**:

- Congruent with the evidence
- Relevant for the level of action
- Clarity, conciseness and face validity

For **indicators**:

- Congruent with outcomes and evidence
- Relevant for the level of action
- Clarity, conciseness and face validity
- Sensitive to changes over time
- Measurable
- Affordable
- Unique and comprehensive

1.11 Service Elements

1.12 Information and Access to Services

1.12.1 National Development:

This National Service Framework by focusing on three streams:

- Information on the knowledge-base for service delivery
- Information for those providing individual service users cares
- Information to support management decision making.

These will support a healthcare framework to measure needs, resources and outcomes, as well as the high-level performance indicators, reference costs and the Performance Assessment Framework.

The mental health information strategy will incorporate a range of national work: work on clinical terms and casemix, and expertise in communications. It will also encompass initiatives where mental health is an early priority; the second National Psychiatric Morbidity Survey planned for 2000; and the Mental Health Minimum Data Set (MHMD), which is being piloted and will be in use nationally by March 2003. Early priority will be given to involving all NHS mental health providers in benchmarking.

1.12.2 Local Development

Services are in place locally to ensure that services provide equitable, accessible, comprehensive mental health services for all the people based on need, irrespective of where they live, their age, gender, sexuality, disability, race, ethnicity or their social, cultural and religious background. Due consideration is given to locally implemented plans and should be sensitive to cultural and social needs, including the needs of people from smaller communities, people with disabilities, homeless people, and people caring for others including their children.

There is good information available to commissioners to support the implementation of this NSF.

Any individual with an identified serious mental illness is able to contact local services on a 24-hour basis in order to have their needs assessed and receive appropriate advice, treatment, care and/or support. Authorities and agencies are to ensure that users and carers and other organizations (e.g. police, homelessness agencies) are informed about how to contact local services and are to establish robust and clear routes of referral (including out of hours) between primary and secondary care to ensure access to services.

Minimum data set established and information made available.

1.12.3 Examples of Local Practice

Information about local Services

Mental Health and well being workshop "Evidence into Practice";
Mental Health Improvement Strategy Workshop;

These workshops were held to include residential training for people who have direct experience of mental ill health or were service providers with the aim of exploring the impact of mental health in western isles and to raise the profile and understanding of mental health. Similarly training and access to the services were improved;

Access into Services

Specialist Outreach Services – Alcohol Team, Homelessness Action Plan 2002-05

Within these specialists outreach services a number of strategies have been put in place to look at how to improve understanding and access to services. Training has been provided for staff, not only to improve and increase availability of services but to promote the awareness of such issues;

1.13 Individual Planning of Services

1.13.1 National Development:

Planning of services falls to a number of commissioned bodies:

- The relevant health board;
- Relevant NHS trust(s);
- Social work department;
- Housing department.

The commitment to planning services should relate to:

- Setting up a robust and continuing system to involve those who receive services and those who care for them;
- The philosophy embodied in the Framework and the Government's principles of a public service which tackles inequalities of health and access to services, focuses on better quality and is efficient;
- Achieve a single plan for local comprehensive mental health services;
- The use of resources employed in the delivery of existing mental health services in the most effective way, avoiding gaps and overlap;
- The delegation of authority to a joint commissioning team;
- The process of identifying an individual to be both responsible for, and accountable for, the functioning of that commissioning team;
- Make explicit the nature of the resource allocation, within health, social work and housing, that it follows the requirements of the implementation of an agreed strategy, and that they have harmonised their internal financial timetables;

- Define the amount of previous resource transfer from health to social work, the current spend, and the services specified;
- Make each other aware of how far their organisations are able and ready to go down the path of joint commissioning at that time.

1.13.2 Local Action

Within a small local health authority it is important for all those involved to agree the process by which an individual can be identified quickly to assume lead responsibility within the joint commissioning team, including consideration of an independent chair from the Voluntary Sector;

- Define a set of core values to be adopted by all concerned, by which the services will be developed and shaped, within the outline set out in the Framework;
- Be clear about the function of primary care, specialist mental health services, social work, housing and voluntary agencies, in the delivery of comprehensive mental health services, and the resources which each will be contributing to the comprehensive service in the future;
- Consider, in the light of individual circumstances, whether an outside consultancy should be employed to facilitate progress to joint working;
- Clarify the relationship between the strategy for developing mental health services, the local community care planning arrangements and children's service plans.

1.13.3 Examples of Local Practice

Individual Assessment of Needs

Joint care planning – JLIP. MHP, – number of agencies involved working alongside each other;

Assessment

Self-Assessment – Advocacy;

Care Planning

Joint care planning – JLIP. MHP, – number of agencies involved working alongside each other;

Joint Protocols;

Care planning – joint care planning procedures regular, predicted outcomes, one key Worker responsible for co-ordinating delivery;

1.14 Services to promote wellbeing and social development

To actively promote good mental health for all, tackle stigma relating to mental illness and to promote social inclusion of people with mental health problems is to :

- Help people develop the skills to stay free of, or minimise the effects of mental health problems at stressful times in their life and survive mental health problems;
- Promote the understanding of mental health issues, in order to reduce the stigma associated with mental illness;
- Ensure that formulation, delivery and revision of other social and economic policies and programmes takes account of potential impacts on mental health. For example, policies and services in education/training, employment and housing;
- Create a society that embraces and welcomes diversity and facilitates people with mental health problems to participate as fully as they wish.

1.14.1 National Development

Health and social services should promote mental health for all, working with individuals and communities and combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Through health improvement programmes and local mental health strategies, local health and social care communities - local health authorities, local authorities, NHS trusts, primary care groups and trusts, and the independent sector - should develop effective mental health promotion.

Performance will be assessed at a national level by:

- A long term improvement in the psychological health of the population;
- A reduction in suicide rates;
- Health improvement programmes demonstrating action within and linkages Between organisations to promote good mental health in schools, workplaces and neighbourhoods for individuals at risk;
- For groups who are most vulnerable;
- To combat the discrimination against and social exclusion of people with mental health problems;

1.14.2 Local roles and responsibilities

Lead organisation: health authority

Lead officer: chief executive

Key partners: primary care groups, including GPs, local authority, NHS trust, independent sector providers, local employers, educational establishments, and service users and carers.

1.14.3 Local Development:

At a local level, it would be now be beneficial to develop inter-agency mental health strategies, which incorporate promotion, prevention and care interventions to improve mental health of whole populations and at risk groups and also reduce mental health problems such as suicide and self-harm. Such strategies would help provide a more coherent approach to local mental health planning and could be supported as necessary by more detailed plans on issues such as mental health services (which are currently in place) and suicide and self-harm. In addition, such local mental health strategies would inform the appropriate integration of mental health issues within other local plans such as:

- NHS Health improvement plans
- Joint Mental Health Service Plans
- Joint community care plans
- Joint Children's Services Plans
- Local authority Community Plans
- Local authority service plans, such as education.

1.14.4 Examples of Local Practice

The Mental Health and Well Being Action Plan 2004-06 is part of a strategy which includes the Choose Life Action Plan, the Mental Health Action Plan, the Community Well Being plan and the Western Isles Local Health Plan;

The 4 key aims were:

- To raise awareness and promote mental health;
- To eliminate stigma;
- To prevent suicide;
- To promote and support recovery.

Two training day sessions have been held in Uist, Barra and Stornoway with the objectives for raising awareness, providing info about initatives, improving knowledge on mental health issues and exploring the ways in which MH promotion can be monitored;

1.14.5 Advocacy, Advice and Info Services

The following agencies and initiatives have been introduced to work towards achieving this;

Mental Health Training for Volunteers – 4 half day sessions with volunteers who work for a range of agencies. Issues raised by participants included confidence, confidentiality, supervision of voluntary sector, risk management, looking after yourself etc; More specific training is planned;

Choose life/WIMHP Suicide Prevention Action Plan – this included statutory and voluntary agencies. The main aims were to improve early intervention through raising awareness, improving earlier identification of those at risk, develop local responses for support etc. This was to be measured through local and joint protocols, screening mechanisms and a review of existing planning systems. Currently a number of outcomes have been achieved with networking links established, recommendations implemented through reviews and information sharing protocols in place following this.

Following this as regards the national framework and objectives which have to be met the Western Isles Suicide strategy has met the majority of milestones. Areas which are unclear are:

Advocacy Services- Advocacy Western Isles focus on groups most at risk from exclusion etc;

Stigma- focus groups held

1.14.6 Areas for Development

As the Western Isles Mental Health and Well Being plan is due for renewal, the following should be considered.

Every Health and Well Being Plan and Social Services Social Care Plan should include a comprehensive mental health component. A Local Mental Health Strategic Planning Group should be set up in each LA/LHB area to co-ordinate the local planning, design, monitoring and evaluation of services. This will ensure the adoption of a comprehensive, integrated and seamless approach. Representatives of all relevant authorities and agencies, including the voluntary sector and users and carers should participate in such strategic planning groups.

Local Authorities, in conjunction with Local Health Boards and voluntary agencies, should identify how they will meet the needs of groups which have particular difficulty accessing services, such as homeless people, ethnic minorities (including travellers) and people with disabilities.

1.15 Services for ordinary living and long-term support

It is widely recognized that people with mental health problems often face a range of difficulties securing appropriate housing and support services. Replacement facilities following the closure of long-stay psychiatric hospitals have not been adequate to meet the needs of new long-term mental health service users. Social services and health services increasingly concentrate on the provision of crisis, high-need services, and housing providers do not have sufficient resources to provide housing-related services to the increasing numbers of people living unsupported in ordinary housing. As a consequence, people often experience a 'revolving door' situation where they are admitted to psychiatric hospital when at crisis point, but services are withdrawn when they appear to be well, only to leave people unsupported, and vulnerable to further readmissions to hospital.

1.15.1 National Development

By having schemes in place to deal with support for ordinary living, there are a number of number of benefits to agencies, including: the freeing-up of mental health professionals to concentrate on higher level interventions; reduced housing management input; and significant improvements in joint working, particularly between health/social services and housing agencies.

1.15.2 Local Development

Most users felt that Home-Link had made an appreciable difference to their lives, helping them to attain and maintain independence. Users felt the most valuable aspects of the services were the provision of good quality housing, the support with household finances, the personal contact of visits and knowing that there was someone there to call on. All users wanted the support to continue on a long-term basis.

1.15.3 Providing housing

The housing department agreed to allocate secure tenancies, on a priority basis, to users. Accommodation was arranged within weeks or a few months of referral and the properties were generally of a good standard.

1.15.4 Individual support from the Home-Link workers

The Home-Link workers were able to provide assistance with any task related to running an independent household. Most users required assistance with managing their household finances (benefits, budgeting, bills, etc.). The support was very practical in nature and could include diverse activities such as helping people redecorate or taking the cat to the vet. The workers appeared to enjoy greater flexibility than professionals, doing things for people as well as enabling people to undertake tasks themselves.

The workers also provided much general support, company and reassurance to users. The support workers were intentionally not qualified as mental health professionals to avoid a medical emphasis, and both users and agencies perceived the worker as being closer to a friend than a formal worker. Relationships between users and workers were easy ones, characterised by mutual respect and trust.

1.15.5 Developing a mutual support network

The Home-Link scheme attempted to address the isolation which can be an unintended consequence of living alone, by introducing people to each other and organising social occasions like lunches and outings. This aspect of the scheme was slow to develop due to an initial reluctance by agencies, for fear of invading people's privacy. However, when organised, social activities were well attended and welcomed by most users, providing opportunities for conviviality and the company of people in similar situations as themselves.

It was also hoped that, as users lived relatively close to each other, they would meet up outside the organised occasions, and perhaps some friendship would develop. However, few users did see each other outside the organised social activities, unless they knew each other previously or lived very close to each other. There appeared to be further scope for promoting the 'good neighbour' aspect of the scheme.

1.15.6 Working with other agencies

Home-Link complemented rather than replaced professional mental health services. The Home-Link workers, in most cases, were working alongside other agencies to deliver support to users. The Home-Link support workers appeared to provide a central or pivotal role in client care:

The main advantages following from the nature of this support scheme is the ability to enable users to feel that the service had made an appreciable difference to their life, helping them attain and maintain independence and the main areas were:

- The opportunity to live independently
- Assistance with household affairs
- The value of personal and social contact
- Being able to call on someone

1.15.7 Areas for consideration

This scheme offered a number of benefits to agencies. Health and social services felt that Home-Link freed up some professional time to concentrate on higher level tasks or people with more severe needs. This also brings about improvements in joint working, despite some operational challenges. In particular, communication and relationships had been built up between housing agencies and health/social services.

However, pressures on resources and tighter eligibility criteria will make the emphasis on continuous, low-level support difficult to sustain. Funding mechanisms will need to be closely monitored if long-term provisions of preventive services are to continue.

1.16 Services offering psychological therapies, including clinical psychology

1.16.1 National Action

Traditionally, when a mental health problem is identified, a member of the primary health care team, usually the GP, makes a referral to a psychiatrist, psychologist, Community Psychiatric Nurse or Social Worker, working in secondary care in a community team base or a psychiatric hospital. Crises are dealt with through involvement of the 'team' psychiatrist and in-patients services.

Service users report a stigma attached to attending some psychiatric services and there are commonly long waiting times for an appointment; they say travelling is inconvenient and they would prefer services to be provided in a `one stop shop.'

Other factors such as the acquisition of a psychiatric record may also have a bearing if patients fear it may impact upon their insurance eligibility or employment prospects. These problems and prompt the question of why the patient is 'transported' from primary care to secondary care.

1.16.2 Psychologists

Psychologists make important contributions to meeting the needs of a wide spectrum of adults with mental health problems, in both acute and non-acute settings. In recent years, with the growth in counselling services linked to primary care, professional oversight of newly-deployed counselling personnel has often been provided by psychologists. This has not been matched with a corresponding increasing in staffing, at a time of growing demand for psychological interventions.

1.16.3 Local Action

Establishing early intervention services will require significant new resources, including specialist trained staff. Rather than a single, uniform service model, several models of early intervention services based on locally determined need might be more realistic and appropriate, and also allow research into their relative efficacy. many teams do not have adequately trained staff to provide psychosocial interventions. Even where such staff were available, care was focused mainly on monitoring medication and risk assessment, with half the teams providing psycho-educational programmes and only a quarter offering individual cognitive-behavioural therapy.

An unmet need for liaison psychiatry services is clearly perceived. The general hospital liaison psychiatry clinic provides an acceptable setting in which to assess and manage patients referred from non-psychiatric colleagues. The lack of adequate psychological treatment services often provided a barrier to optimal management of some of the more disabled patients.

Secondary mental health services are being targeted towards the more needy patients. The provision of special services in practices can shift care further away from secondary care while still meeting patients' needs. Two factors remained significant predictors of contact in a logistic regression model: whether or not the patient's practice offered a special service on site, and greater patient needs for care.

1.16.4 Example of Local Practice

Provision of formal psychological therapy to patients

Current therapies available in the Western Isles are:

CBT therapist;
CPN'S
Nurse Counsellors (24 hour availability)
Psychotherapy Sessions;
Western Isles Counselling and Family Mediation;
Counsellors based at General Practice;
Lifestyle ADSAT
Substance Misuse;

Doing well by people with depression – service development and positive outcomes; Clear referral channels, comprehensive assessment and flexibility in treatment, is this possible with lack of specialist services and small demand for services?

1.16.5 **Local Support, Training and Supervision**

Community mental health teams (CMHTs) are still the cornerstone of specialised mental health care. Most of the "hands on" work is carried out by Community Psychiatric Nurses (CPNs) who manage people with varying degrees of severe mental illness and those with complex common mental health problems. Ongoing complex cases are commonly supported, for example, through the provision of assertive outreach. CPNs also contribute to the assessment of people identified by the GP as requiring specialist input and, if adequately qualified, they will deliver therapies.

However, caseloads are invariably high. CMHTs have little opportunity to influence the referrals they receive from the GP, or address the mental health needs of a whole community. There is very little opportunity to assist GPs and others in primary care in improving and enhancing their ability to manage people with mental health problems. However, communication between primary and secondary care for patients with mental illness is commonly poor.

In view of the high risk of death by suicide amongst those discharged from psychiatric Hospital it is essential that communication and information systems improve.

The Acute Psychiatric Unit at the hospital to is in place to deliver assertive outreach, crisis intervention and home treatment, and early intervention teams to offer effective treatment when the first signs of psychosis appear. It will be essential that CMHTs review their roles and functioning to ensure that there is a coherent approach to the management of mental illness – in particular the interface with primary care.

The introduction of two systems – primary and specialised care - to meet demand will ultimately hinge on their ability to integrate services.

There is a shortage of trained clinical psychologists as well as a shortage of funded training posts. These impair the service's ability to meet the current demand for psychological assessment and support, and to prepare to meet future demands. Tackling this requires both an increase in the number of psychology assistant posts to provide structured experience prior to training, and an increase in the number of funded training posts.

1.16.6 Areas for Consideration

The establishment of a primary care mental health lead in each region;

Improved systems for liaison between primary and specialised care;

Performance Target Evidence of case load management - Waiting lists for psychological therapies;

Independent studies have demonstrated that, for many psychologists in practice, lack of – or dispersed – management and accountability structures in NHS Trusts relevant to psychology impairs those organisations' ability both to attract and retain skilled and experienced staff. Lack of such arrangements is also, too often, associated with inadequate supervision of professional practice and insufficient focus on continuing professional development of staff. These further prejudice staffs' continued preparedness to work in such organisations, prompting increased turnover.

1.17 Services offering physical methods of treatment

1.17.1 National Development

The main areas which are to be considered when looking at physical methods of treatment in relation to those with Mental Health are:

- People who may benefit from treatment are identified;
- People who are asked to take a form of treatment are fully informed and able to make an appropriate choice;
- Care staff working with people receiving treatment are trained adequately;
- Strict compliance with legislative framework;
- The budget available within a service or locality to fund treatment is used to the best effect;
- The Physical Environment for the Giving of Treatments is Appropriate.

Certain mental health problems or particular groups of symptoms respond to the use of medications, in a way which cannot be achieved by other forms of treatment, e.g. psychological therapies. Training for Primary Health Care Team (PHCT) staff, and staff from partner agencies, in recognition of disorders which may well respond to treatment and in the benefits which will flow from this.

The administration of medication and other treatments against an individual's wishes in certain circumstances is discussed in terms of the following:

- Local audit of the use of Forms 9 and 10 to ensure compliance with 1984 Act, Sections 97 and 98;
- Widespread availability of information and individual independent advocacy for persons subject to detention about their legal rights;
- Appropriate use of the Second Opinion Doctor mechanism through the Mental Welfare Commission, as laid down in the 1984 Act.
- Multi-disciplinary training, involving people who receive services, in the implementation of the New Mental Health Act;

When discussing the use of treatment and its use being most cost-effective this is discussed in terms of a balance has to be achieved between:

- Use of the cheapest available medication;
- The resulting side effects, (the older the drug, the more inexpensive, but the more side effect-full);
- The effect of side effects on compliance by those who receive the treatment; and
- Efficacy;

It has also been suggested within the National Framework that:

- The locality or service formulary group should liaise with the Health Board and Joint Commissioning Team on the fiscal implications of a new treatment;
- The formulary group should assess the evidence for the effectiveness and indications for the new treatment;
- Any national or professional guidance should be considered;
- A protocol should be developed for use of the new compounds, indicating when they can be used (often after two different existing treatments have failed to produce an improvement);
- Means of assessing any betterment for the person receiving the treatment, including his/her personal experience, should be specified;
- A criterion by which the new treatment should be withdrawn or continued on the basis of its success or failure - including the views of the person taking the treatment and the person looking after him/her - must be established;
- The view of the GP who may have to continue prescribing the new treatment must be sought.

Certain treatments, particularly ECT, must be given in a safe environment with the correct equipment available.

- Purpose designed ECT suite.
- Active supervision by a nominated consultant.
- Separation of activities, e.g. waiting, treatment and recovery.
- Full range of modern monitoring and treatment equipment.
- Adherence to protocols and national guidance.

1.17.2 Local Development

Giving more information or giving it in a way which people can understand is the best way of making a partnership in treatment work. Early recognition of side effects, and awareness of the likely experience of the person taking the treatment, and of the means to improve this will enhance the prospect of successful treatment.

Training for the PHCT, staff from partner agencies and staff working within the CMHT;

Support by a member of the CMHT for practice and treatment room nurses in primary care settings who give long-term treatments;

Use of outcome measures and feedback from people receiving treatment;

Clinical audit focused on areas of risk e.g. long term treatments, acute treatments in urgent situations;

Protocols for the administration of treatments and an audit of compliance with these carried out on a regular basis, e.g. ECT;

Benchmarking with comparable service areas elsewhere;

Use of professional, SIGN guidelines and CRAG/SCOTMEG Good Practice Guidelines.1

A locality or service formulary group composed of representatives of primary care, the mental health services, pharmacists and people who receive services;

The possibility for particular persons to receive a treatment not within the formulary if the responsible doctor can give a reasoned agreement based on enhanced health gain for the person;

Regular review of the formulary in the light of experience, audit findings, reported adverse effects, and the professional literature.

1.17.3 Examples of Local Practice

People who can benefit identified

Target Groups and levels were determined using the Training Template, Specific Planning for training etc;

People who are asked to take treatment informed

Advocacy services must too now work with patients and carers for information regarding legal rights and changes to this;

Care staff trained adequately

Western Isles Training Report - introduced training delivery in preparation for the introduction of the new Act. Information was given on how to deliver to small, specific groups and future training info;

Strict Compliance with legislative framework

Under the direction of the new Mental Health Act regarding administration of medicines, treatment orders etc it must be ensured that staff are now fully trained and versed in multi-disciplinary approaches;

1.17.4 Areas for Consideration:

New treatments for psychiatric disorders and new antidepressants offering fewer side effects, and sometimes greater efficacy, but at greater immediate cost, continue to be introduced.

1.18 Service Profiles

1.18.1 Adults with Mental Health Problems

Inpatient and community services are provided in fit for purpose environments. These are to offer dignity, privacy and appropriate space and resources for purposeful activity for users and staff. A therapeutic, supportive environment must be created and properly staffed. People are to be treated in the least restrictive environment possible.

New purpose-designed psychiatric wards can result in positive changes in the perceptions and behaviour of nursing staff. Community mental health teams are to be fully multidisciplinary and working from a common base. They are to effective liaison with primary care and specialised services. Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide.

Shifting to a consultation-liaison relationship increases rates of referral of patients with serious mental illness, including those who can most benefit from the skills of CMHTs. Increasing the provision of primary care-based psychology might improve practice use of mental health services, reducing avoidable outpatient psychiatric referrals.

The overall impression of primary care teams encountering high levels of need for which they felt unprepared, and of a community psychiatric nurse (CPN) service torn in two by the opposing demands of general practitioners (GPs) and their employing trust.

Each LA/LHB is to have a range of alternatives to admission and facilities to support individuals after discharge, including day services. This should include supervised short or medium term accommodation with residential care staff on site and mechanisms to support people in their own accommodation:

Acute day hospitals: Caring for people in acute day hospitals can achieve substantial reductions in the numbers of people needing inpatient care, whilst improving patient outcome.

Day hospital versus outpatient care: There was some limited evidence to support the use of day treatment programmes for patients with anxiety or depression who have not responded to standard outpatient treatment.

Home treatment / crisis resolution: The benefit of home treatment over admission in terms of days in hospital was clear.

Partial hospitalisation: Although partial hospitalisation is not an option for all patients requiring intensive services, outcomes of partial hospitalisation patients in these studies were no different from those of inpatients. A clearer definition of partial hospitalisation will help consolidate its role in the continuum of mental health services.

The use of short-stay admission coupled with extended day care and crisis line support can provide a viable alternative to admission to the acute ward.

Clinicians have a strong gate-keeping role in which collective views about appropriate patients, and the need to ensure turnover of places, are dominant considerations. The gate-keeping role involves managing expectations of referrers and managers, and the level of risk taken on by the medium secure service.

The aim of all National Service Frameworks is to drive up quality; tackle variations in access to care, increase the effectiveness of care and enhance user and carer experience by ensuring changes are systematic and sustainable. Changes must;

- Be measurable and make a difference to the quality of services received by service users
- Set standards that are ambitious but achievable
- Ensure all the partner agencies work together at local and national level to secure change.

Every local health board (LHB) should have a Local Mental Health Strategic Planning Group to co-ordinate commissioning and each will be expected to include plans to prioritise and improve local mental health services as part of its wider improvement plans. This group should include representation from voluntary/independent sector service providers.

The revised Care Programme Approach (CPA) will be implemented to provide systematic arrangements for assessing the health and social needs of people accepted into the specialist mental health services. This will assist in he formulation of a care plan that identifies the health and social care requirements from a variety of providers. It will ensure regular review of the care plan and it formalises the appointment of a care co-ordinator to keep in close touch with the service user and monitor and co-ordinate care. This should ensure effective care co-ordination and allow access for individual service users to the full range of health and community services they need to promote their recovery and social inclusion**.** Authorities will need to ensure a fully integrated approach to the CPA and the health and social services unified approach to assessing and managing care.

Services are expected to follow the aims set out in the Strategy and to work together in order to provide a spectrum of care appropriate to level of need. This will require:

- Close co-operation between social services, health authorities and the voluntary and private sectors in order to commission effective, comprehensive and co-ordinated mental health services which are accessible by all;

- Specific arrangements to be in place to ensure the constructive participation of users and carers in the planning, design, monitoring and evaluation of services in order to empower them in relation to service providers

- Clinical governance and best value arrangements to be in place in order to ensure that matters of effectiveness and quality are given high priority in mental health services

- Good communication and co-ordination within and between different parts of the mental health services in order to provide efficient and responsive care

- Provision of effective and high quality medical, nursing, psychological and social care for service users and carers based on best evidence and practice

- Mental health services in settings that are fit for purpose and provide dignity and privacy

- The provision of seamless care for users irrespective of who is delivering the service and where, e.g. whether they are in-patients, attending the community mental health team (CMHT) or utilising day services.

- Clear, appropriate and helpful information for users and carers on aspects of mental health problems and accessing support and services;

1.18.2 Local Development

- In-patient beds
- Staff in Community Mental Health Teams
- Day services and Day Treatment Units for adults and older adults with mental health problems
- Psychology services
- Therapeutic services for people with learning disabilities
- Services for people with alcohol problems
- Services for young people with mental health problems

In developing services the following should be considered. Firstly, the development of community crisis resolution/home treatment services, for hospital admission and when admission is necessary facilitate safer and more prompt hospital discharge. Secondly, improvements in inpatient environments through the enhancement of staffing and the reconfiguration of wards, as such improvements have been demonstrated to improve patient safety, privacy and dignity and therapeutic outcomes.

Secondary mental health services are being targeted towards the more needy patients. The provision of special services in practices can shift care further away from secondary care while still meeting patients' needs. Two factors remained significant predictors of contact in a logistic regression model: whether or not the patient's practice offered a special service on site, and greater patient needs for care.

Implementation of the plan needs to be organised and coordinated in such a way that allows individuals and organisations to take initiatives of their own whilst working within a common framework. This will only be achieved through the work of clinicians and other staff directly in contact with service users.

This includes:

- Planning, development and management based on teams who care for service users in their journey through the system meaning a greater emphasis be placed on the creation of networks of people and pathways of care and where investment follows the service user rather than be targeted at the organisation or institution;
- An organisational framework based on common ways of operating;
- A value base shared by all
- Recognition and facilitation of best practice and sharing of knowledge;
- Shared and effective communication across the health and social care community;

1.19 Children and young people with mental health problems or behavioural problems

1.19.1 National Development

Many of the issues addressed in relation to the workforce needed for mental health services for working age adults are of relevance to child and adolescent mental health services (CAMHS), too. The national strategy for improving CAMHS, has a different emphasis and its implementation is being considered separately from but in parallel with the NSF for adult mental health.

The Government priorities for CAMHS are set out in the National Priorities Guidance 1999/2002. To improve provision of appropriate, high quality care and treatment for children and young people by building up locally-based CAMHS through improved staffing levels and training provision at all tiers the following should be considered; improved liaison between primary care, specialist CAMHS, social services and other agencies; and should lead to users of the service being able to expect:-

- A comprehensive assessment and, where indicated, a plan for treatment without a prolonged wait;
- A range of advice, consultation and care within primary care and Local Authority settings;
- A range of treatments within specialist settings based on the best evidence of effectiveness; and
- In-patient care in a specialist setting, appropriate to their age and clinical need.

1.19.2 Perinatal Mental Health

Perinatal mental health problems are common, many are serious and they can have long-lasting effects on maternal health and child development. Perinatal mental health problems present at all levels of health care provision. Every health authority should have a perinatal mental health strategy that aims to ensure that the knowledge, skills and resources necessary for detection and prompt and effective treatment are in place at all levels of health care provision.

Every health authority should identify a consultant with a special interest in perinatal psychiatry. This consultant should take a lead role in promoting these aims and in establishing a specialist multi-disciplinary team. All women with perinatal psychiatric disorder who require specialist psychiatric care should, irrespective of their place of residence, have access to a consultant and other mental health professionals with a special interest in their condition. Mother and baby units to serve the needs of a number of health authorities should be established.

1.19.3 Local Development:

Child and Adolescent Mental Health is an area within the Western Isles which has been developed over the years. Compared to the rest of Scotland is has received positive feedback but the need for specialist services were looked at.

Local Development for the CAMHS Mental Health Provision has included the following:

- Strong inter-agency commitment over the medium to long-term, including a steering group willing to tackle tricky issues, and a commitment to consulting with and acting on children's and families views;

- Links with existing services within CAMHS, including the integration of the service within the CAMHS tiered framework and CAMHS development strategy;

- Links with other services and initiatives outside CAMHS e.g. education, the voluntary sector and area-based initiatives;

1.19.4 Areas allowing for further development

- An ability to attract new sources of funding;

- Retention of a stable, multi-disciplinary staff group with opportunities for training and development;

- Positive commitment to continued evaluation and audit; and

- Balance between providing a direct service to users and influencing the broader network.

1.19.5 Example of Local Practice

Organisation
A comprehensive CAMHS service operates at many levels. This has been filled with the following:

Tier 1: problems which require non-psychiatric professional help at the primary care level, in schools or the wider community;

- Child mental health worker employed;
- Assisting teachers and youth groups contributes to non-psychiatric help;
- There is a gap where there is no supervision from above;

Tier 2: More serious problems which require the intervention of professionals with specialist knowledge of child mental health in support of Tier 1 care staff;

Tier 3: Serious and complex disorders which require specialist help;

- Done through outpatients;
- CPN Barra

Tier 4: Extremely severe and complex problems;

- policies on admittance;
- the CAMHS team consists of an educational psychologist, NCH, speech therapist, CH occupational therapist, Child nurse and Counsellors.

Identification of Services and Availability of Services

The service provided is multi-agency, collaborative and planned to a protocol to health. The medicilisation of social problems should be avoided especially in an area as small as this.

Children and Drugs

This is primarily dealt with through health promotion.

Are there drug workers on the street?

No specialised ADSAT worker for adolescents;

1.19.6 Areas for Discussion

Improved identification, referral & tracking procedures, integrated assessment and targeted prevention work;

Consolidate the work of the Joint Agency Teams (JATs) to include mental health and better links;

Support the implementation of the Children's National Service Framework (NSF.)

Strengthen staff skills development and training opportunities within early years provision;

Simplify and improve joint planning and commissioning arrangements between agencies working with vulnerable adolescents;

1.19.7 Areas for Development

The number of training placements in some specialisms, e.g. clinical child psychology, is limited by the lack of available and eligible supervisors. Other specialisms, e.g. Child Psychiatry, are experiencing difficulties to trainee places. Child Psychotherapy training, whilst becoming more widely available, is largely centred Social workers in children's services have a range of skills in working with children and their families but may not have had any specific mental health training. In contrast, mental health expertise within social services is mainly located within the adult social work service.

The provision of social services for children and young people with more complex or severe mental health problems may, nonetheless, require both types of skill. At present, opportunities for such dual training are limited.

1.20 Older people with mental health problems, including early onset dementia

The National Service Framework for Older People, published in March 2001, has four main themes

- Respecting the individual
- Intermediate care
- Providing evidenced-based specialist care, and
- Promoting an active, healthy life

1.20.1 National Development

All these themes will impact on the desired improvements in health and social care services for older people with mental health problems. Within the general theme of evidenced-based specialist care there is a focus on those conditions which are particularly Significant for older people and which have not been addressed elsewhere, in other frameworks or strategies. This includes a specific standard that addresses the major mental health problems associated with older age. It recognises that conditions such as dementia are not limited to older people, and that the standards and service models it describes will apply for all who need the particular services, regardless of their chronological age.

Although the focus tends to be on depression and dementia, which are particularly common in older people, illnesses such as schizophrenia also occur. Where an older person has a severe mental illness due to a psychotic illness such as schizophrenia, they will require packages of care set out in the NSF for Mental Health and the same standards should apply as or working age adults.

1.20.2 Local Development

The planning of workforce requirements and the strategies needed to ensure that these are met will be a vital aspect underpinning delivery of the NSF standards. There are considerable overlaps in the workforce issues for younger and older adults including, generic and joint training across the specialisms within psychiatry, considerable movement and responsibility of staff between the two groups and the varied configuration of services at local level.

The Joint Strategy for Services for people with dementia was introduced. Their baseline principles were as follows:

- People with dementia can choose to live in their own home;
- Needs of unpaid carers needs to be considered;
- Emphasis placed on people maintaining structures in their day to day lives;'
- Help to maintain a good quality of life for people with dementia and those around them;

In the WIMHP report a number of key issues were discussed to ensure service improvement:

- Locally based services needed to minimize crisis situations;
- The need for comprehensive yet flexible home support service;
- Multi-agency dementia teams;
- Training for workers;
- Development of day care;

The reconfiguration of existing services alongside new structure for care and assessment would be critical and the development of the following priorities will gauge this:

- Establishment of a specialist nursing home and the provision of sufficient respite care;
- All care homes to have systems in place to deal with people with dementia supported by the establishment of one specialist assessment bed in each hospital;

1.20.3 Example of Local Practice

Psych/Physical and Psycho-Social Assesment

Specialist multi-disciplinary assessment team including GP's, Social Work, Family Carer and CPN's
Outpatient Assessment Facilities
Liaison Assessment

Specialist treatment and Intervention

There are at the moment in patient/Residental Care and Nursing Home Care offered through long stay beds, respite care beds, assessment beds, emergency beds.

One consultant psychiatrist specialising has just retired;

One community Psychiatric nurse specialising in dementia;

Alzheimer Scotland Action

Similarly a number of key recommendations were made:

- Specialist dementia teams should be established;
- These teams would consist of CPN, Social Worker and an OT;
- This team would be responsible for setting up and maintaining information data base and links with other organizations;
- This team would work in partnership with other local teams, with families and carers in decision making and reviewing;
- The devolution of a purchasing budget;
- Regular specialist clinics for people with dementia in all localities;

Support to remain in own home
Specialist teams
Day hospital

Respite
Current services offered are in patient/residential nursing, non specialist services, Alzheimer Scotland Action;

Continuing Care
Nursing homes

1.20.4 Areas for Consideration

Working with partners to map preventive services.

Develop a framework for monitoring the progress of schemes and the outcomes achieved to ensure consistent approach in commissioning and provision.

Develop and implement an information sharing process about preventive services, which is up to date and shared with staff, users, carers and other stakeholders.

To improve preventive health care to BME persons.

1.21 Mentally disordered offenders

Workforce development confederations have been instructed to reflect the needs of NHS and non-NHS organisations involved in the delivery of health care. The guidance specifies that a Prison Service representative must be included in the membership of the Confederation, where appropriate. Although the Prison health care workforce is relatively small, prisoners suffer from high levels of mental health morbidity and it will be important for confederations to take into account the needs of this group of staff in workforce planning and development. Consideration should be given to developing joint learning opportunities to reduce the professional isolation of prison health care staff and also to allow staff in the community to benefit from some of the specialist skills gained by staff working in custodial settings.

1.21.1 National Development

Mental health services are increasingly provided by multi-disciplinary community teams or by other specialised community services. Primary care services also link with the care provided by local authority community care services, which in turn are supported by a range of partners including housing, education and voluntary and independent sector organisations. Most mentally disordered people who have, or are alleged to have, offended are not in hospital but are in the care of health professionals and social work staff in the community.

It follows that there is a need for comprehensive, well-integrated community services which operate in a variety of settings, with sufficient flexibility to respond to individual needs, whether or not the offender is under any form of statutory supervision.

Health boards and social work authorities will therefore already be including mentally disordered offenders in their local assessment and care management procedures. The available services and possible development proposals should be identified in a section in their community care plans devoted to this client group and in annual and strategic plans for 100% funded criminal justice social work services.

NHS staff play an important role in contributing to community-based assessments and in the development of programmes of community care. Community care planning teams in developing their joint links between social work departments, housing agencies and health boards should ensure that local psychiatric and psychological services have an opportunity to contribute to the planning process. These links will also assist in the development of a joint approach to assessment and service delivery. Planning for social work services in the criminal justice system should be aligned as far as practicable with planning for community care services to ensure that appropriate access to social care services is available.

Each case must be jointly assessed with criminal justice and community care interests closely involved to determine an outcome which meets the following aims:

(a) safeguards public safety;

(b) delivers any statutory requirements (such as probation, etc);

(c) meets the needs of the offender in a way that is likely to reduce offending behaviour.

In the majority of cases there are no special forensic needs arising from the offending behaviour. Decisions about the provision of local services must therefore take account of the need to cater for mentally disordered offenders, and for ensuring that they gain access to them. All mentally disordered offenders, especially those who require services that take account of their "special needs", should be provided with a properly co-ordinated programme of specialised care, treatment or supervision and effective multi-disciplinary pre-release planning undertaken before discharge from hospital or release from custody. In all cases service provision is tailored to meet individual needs while ensuring that public protection is a key consideration.

1.21.2 Individual Care Plans

The Care Programme Approach specifies arrangements for ensuring that people in the community who have severe and enduring mental illness and complex health and social service needs are provided with individual care plans which set out the support and care they will receive.

All severely mentally ill people whether in the community or in hospital prior to discharge should be assessed for the Care Programme Approach. This applies to patients in all hospitals including the State Hospital.

1.21.3 Local Development

Local government re-organisation provided opportunities for building fresh links between the new councils and health boards. Services for mentally disordered offenders require multi-agency working as recommended in the Framework for Mental Health Services in Scotland. The health board could act as the base for a local forum to consider the needs of this group. This would provide a source of co-ordinated expertise and guidance for local developments; it would also be able to identify service needs and gaps in provision. The local forum should include nominees from the health board, social work, criminal justice and community care services and housing departments; appropriate voluntary organisations should also be included as well as the police, procurators fiscal and the courts. The forum should communicate directly with both general and forensic psychiatric services in the health board area and also with the services provided for people with learning disabilities. Agencies should work on an integrated basis to secure better results for those who use community care services.

As this is a smaller health board area we will not be able to support a viable multi-agency approach to the provision of the more specialised services for mentally disordered offenders. When this is the case, a joint approach with social and health care agencies in adjacent health board areas should be pursued. Shared objectives and on setting agreed strategic targets and priorities at a local level, should where possible have the authority to commit agencies to action on services for mentally disordered offenders and to resource contributions. There should be a mandate to deliver the committed action, to devise practical arrangements for securing collaborative assessments and to develop both service provision and monitoring requirements.

Services for mentally disordered offenders are provided on a case-by-case basis with support services working to monitor and review progress.

1.21.4 Example of Local Practice

Focus

For example, an individual who is transferred from prison to hospital and subsequently discharged could become subject to the Care Programme Approach. This would involve already established links being utilised between the Court system, Criminal Justice Social Work, the CPA core group, psychiatric services and others, such as housing.

Assessment

The JLIP plan highlighted the need to include assistance for functions relating to the new Mental Health Act including emergency detention, named persons etc and more importantly Section 22, approval for GPs and attendance at Tribunals;

Access to Services

Access to structured day activities is central to the successful habilitation or rehabilitation of many mentally disordered offenders. These individuals have difficulty in obtaining employment and the day services should enable retraining to take place alongside any continuing rehabilitation or educational initiatives which were begun in hospital. Multi-agency centres, providing "drop in" and timetabled access to psychiatric, general medical, nursing, and social work support, will be particularly valuable. As voluntary bodies will contribute significantly to these day services, both through their own provision and through support to statutory services, their representatives should be involved at the earliest possible stage in the planning process. The Social Work Services Inspectorate has reported on day services for people with mental illness. This includes much valuable information on good practice.

Objectives

Appropriate Response

Services for mentally disordered offenders require multi-agency working as recommended in the Framework for Mental Health Services in Scotland (9). The health board could act as the base for a local forum to consider the needs of this group. This would provide a source of co-ordinated expertise and guidance for local developments; it would also be able to identify service needs and gaps in provision. The local forum should include nominees from the health board, social work, criminal justice and community care services and housing departments; appropriate voluntary organisations should also be included as well as the police, procurators fiscal and the courts. The forum should communicate directly with both general and forensic psychiatric services in the health board area and also with the services provided for people with learning disabilities.

1.22 Homeless people with mental health problems

1.22.1 National Development

Each Local Authority area are to ensure there is a range of housing options with appropriate levels of support available for people with mental health problems. Forming and delivering effective Local Housing Strategies, Local Homelessness Strategies and Supporting People Operational Plans requires effective joint working between health and housing and social care agencies. This will necessitate health representation on Local Housing Strategy and Homelessness Strategy partnerships and on Supporting People Planning Groups.

The strategic approach should then be reflected in the operational and business plans of Local Authority housing services and RSLs and local health bodies. Housing options are to range from 24 hour staff support to floating and low-level support for individuals in the community with equality of access to mainstream housing opportunities. The housing options are to be provided in collaboration with the independent sector and other partners. Teams admitting people to hospital are to consider practicalities such as keeping up rent or utilities payments as part of the care plan. They are to work with housing and advice agencies to ensure that people will not be homeless following discharge, and that their housing conditions do not undermine their recovery.

1.22.2 Local Development

Example of Local Practice

Proactive outreach

The Western Isles Health and Homelessness Action Plan 2002-2005, published in February 2003, is the basis for a support network for homeless people.

The four areas of work were:

To undertake needs assessment and service activity exercises that identify the major issues and to show where gaps in knowledge and service provision occur. The service activity exercise also will be used to identify the barriers to the accessing of appropriate health care.

To ensure that the strategies and plans of all partners reflects the needs of the homeless.

To provide training on health and homelessness issues to staff in a variety of agencies and organisations.

To implement service improvements/developments that will meet the specific health and healthcare needs of those experiencing or at the risk of homelessness.

Liaison

As regards Homelessness and Mental Health the action points were:

A shared care/dual diagnosis service has been established in Lewis/Harris and Uist/Barra to develop protocols and to respond to the needs of those with drugs and alcohol problems and the service includes the needs of the homeless.

Joint work between CPN/housing/social work and voluntary organisations is well established.

The Church of Scotland Lifestyle project is a partnership involving the Comhairle and NHS Western Isles. It provides counselling advice and supported accommodation for people recovering from alcohol misuse. The supported accommodation is provided by the Comhairle, in Stornoway and clients are guaranteed their own tenancy at the end of one year's successful period of residence with intensive support from Lifestyle staff. However, demand for this service has decreased and use of this accommodation is currently subject to review;

1.22.3 Areas for development

Evidence of incorporation of mental health need into local housing plans.

Suitable opportunities should be available for groups with particular needs, including homeless people. Local employers are to be engaged in this process to ensure that they understand the needs of workers with mental health problems and are supported.

Production of protocol for engaging homeless people.

Inclusion of supportive outreach.

Evidence of Community Mental Health Team (CMHT) procedures for in-reach to homeless people's services.

1.23 People with mental health problems who misuse substances of alcohol

1.23.1 National Development

The Mental Health National Service Framework is the primary planning document of the Government's mental health strategy. These standards are mandatory and are implemented by Local Implementation Teams (LITs). LITs consist of health, social services and independent sector representation, and produce annual implementation plans that set out local mental health issues and outline how they are
to be addressed.

The focus for delivery rests with local health and social care communities - health authorities, local authorities, NHS trusts, Primary Care Trusts, and the independent sector.

The link between mental health problems and alcohol misuse is well- known.

The MHNSF acknowledges alcohol misuse as a significant factor contributing to and with mental health problems, as evidenced by the following examples:

- Alcohol problems can exacerbate mental health problems
- Alcohol can be the physical cause of anxiety
- Alcohol misuse is a psychiatric condition, and one of the 10 leading causes of disability Approximately half of those reporting substance misuse have experienced other mental
- health problems
- People who misuse alcohol or drugs are at significantly greater risk of suicide than those who do not;

Given the complex health and social issues of people with co-existing mental health and substance misuse problems, there is emphasis placed on the importance of careful assessment and awareness of appropriate treatment and referral processes, regardless of the clinical setting.

1.23.2 Local Development

Assessment of individuals with mental health problems, whether in primary or specialist care, should consider the potential role of substance misuse and know how to access appropriate specialist input. Clients with dual diagnosis where the mental illness is a severe one are best treated by services and agencies with expertise in this field. The needs of people with dual diagnosis should be met within existing mental health and drugs and alcohol services.

This service is provided primarily in a primary care setting. Any service user who contacts their primary health care team with a common mental health problem is assessed and offered appropriate treatments including referral to specialist services where necessary. Any individual with a common mental health problem is able to access local services on a 24-hour basis.

Primary care deals with the majority of mental health care provision. Consequently, the issue of co-morbidity (of common mental health problems and substance misuse) needs to be addressed within primary care settings. Primary care also has a critical role in ensuring access to appropriate specialist input for the treatment of people with severe mental illness.

All mental health service users on the Care Programme Approach (CPA) receive care that optimises engagement, reduces risk and prevents or anticipates crisis. Each service user requiring care away from home should have timely access to a bed.

These standards emphasise the importance of a well-coordinated, multi-disciplinary approach to assessing and treating people with dual diagnosis with severe mental illness. Integrated systems of assessment and care planning, care delivery help ensure a seamless provision of service.

There must be specific arrangements in place to agree protocols for management of individuals with a serious mental illness complicated by an alcohol and/or a drug misuse problem. Lead status will be given to general psychiatry for treating the mental illness component of the problem with support from addiction services to manage the substance misuse issues where appropriate.

1.23.3 Areas for Consideration

The needs of people with dual diagnosis through existing mental health and drug and alcohol services;

People with severe mental illness who have high rates of psychological or physical morbidity should receive appropriate and responsive care. Services should ensure that crises are anticipated or prevented wherever possible;

Assertive outreach and crisis resolution services are seen as the main focus for work with people who have dual diagnosis. These must be adequately resourced and trained. Training for all staff, particularly in substance misuse and long-term engagement with clients, is identified as important;

Rehabilitation – through supported housing arrangements, employment opportunities also;

1.2 People with a learning disability who have mental health problems

1.24.1 National Development

The further development of Joint Community Teams to ensure single point of access via single referral and the creation of re-investment for preventative and inpatient services is a key recommendation for mental health service for those with learning disabilities and are further discussed in the following terms:

Services during the day - modernise whole stock of day services provision according to service vision i.e. three tiers of modernised service - complex care in buildings, community based individual support through direct payments, and investment in community infrastructure. Development of routes into mainstream services for employment, leisure, education, opportunities create sustainable personal networks.

Accommodation and support - greater choice, better value, more effective leverage in the market, strategic partnerships with key providers, development of alternatives to residential care including supported living, adult placements. Explore options for shared ownership.

Development of comprehensive short breaks service by transforming current overnight respite. Create individual family centred flexible service.

Involvement - continue to develop embedded involvement - moving from consultation to assured involvement at every stage. Continue to invest in advocacy and speaking up capacity.

Continue to evolve our partnership working both with the health and social care service and with the wider learning disability network.

1.24.2 Local Development

Community Assesment

The multi-disciplinary community learning disability team consists of the CPN, Community Learning Disability Nurses (2) and Psychiatry and Generic Social Work.

The CPA group takes referrals for people with learning disability who have mental health problems.

There are currently 8 beds supported by health.

Service Planning

There is a database of people with learning disability in the Western Isles.

There is a current Partnership in Practice Agreement with Action Plan which the LDP has to monitor and ensure is carried out.

A locality joint planning and commissioning team is really the Learning Disability Partnership. They make recommendations for development, and include representation from all elements.

There is a development of Person Centred Planning in the Western Isles, as the 2 LACs are trained PCP facilitators.

Community treatment and Support

The Community Learning Disability Nurse looked into single shared assessment but this is being developed.
Regular review – there is no community team so this is problematic.
Care packages;

More Specialised Service

There is a small percentage of very specialised support – mainly those with challenging behaviour. Treatments are not available locally and there is now no psych input. These treatments show a need for a specialist which so far has not been developed.

There is no team support for individuals and group therapy is not provided.

Short-term Care

This dual diagnosis is really dealt only through the APU Unit, though there is no inpatient care.

Longer term care

Does not exist. There is perhaps a need for residential v specialised treatment. Support for residential support and mainland living.
Skills acquisition is essential.

Care in secure environment
There are little numbers of people with serious mental health problems and forensic problems and those who do exist go to state hospital.

Special needs

Respite care;
There perhaps needs to be a move towards a more specialised service and this continually evolved to changing needs.

Dementia

Currently 2 people with dementia in a residential service.
(What does the LDP propose to do about any such gaps??)

Areas for consideration:

The development of a multi-disciplinary Learning Disabilities team.

1.25 People with a physical illness who present to a general hospital who have a mental health problem, including those who self harm

1.25.1 National Development

Addressing the physical well being of patients is as important as treating their mental health. However, often too little attention is paid to the physical needs of this patient population. At a national level, it would be now be beneficial to develop inter-agency mental health strategies, which incorporate promotion, prevention and care interventions to improve mental health of whole populations and at risk groups and also reduce mental health problems such as suicide and self-harm. Such strategies would provide a more coherent approach to local mental health planning and could be supported as necessary by more detailed plans on issues such as mental health services (which are currently in place). In addition, such local mental health strategies would inform the appropriate integration of mental health issues within other local plans such as:

NHS Health improvement plans
Joint Mental Health Service Plans
Joint community care plans
Joint Children's Services Plans
Local authority Community Plans

Guidance has been provided about the need to support actions that are effective at population, risk group and individual level and that they need to be informed by some evidence of effectiveness. However, some if not all local actions need support at national level. For example, if we are to improve emotional literacy amongst children and young people, especially boys and young men, this will require changes to national educational policy to create the climate in which local efforts can be effective. Equally, factors such as unemployment amongst young men or excessively demanding working lives amongst some professional groups require national measures around employment and health and safety at work.

To help address this unmet need, a new treatment approach was developed that combines education and lifestyle intervention in order to advance patient care and outcomes. The Complete Wellness approach helps patients combat primary mental illness symptoms and provides resources to mental health professionals to help learn about diet, exercise and healthy lifestyle modifications.

Alcohol abuse and use of illicit drugs are also common problems among people with mental illness. Around half of people with psychotic disorders report illicit drug use.
If a mentally ill person has a physical illness when being treated for a mental illness, there is a strong possibility that the physical illness will not be diagnosed. This can occur even when the physical illness is either causing or exacerbating the mental disorder. Proper treatment of physical and mental conditions at the same time improves the overall well being of the consumer. Barriers to effectively treating people with mental illness in general practice setting have been identified. The separation of mental health services has led to fragmented care for people with mental illnesses.

1.25.2 Local Development

More integrated and cooperative approaches to health care are required to effectively meet all of the health needs of people with mental illness. Currently the fragmented approach to health care for the mentally ill sees too many people falling through the cracks, too often resulting in illness not being diagnosed or treated. Substance abuse and addiction are major problems for the mentally ill. Services to deal with addiction need to be incorporated into every day care of people with mental illness. Specially targeted programmes would be welcome. More outreach services and more proactive health care is needed for people with mental illness; otherwise, they risk missing out on vital health care.

Health care services must adapt to the needs of people with mental illness. There are several steps that could be taken to address these issues, including developing integrated health services that make diagnosing, treating and managing physical

General interventions which will promote mental well-being (and often physical and social well-being too) and will also contribute to reduction in mental health problems generally, including suicide and self harm, in the short, medium or long term. It would therefore seem appropriate for such interventions to form part of overarching mental health strategies at national and local levels, linked to Health Improvement Plans and Community Plans rather than be located within a separate suicide and self harm prevention plan. Such measures will contribute to multiple health and social goals. It would therefore seem appropriate that such interventions continue to be driven through other strategies, but with their contribution to reduction of suicide and self-harm made clear. A local plan could then be more focused, demonstrating how these wider socio-economic interventions contribute as well as driving interventions which specifically relate to reduction at population level (e.g. access to means, safer settings, public and professional education and training) and at high risk group level.

In terms of timescales, many interventions in both the population and high risk groups could deliver results fairly quickly as long as there is appropriate and timely investment and action, whilst some other interventions will take much longer, even given appropriate investment and action.

Examples of interventions include:

- improved knowledge about sources of help for suicidal individuals
- assessment of the impact of public policies
- enhanced responsiveness of mental health services
- identifying risk and opportunities for early intervention for high risk groups (e.g. people with terminal illness, people experiencing life crises/transitions; people who have been abused; people who misuse addictive substances; key occupational groups)
- improved understanding of mental health amongst the public, professionals and others
- improved community support networks
- increased resilience and capacity to cope amongst individuals, communities and families

Suicide prevention is a priority for services. It should be addressed by delivering high quality and responsive effective evidenced based care using relevant NICE guidelines. This applies to both primary and secondary care.

1.25.3 Areas for Consideration

- Care plans for all discharged inpatients that have a severe mental illness or recent history of deliberate self harm should include specific follow-up arrangements after discharge and more intensive provision for at least the first three months after discharge from in-patient care.

- Additionally there should be support for local prison staff in preventing suicides among prisoners and those who are being rehabilitated after prison.

- There should be local systems for audit, (and all other significant untoward incidents) to learn lessons and take any necessary action.

1.25.4 **Examples of good initative**

Traditionally, there is organisational, professional and cultural separation between primary and specialized services. Most primary and secondary services work quite distinctly. They focus on different client groups and the division in mental disorders between ‘severe’ and ‘common’ is both a symptom and a cause of this. Attempts to facilitate closer working between primary and specialised services have seldom been sustained, although there are a few examples of excellent practice. Models of specialist mental health care do not translocate well into primary care with its own unique goals, strategies and culture. Conversely a traditional ‘primary’ health care model is inappropriate for specialised services.

But reducing the burden of unmet need and improving care pathways will ultimately hinge on the ability of the two systems to integrate, and then work in partnership with the non-statutory sector. It is also clear that primary care will shoulder the greater burden of mental health care; that specialist mental health services could or indeed should respond on the scale required is inconceivable.

1.25.5 **Items allowing for development**

The following areas allow for further development and are discussed in further detail in the accompanying action plan:

- Joint Formal Procedures and Protocols;
- Joint Protocol for Suicide;
- Specialist Children and Adolescent Services including Eating Disorders and Self-harm;
- Learning Disability Services and the development of a multi-disciplinary team;
- Mental Health Occupational Therapy;
- Psychology Services
- Dementia Services;
- Services for Mentally Disordered Offenders;
- Depression – raising awareness;
- Diversity and Equality Agenda;
- Measurements for performance and management;

1.25.6 Quality Improvement Scotland

NHS Quality Improvement Scotland (NHS QIS) was established to improve the quality of care and health outcomes for people in Scotland. The Clinical Standards for Schizophrenia have stimulated much quality improvement and remain central to the work of QIS. As follows this, the work of the QIS states that mental health should be concerned with the quality of care given to the whole age range, including children, young people, older people and this should be to a set standard across hospital, specialist services and community services.

Therefore the need for a consistent approach to care in mental health services has become paramount. This is thought to be achievable through the development of Integrated Care Pathways (ICP). The proposed areas for action are then to cover all mental health services and the development and support of local initiatives and services improvement will be within the areas of –

Information – with the development of better information systems enabling standardisation of information and recording, thus allowing clearer measurement of performance;

Outcomes – a focus on outcomes for individual users follows on from QIS conclusion that there be clear evidence for benefit for users and carers as the test of mental health service quality in deliverance

The extent to which this opportunity to develop and re-focus on processes within mental health services should not be underestimated as the need for continuous improvement in line with the major changes in Mental Health at the moment, including the Mental Health (Care and Treatment) Act and the establishment of Community Partnerships, is crucial in delivering better outcomes for all across the Mental Health Services.

1.26 Suggestions for taking the Local Mental Health Service Forward

Service organisation – development is needed to to promote new service models, and new ways of working. We consider the service would be greatly strengthened by the establishment of a multidisciplinary primary care mental health team. Although few such teams exist at this point in time, in five to ten years, specialised care and treatment will be radically re-structured. During the coming year, mental health services will be reviewed systematically to examine progress on NHS Plan implementation. The extent to which services operate as an integrated whole will be a defining characteristic of their quality.

We propose the appointment in each PCT of a mental health lead to facilitate implementation of the National Service Framework and NHS Plan targets for mental health. This to some degree has already been established at practice level to ensure service users and carers are actively involved in service development, commissioning, delivery and evaluation.

Training, education and support – in addition to the training needed for new staff, there is an overwhelming case to strengthen the provision of education and training in mental health in primary care for staff who currently provide services. We propose the development of mental health education and training. It should be competence-based, modular, and multi-disciplinary, involve service users and carers, be locally provided and nationally accredited.

New resources - there is a clear case for more staff, more time, more and different skills to be developed to strengthen mental health in primary care for people with common mental disorders. Roles for new primary care workers must be developed carefully in relation to existing systems and networks to ensure integrated and safe systems of care. In addition, there are arguments that existing staff may need to work in new ways.

Quality assurance – our proposals in this section concern the importance of developing a good map of local training needs, a framework for mental health clinical governance, systems for the evaluation of the changes proposed, and clear measures of the outcomes for patients and service users. We also acknowledge that the mental health knowledge base is still poor in primary care mental health, although there are some excellent examples of good practice.

References:

The National Framework for Mental Health Services: September 1997, Scottish Executive;

Mental Health National Service Framework: Workforce Planning, Education and Training, Underpinning Programme: Adult Mental Health Services: August 2001;

A quality strategy for social care 2000: August, 2000, Department of Health, NHS England;

National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08: July 2004, Department of Health

Child and Adolescent Mental Health: Its Importance and How to Commission a Comprehensive Service: YoungMinds, 2001

Mental Health Minimum Data Set