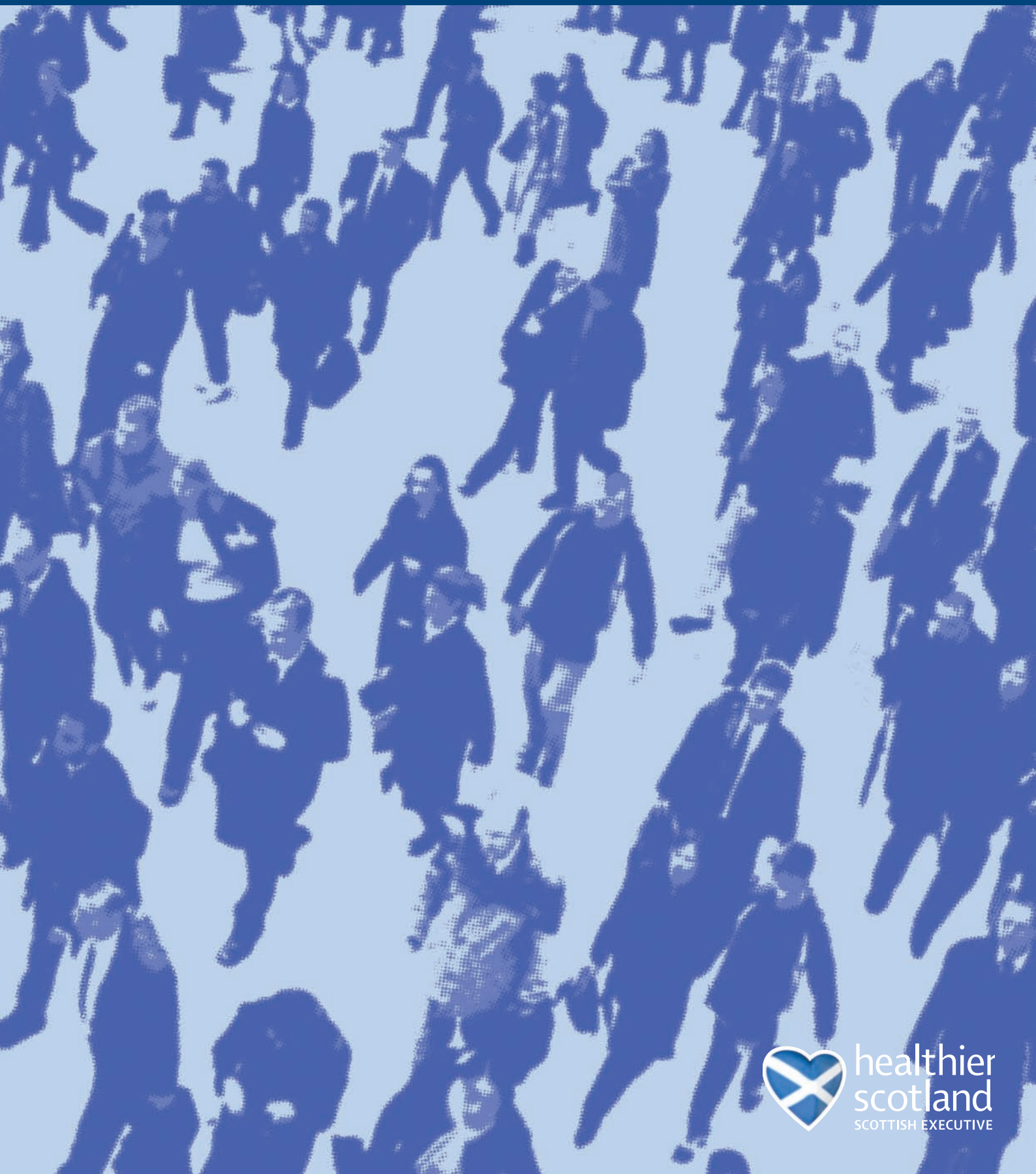
NHS SCOTLAND

“DELIVERING FOR mental health”



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“DELIVERING FOR mental health”

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Foreword

Improving mental health is a high priority for Scottish Ministers and the NHS in Scotland. In 2003 we enacted ground-breaking mental health legislation that puts rights and treatment at the heart of the mental health system, legislation that has generated interest from countries across the globe who want to learn from what we have done. We are also continuing our internationally recognised work on social inclusion and population mental health. The more that we can do to promote good mental health for all the people of Scotland the better. We want to see people living productive, enjoyable and worthwhile lives with good mental health accompanying good physical health and wellbeing.

We can be proud of what we have already achieved, but there is more to do. In *Delivering for Health,* we said that we would "develop a national Mental Health Delivery Plan by the end of December 2006 and in so doing, accelerate improvements in mental health services". This document fulfils the first part of that commitment. Our objectives are grounded in the principles set out in *Delivering for Health* that NHS services should be delivered as locally as possible, provide systematic support for people with long-term conditions, reduce the health inequality gap, and actively manage admissions to, and discharges from, hospital. All of these principles apply to mental health.

Mental health services are well placed to take this agenda forward and to build on previous work in developing local and community services. In so doing, we will build on the positive contribution that mental health services can make to better physical health.

This agenda is not just for the NHS. Much of it is about NHS services, but it is also about what happens in non-health settings and will only be delivered by partnerships between the NHS and local authorities, between the statutory and voluntary sectors and between service providers and users and carers. Service users are central to their own care, treatment and recovery. Patients and carers should therefore be partners in designing and delivering services.

The process used to develop this plan has been important. We have worked over the last 12 months with professionals, managers, the voluntary sector, users and carers to develop the plan. We held two national events to discuss the plan and had an advisory group to assist us in its development. I am grateful to all who made a contribution and I hope that you will continue to stay involved as we move the agenda forward.

Lewis Macdonald MSP

Deputy Minister for Health and Community Care

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Our Vision

Good mental health is important to everyone living in Scotland. It underpins the Executive's vision for a healthier, more successful Scotland. Mental illness takes away opportunity. We must work to promote health and prevent illness and where illness occurs to treat it or minimise the damage that it causes.

This is not just about severe and enduring mental illnesses such as schizophrenia, bi-polar disorder and dementia, but also about a wider range of disorders and illnesses including depression and anxiety. While the focus in this plan is on treating and preventing illness, we also want to continue to promote mental health and wellbeing.

Population and social inclusion approaches are important in reducing the number of people who develop mental illnesses and in addressing inequalities in mental health. The Executive is committed to social justice and is working to address poverty, deprivation, inclusion and exclusion across Scotland.

We need to continue to address the stigma still attached to mental illness and ensure that patients, their carers and all who work with them are treated with dignity and respect.

We must ensure that we deliver on our commitments in respect of equality, social inclusion, recovery and rights. Doing this is central to our vision and to the success of the plan.

We have good evidence about what works in the delivery and organisation of care and year on year the treatment available to those suffering from mental illness improves. We also have a better understanding of the importance of other interventions and supports, such as exercise, a good diet, better physical health, good relationships in promoting good mental health and recovery. We must use this evidence effectively to produce better outcomes.

Functional model

This delivery plan is not prescriptive about the particular structure of services that needs to be in place to deliver good outcomes. Rigid structures can often lead to a reduction in innovation and are not appropriate for the changing populations they serve. Instead we propose a functional approach that focuses on the key elements of services that need to be in place at each point in a journey of care so that clinicians, service users and carers can be clear about what needs to be delivered.

In any service we would expect to see a description of the purpose of the service, the target population, as well as arrangements for standardised joint assessment, referral, admission and discharge, and a range of interventions and therapies which meet the range of needs within the community.

There is good research evidence for what works in mental health services and what leads to better outcomes for people who use them. We have built our guidance around this evidence and have specified the functions that we expect within our services. We recognise that how services are delivered in large cities may be very different from how remote and rural areas may choose to configure their services, but there should be good governance arrangements in place to ensure good standards of care and treatment are available regardless of the location.

Local populations must develop local solutions that best fit their needs. In doing this they will receive support from the Health Department through the establishment of the national improvement programme as well as the work that we are doing in benchmarking and information gathering and through better performance management systems. Information is vital and we need to be able to show what difference is being made and to be able to measure ‘like with like’ in order that we can learn from and share success across the country.

Improve patient and carer experience of mental health services

Though much of the focus of the work on this plan was on the improvement of services, the strongest message we heard was that service users and carers still had experiences of the mental health system that did not match their expectations and the commitments of public and other bodies.

This is not a new problem, but it is disappointing that more progress has not been made. We need to address this issue more directly, not simply restate existing principles or develop new ones. Change is possible, but we need better levers to produce change and clarity about the changes that we expect to see. By addressing cultures and behaviours in our services we will improve the experience of all those who work in the system and those who come into contact with it.

> **Commitment 1:** We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.

Work has already begun on the tool and is being led by the Scottish Recovery Network, drawing on the Recovery-Orientated Practices Index methodology developed in the United States. The key areas the tool will cover are:

- Equality, non-discrimination and respect for diversity
- Social inclusion, particularly in relation to the new duties under sections 25 to 31 of the Mental Health (Care and Treatment) (Scotland) Act 2003
- Recovery, the degree to which services are structured to deliver better outcomes across a range of domains, including employment, housing, education and training opportunities, family and social life
- Rights, in particular the Millan Principles, notably reciprocity, benefit, and participation

The tool will establish expectations and support local assessment of structures and services and enable the identification of where change is required. This will complement the work that we are doing on benchmarking, in order that we can start to gather information and start to measure ‘like with like’ and see where we are making improvements or where more work is needed.

In addition, we will work with NHS Education for Scotland and other professional bodies to develop a common set of behavioural expectations for those working in mental health services, which in turn should influence practice and service delivery.

We believe that we can also support change in cultures and behaviours by embedding peer support workers in mental health services. Peer support workers are an example of expert patients, being trained staff who themselves have direct experience of mental illness who are part of the care team.

> **Commitment 2:** We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas later that year.

Responding better to depression, anxiety and stress

Depression, together with the related conditions anxiety and stress, is the most common mental health problem or illness in western industrial nations. The World Health Organization says that by 2020 it will be the number one form of disability. We can work to promote resilience and capability to reduce the likelihood that people will develop these disorders and offer support to reduce their impact, but we also must offer an effective treatment response.

In Scotland between 25% and 30% of all General Practitioner (GP) consultations involve depression, stress or anxiety. Historically the options available to GPs were prescribing, referring the person to more specialist services or offering limited support. Work that we have taken forward under the Doing Well by People with Depression programme and the subsequent National Evaluation Report published in 2006 has shown how we can offer a response that better meets the needs of patients. This can be achieved by addressing needs using a stepped care approach and providing a range of appropriate treatment options.

The General Medical Services Quality Outcome Framework (the 'GP contract') rewards GPs for identifying patients with depression, and we will work with and build on this.

> **Commitment 3:** We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes, who are identified under the new QOF arrangements.

The 'Keep Well' (Prevention 2010) initiative will focus on increasing the rate of health improvement within the age 45 to 65 population group in deprived communities. In particular it will allow us to develop ways of taking a population based approach on diet, exercise and alcohol use, recognising that these problems are often linked to problems such as depression, anxiety and stress.

Widening the approach that we need to take, we also know that many prisoners have mental health care needs, which while they do not warrant a transfer from prison to secure health care, do require a response. We will provide a better response

to those inmates within the Scottish Prison Services who have depression, anxiety and stress by exploring opportunities for introducing and rolling out the lessons from the Doing Well by People with Depression work, particularly self-help approaches and psychological therapies.

However, if we are to provide a range of appropriate treatment options consistent with the stepped-care approach that means significantly increasing the availability of and access to psychological therapies and support for self-care.

> **Commitment 4:** We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

To do this we will work with NHS Education for Scotland, Health Boards and other service providers to increase the capacity within the current workforce who are trained to deliver psychological therapies and support service change and to ensure that the new resource is used effectively in practice. A plan for increasing capacity to deliver these interventions will be in place by April 2007.

This work will support the achievement of a new NHS target on anti-depressant prescribing that seeks to reduce the year-on-year increase in prescribing of anti-depressants and to improve the fit between guidance on best treatment and practice. This is not a criticism of existing practice or of anti-depressants, but reflects the need to ensure that general practitioners are able to call on and offer the best treatment for these illnesses and not just those that are the most convenient.

Target 1: Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.

In *Delivering for Health*, we committed to producing an evidence-based practice guide on depression in primary care in 2006. That work, which focuses on guided self-help, has been completed and will be published before the end of 2006. The lessons from the wider Doing Well by People with Depression programme are being embedded within the standards for the Integrated Care Pathway on depression, as well as in the GP contract, the work on promotion and prevention, commissioning more training and education in talking and psychological therapies and the HEAT target for levelling off the prescribing of anti-depressants.

Improving the physical health of people with mental illness

Those who suffer from mental illness have greater risk of, and higher rates of, heart disease, diabetes, respiratory disease and infections. They also have higher rates of smoking, alcohol consumption and drug misuse. They die younger and have a poorer quality of life. This is unacceptable.

GPs are paid for managing illnesses such as schizophrenia, bi-polar disorder and dementia, including making sure that physical health issues are addressed. We want to intervene early in the management of physical health problems of those with mental illness to prevent deterioration in their health and act to prevent physical health problems occurring in the first place. Often, many people who have severe mental illness experience difficulties accessing services appropriate to their physical health care, prevention and health promotion needs. This requires a different and more targeted response to treating this group's physical health problems, and promoting their overall health.

> **Commitment 5:** We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient where possible and appropriate has a physical health assessment at least once every 15 months.

We will also ensure that people with severe and enduring mental illness have equity of access to health promotion and prevention services and the full range of free prevention services available to the general population. This means providing services in a way that is responsive to the needs of people with mental illness. This will include general health promotion advice and support, particularly in relation to diet, nutrition, exercise, alcohol consumption, drug misuse and sexual health.

We also want to make sure that people with mental illness also get access to the wide range of services and supports available for those who wish to give up smoking. As well as this we will also work towards ensuring that we increase people's access to free dental and optical examinations and relevant immunisations such as annual flu vaccinations.

Better management of long-term mental health conditions

The management and organisation of care has a direct impact on health outcomes. Service users should get the right care and treatment at the right time. In *Delivering for Health* we committed to developing standards by the end of 2007 for Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and personality disorder. NHS Quality Improvement Scotland (NHS QIS) is taking this work forward in conjunction with clinicians, social care professionals, service users and others and it is expected to be complete in the Summer of 2007, ahead of schedule.

An ICP sets out the process of assessment, care and treatment for service users with similar diagnoses or symptoms. It lets service users know what they should expect from services. It should set expectations for the local management and organisation of care and act as a point of comparison for treatment and care provided. A good ICP will look beyond treating the disorder and will focus on the full range of needs and capabilities of the individual.

NHS QIS are not writing national ICPs, but are describing the functions of the services and setting standards which individual boards will need to meet to be accredited. Those standards will address the process of developing and implementing an ICP, handling information, treatment, outcomes. They will look at both research evidence and good practice in respect of each of the condition specific ICPs.

NHS QIS will work together with the implementation programme for the Delivery Plan, and in particular the improvement programme to support NHS Board areas in the preparation and implementation of local ICPs and will accredit that process. The ICP standards will have three elements: process standards for developing an ICP, care standards for the content, and the service standards for demonstrating quality improvements. These will be in place by the end of 2007.

> **Commitment 6:** NHS QIS will develop the standards for ICPs for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.

In addition to the condition specific ICPs, NHS QIS is looking at the generic elements of an ICP, in particular risk management and patient safety. A journey of care may also include an admission and discharge from hospital. This element of the work will be informed by the acute in-patient forums we are developing so that service users, carers and staff can influence the shape of their local service.

This work will be of value to the target that has been set for 'reducing the number of re-admissions (within one year) for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009'. As well as this, and working alongside it will be the establishment of Acute Inpatient Forums which will help to drive the agenda around improving the therapeutic and physical environment into which people are admitted.

Early detection and intervention in self-harm and suicide prevention

A key skill for all staff working across the NHS and social care system is their ability to identify and assess individuals using their services who may be at risk of self-harm or suicide and to be aware of how to provide and obtain help and support for people.

Much has already been done to help prevent suicide in Scotland and the Executive's 10-year 'Choose Life' national strategy and action plan, which was launched in December 2002, has added additional impetus, momentum and support. The first phase of this strategy has recently been independently evaluated. The progress being made is encouraging and there is a good infrastructure both nationally and locally to build on. But there is still much to do. The evaluation highlights the importance of concentrating additional efforts on those groups at highest risk of suicidal behaviour. This includes people with mental illness.

Evidence shows that people with a mental illness are the highest 'at risk' group for suicide, with a rate of suicide 10 times that of the general population. In terms of diagnosis and risk, the most at risk groups are those with a diagnosis of severe and/or enduring clinical depression, followed by bipolar affective disorder, schizophrenia and other psychoses.

The other commitments outlined in this plan will play their part in helping preventing suicide amongst those experiencing mental illness. However, we wish to go further. In addition to this, work will also take place to extend and target suicide prevention training to those working in the frontline of mental health care services, primary care and accident and emergency services. This will concentrate on improving the assessment and management of risk of suicidal behaviour and self-harming behaviour, particularly people whose self-harming behaviour puts them at high risk of suicide. The training will provide staff with the skills and competencies to assess and respond to people at risk of suicide.

> **Commitment 7:** Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/ suicide prevention training programmes. 50% of target staff will be trained by 2010.

National and local work will continue on suicide prevention through the continuing implementation of the Executive's 'Choose Life' strategy. The target set is to reduce the national rate of suicide in Scotland between 2002 and 2013 by 20%.

Work across the NHS helps contribute to this target and continuing support will be given by the NHS through the existing NHS Performance target for reducing suicides through Local Delivery Plans and through the NHS's role as part of local Community Planning Partnerships.

Target 2: Reduce Suicides in Scotland by 20% by 2013.

Progress is already being made towards achieving a reduction in Scotland's suicide rate. Between 2000 and 2005, there has been a 12% decrease in the overall national rate. While this figure is encouraging, it is too early to tell if there is a longer-lasting downward trend. There are still significant challenges. Scotland has a higher rate of suicide than the other countries within the United Kingdom and rates of suicide in areas of social and economic disadvantage in Scotland are almost twice those of more affluent communities. That is why the Executive and its many national partners and local Community Planning Partnerships are committed to continuing work on suicide prevention over the next few years.

Manage better admission to, and discharge from, hospital

Shifting the balance of care from hospital to the community is a key challenge within *Delivering for Health.* There should also be an effective discharge process in place to minimise the incidence of delayed discharge and inappropriate readmission. However we know that though lengths of stay are reducing, people are often re-admitted soon after discharge.

We need to better manage the admission process, in particular, by ensuring that local crisis services are functioning effectively. To be effective crisis services must deliver several important functions. They will require to have rapid, same day response times, provide intensive specialist input of assessment, treatment and risk management including that for self-harm, in a community setting and focus on those people who might otherwise require admission to hospital.

The introduction of crisis response services is a major step in the redesign of existing mental health services and will enable people experiencing mental health difficulties to be treated in community settings and with the minimum of disruption to their lives. In *Delivering for Health* we committed to developing standards for crisis services in Scotland. This work has been taken forward by the Mental Health Foundation and the Scottish Association for Mental Health in conjunction with the service. These standards are important in enabling services to manage and care for people better in the community, the emphasis should be on safety but at the same time ensuring access to services which meet the individual's (and their family's) needs.

> **Commitment 8:** Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009.

Secondly, we need to make sure that for those admitted that inpatient services meet their needs. This is partly a function for local ICPs, but also about the quality of inpatient units themselves. The functions of an acute admission ward are to provide support and treatment in an acute phase of illness when it is no longer possible to provide safe effective care in the community.

Commitment 9: We will establish acute in-patient forums across all Board areas, comprising service providers, service users and carers as well as other stakeholders such as local authority colleagues.

These forums will undertake a service mapping exercise at the outset and look with others at policies around admissions, re-admissions and discharge planning. They will also assess ward environments and activities that take place and recommend areas for improvement. As well as this they will also look at the quality and usefulness of the information which is provided to both service users and carers.

Thirdly, we need to ensure that discharge processes work effectively and that community services and support are in place. Again, this is primarily the focus of the work on ICPs.

To draw these elements together, we have set a target of reducing the number of acute inpatient readmissions. While this focuses on one component of the service, achieving the target will require action in each of the areas identified above.

Target 3: We will reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009.

Child and adolescent mental health services

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care was published in October 2005. We are committed to implementing the Framework by 2015 and the development of *Delivering for Mental Health* is intended to support the implementation process. *Delivering for Health* said that milestones to track progress by 2008 and 2010 would be identified and put in place. Milestones have been consulted on and will be published in early 2007 as part of *Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland.* Many of the milestones relate to the planning and development process and to workforce development and progress against all of these milestones will be monitored. In addition, two key delivery milestones will be tracked as part of the mental health plan. The identification of these milestones within the plan is intended both to signal our policy intentions with regards to child and adolescent mental health and to raise the profile of the issue for local service delivery agents.

Commitment 10: We will improve mental health services being offered to children and young people by ensuring that by the end of 2008:

- a named mental health link person is available to every school, fulfilling the functions outlined in the *Framework*;
- basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people.

In *Delivering for Health* we said that implementation of the psychiatric adolescent inpatient proposals in regional planning areas would be complete by 2010, with 47 beds available nationally by 2008 and 56 beds by 2010. Work to deliver this is being progressed by Regional Planning Partnerships. An increase in the number of beds, together with the development of community services in line with the objectives of the Framework should reduce the need for admissions to adult wards. Therefore we have agreed a third commitment for child and adolescent mental health to reduce inappropriate admissions to adult mental health beds.

Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009.

Enhancing specialist services

In *Delivering for Health* we said that we would develop a national and regional analysis of specialist service needs and the actions required to meet those needs, including the implications for service redesign. That work has been completed during 2006 in respect of forensic, eating disorder, specialist child and adolescent and perinatal services.

FORENSIC SERVICES

In July the Health Department published HDL (2006) 48 on Forensic Mental Health Services. The HDL sets out the national and regional need for high, medium and low secure beds for men and women and for those with mental disorder and learning disability. Work is ongoing to develop the forensic estate with the redevelopment of the State Hospital and a new medium secure unit opening in Glasgow in spring of 2007 and planning for new medium and low secure accommodation for the North of Scotland and Tayside in 2012. Statutory guidance on how the Care Programme Approach should operate for patients subject to the provisions of the Management of Offenders (Scotland) Act 2005 will be published shortly and will support better discharge planning and risk management. Further work to develop forensic services in Scotland is underway and is detailed in the HDL.

> **Commitment 12:** We will implement the new Care Programme Approach for all restricted patients by 2008.

PERINATAL SERVICES

Mental health problems which occur during pregnancy, or in the first postnatal year, affect 10-15% of women, but, if detected, respond well to treatment. While severe illness is relatively rare, its onset is usually rapid and requires urgent intervention. The Mental Health (Care and Treatment) (Scotland) Act 2003 placed a specific responsibility on NHS Boards to provide specialist facilities for admitting mothers with their babies where necessary (0.2-0.4% of cases). The first unit opened in Glasgow in 2005 and provides services for the west of Scotland and a further unit will open in early 2007 in Livingston to provide services for the east and north. Two Health Boards, Grampian and Forth Valley have developed local solutions. In addition, Health Boards have been developing care pathways for delivery of perinatal services covering both community and inpatient services.

EATING DISORDERS

The Health Department, Regional Planning Partnerships and Health Boards have been working to develop eating disorder services in Scotland to improve the coverage and quality of inpatient and specialist community services. The Regional Planning Groups have agreed a service specification for inpatient services, the level of need for inpatient beds at national and regional level and functions to be taken forward in each regional area. This work fits with the work that has been taken forward by NHS Quality Improvement Scotland in developing recommendations for the management and treatment of eating disorders in Scotland, launched in November this year.

Areas of further work

Mental Health and Substance Misuse

Mind the Gap and *A Fuller Life* set out the issues in relation to meeting the needs of people with co-occurring mental health and substance misuse problems and while highlighting good practice in some areas, paint a picture of unmet need, service gaps and lack of clarity about pathways and ongoing support. These findings are reflected in the Centre for Addiction Research and Education Scotland (CARES) report on co-morbidity and the recent evaluation of the Choose Life suicide programme. Over the course of 2006 a short life working group has been in place pulling together and extracting the key actions required to be delivered that will also help to shift the agenda in relation to substance misuse.

> **Commitment 13:** We will translate the principles of *Mind the Gap* and *A Fuller Life* into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007.

Improving services for older people with mental health problems

More people in Scotland are living longer, with a better quality of life, but the number of people living into old age with chronic physical and mental health problems is also increasing. In addition to the number of elderly people who develop dementia, the number of people with anxiety and depression is also increasing. We will ensure that this population group is properly taken account of in the work on depression and in respect of their physical health needs. In addition, with the growing numbers of people suffering from dementia (assessed as around 65,000 now, but likely to grow to 192,000 by 2040) we will put in place work to develop services.

> **Commitment 14:** We will work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme in improving dementia services. The pilot will be evaluated in 2008.

Learning Disability Co-Morbidity

People with learning disability who have challenging behaviour and mental health needs require improved access to evidence based support and services. Evidence shows that challenging behaviour does not respond to short and medium term interventions and requires a sustained approach over decades. Therefore the role of assessment and treatment beds needs to be considered carefully within a whole system approach. We will to continue to work with NHS Boards and Local Authorities to share and build on positive practice through the development of local and regional networks and we will take this work forward during 2007/08.

Mental Health and Employment

We know that employment can be key to recovery for many people suffering from mental illness and programmes to maintain employment or to facilitate re-entry into the labour market can be very effective in supporting social inclusion. Pilot work in primary care and in particular labour markets will be evaluated and where appropriate the lessons applied more generally. We will also learn from the work being taken forward by the Scottish Development Centre for Mental Health on behalf of the European Commission.

Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003

The implementation and research programme that underpins the new Mental Health Act will continue and we will support work between Health Boards, Local Authorities and the Mental Health Tribunal for Scotland to improve the overall efficiency of the system to better secure the objectives and principles of the legislation. We will also evaluate how the Act is operating to improve the quality of care and the experience of service users and carers.

Support for change

A National Improvement Programme will be established to ensure the delivery of the targets and commitments set out within the plan over the next four years. The Programme will run from April 2007. Solutions must meet local needs and circumstances and more importantly we need to engage with and actively involve staff in the change process in order to achieve sustainable improvement.

With the Improvement and Support Team in the Health Department we will commission an improvement programme, known as a 'Collaborative'. Collaboratives are a method of improvement where teams, including front line staff use a variety of design tools and techniques to diagnose the cause of waits and delays and then test potential solutions through small scale rapid cycles of change. Fundamental to the methodology is rigorous data analysis and the use of 'information for improvement'. This will sit well with the need to better improve the information which we currently have in relation to mental health care in Scotland, particularly in primary care. The Programme will also apply other Collaborative ways of working, for example, by sharing ideas, information and change management knowledge.

LEADERSHIP PROGRAMME

A leadership programme will be commissioned to work alongside the improvement programme in order to ensure that the leadership component of change is tailored to meet the needs of those working in both the delivery of services and also those using them. Therefore the design of the programme needs to be tailored to meet the needs of a wide range of participants from users and carers to senior managers. We will work with NHS Board Chief Executives to identify who from within their Board area (including national and local partner agency staff) will participate within the programme. Selection will be based on, amongst other criteria, the ability of the Chief Executive to put forward a project specification that the cohort could work on and develop, both as part of their personal development but also by way of making a contribution to the delivery of a key target or commitment within the Delivery Plan. In the first year we would select up to seven NHS Board areas to participate.

Within the programme a number of different approaches will be taken in relation to ensuring effective learning and sharing takes place. These will range from e-learning to face to face seminars and from taught modules to web-based learning. The key learning outcomes will be around the need to develop qualities and skills for leadership, to increase knowledge, translate learning into practice and demonstrate improvements in service design and delivery, whilst growing capacity for leading

change in the future. The first cohort of participants will be selected in early 2007 and the programme will commence in April the same year. We will also evaluate the programme at the end of the first year.

TRAINING AND EDUCATION AND WORKFORCE PLANNING

We will work with NHS Education for Scotland, NHS Boards, Local Authorities, Voluntary Organisations, Non Governmental Organisations and others to ensure that we can grow a stable and adaptable workforce in order to deliver the targets and commitments set out within the plan, particularly in relation to talking and psychological therapies within community and primary care.

BENCHMARKING AND INFORMATION

Benchmarking activities support the search for further opportunities for efficiency, the demonstration of best value for investment and the implementation of redesign. It will allow us to measure 'like for like' in the future.

Work has been undertaken to identify potential mental health and social care indicators by using particular domains and key areas for development. At the same time we are reviewing the available baseline data with stakeholders and its coverage which relates to mental health demand, capacity and utilisation to establish its relevance, reliability, completeness, accuracy and validity in terms of supporting a continuous improvement process for mental health. This work will provide information and trend data that will assist the service in their formulation and implementation of local plans for delivering change. Benchmarking information will also support the setting of delivery targets and supporting measures. It will allow us to link with other domains around health improvement and/or patient experience and will enable an assessment of quality or other added benefits and so support Best Value analysis.

Scotland is working as a collaborating country with the World Health Organization European Office to develop a benchmark of services relative to the commitments made in the Helsinki Declaration on Mental Health which was signed by Ministers in January 2005 and that work will allow us to assess delivery of mental health policy and services in Scotland relative to other European countries.

We will work with the Information and Statistics Division (ISD) of NHS NSS and other related partners to ensure that we have the right level of information, infrastructure and analytical capability.

PERFORMANCE MANAGEMENT

Performance indicators should cover three key areas:

- Outcomes supported by existing evidence which are easily collected and measurable
- Health systems checks in keeping with clinical governance strategies
- Quality assurance measures, not supported by evidence but which can contribute to ensuring that the clinical care provided is of the highest quality

We will put in place a robust performance management system that allows the Scottish Executive, NHS Boards and Local Authorities, as well as service users and

carers to see what progress we are making in delivering change. We will build on what we already have by way of performance management systems and information, such as the Joint Local Improvement Plans process and the annual accountability review process for NHS Boards. We are awaiting the joint outcomes work being taken forward between the NHS and Local Authorities and would intend to draw on that as part of the implementation process.

PROGRAMME EVALUATION

We will commission an external evaluation of aspects of the programme that will add value to and complement the performance management and benchmarking work as well as the programmes for improvement and leadership.

FINANCE

Spend in healthcare in Scotland has never been greater. Indeed NHS spend in mental health has risen from £400m in 1999 to £670m in 2006. However, we recognise that some financial support is needed to deliver the targets and commitments within this plan. That is why the Health Department will fund the central support programme and the various strands of work that sit within it. In doing this we will work with NHS Boards and other partners to ensure that clinical, as well as financial solutions are found that will help to drive forward improvements in the care and delivery of mental health services across Scotland.

CONCLUSION

We are in a process of change. This document is not the beginning, we have achieved much already, nor will delivering our commitments be the end, there will still be more to do. But the commitments in this plan are important steps along the road and take us in the direction we need to go to improve mental health in Scotland.

Commitments	Timescale	Related Target
Commitment 1: We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010	Pilot 2007 Implemented 2010	Target 3
Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas, later that year	Pilot completed by end 2008	Targets 2 & 3
Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes who are identified under the new QOF arrangements	2009	Target 1
Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers	2010	Target 1
Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months	2009	Targets 2 & 3
Commitment 6: NHS QIS will develop the standards for ICPs for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.	Standards – Summer 2007 ICP development & accreditations 2009	Targets 1, 2 & 3
Commitment 7: Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010	2010	Targets 2 & 3

Commitments	Timescale	Related Target
Commitment 8: Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009	2009	Targets 2 & 3
Commitment 9: We will establish acute inpatient forums across all Board areas comprising service providers, service users and carers as well as other stakeholders such as Local Authority colleagues	2009	Target 3
Commitment 10: We will improve mental health services being offered to children and young people by ensuring that by 2008: • a named mental health link person is available to every school, fulfilling the functions outlined in the *Framework.* • basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people	2008	Target 3
Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009	2009	Target 3
Commitment 12: We will implement the new Care Programme Approach for all restricted patients by 2008	2008	
Commitment 13: We will translate the principles of Mind the Gaps and a Fuller Life into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007	2007	Targets 1, 2 & 3
Commitment 14: We will work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme in improving dementia services. The Pilot will be evaluated in 2008	2008	Targets 2 & 3

Targets	Timescale
Target 1: Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.	2009/10
Target 2: Reduce Suicides in Scotland by 20% by 2013 (existing target).	2013
Target 3: We will reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009	Dec 2009

MENTAL HEALTH IMPROVEMENT IN SCOTLAND INITIATIVES AND LINKS

The Scottish Executive's **National Programme for Improving Mental Health and Well-being** works in collaboration with a range of agencies and organisations on mental health improvement with the keys aims of **Promoting** the mental health and well-being of the people of Scotland, **Preventing** mental health problems and suicide, and **Supporting** improvements in the quality of life and social inclusion of those experiencing mental health problems or illness. The following table offers some of the products and services supported by Executive funding and provided by a range of agencies and organisations: This list is not exhaustive and initatives are subject to review, but helps to illustrate the additional support and activity offered in this area.

Agency	Products	Audience
Choose Life www.chooselife.net	The national strategy and action plan to prevent suicide, which also offers advice and information about suicide statistics, suicide prevention, research and training (including ASIST and STORM) via the Choose Life website.	A combination of practitioners and public interested in suicide prevention.
'see me' www.seemescotland.org	'see me' – the award-winning anti-stigma and discrimination campaign and website which offers resources, information and personal stories around stigma.	A combination of practitioners and public interested in eliminating stigma and discrimination around mental ill health.
Scottish Recovery Network www.scottishrecovery.net	A website that offers information about recovery including personal testimony, research and international models of recovery.	A combination of practitioners and public interested in recovery.
NHS Health Scotland www.smhfa.com www.healthscotland.com	Scotland's Mental Health First Aid Training (SMHFA). A training course that helps people recognise the signs and symptoms of mental health problems and how to offer initial assistance, support and guidance.	Community groups, frontline NHS staff, local authorities, police, prison staff and the general public.
HeadsUpScotland and Scottish Development Centre www.headsupscotland.com	Training courses – aiming to develop an understanding of the mental health needs of children and young people.	Frontline staff working with children and young people.
NHS 24 www.breathingspacescotland.co.uk	Breathing Space Helpline 0800 83 85 87 – a telephone listening, advice and signposting service (and website) for people experiencing low mood and depression. This service is free and confidential and is open daily between 6 pm and 2 am.	The general adult public in Scotland. With a specific target audience of men.

Agency	Products	Audience
National Programme Team www.wellscotland.info	*Well?* – A magazine distributed to approximately 80,000 people in Scotland twice a year, that highlights mental health improvement work, contacts and news. WellScotland.info – the website for mental health improvement work in Scotland which acts as the main source of news, research and information.	A combination of practitioners and general public interested in mental health issues.
Health Working Lives www.healthworkinglives.com	A course that helps employers understand their role and responsibilities in relation to employees' mental health and well-being.	People responsible for the health of employees.
National Resource Centre for Ethnic Minority Health www.nrcemh.nhsscotland.com	A network of agencies across Scotland aimed at improving the mental health of people within black and minority ethnic communities.	Community groups, frontline mental health staff, planners, BME communities and service users.

SCOTTISH EXECUTIVE

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