Mental Health Strategy: 2012-15

MENTAL HEALTH STRATEGY: 2012-15

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The Scottish Government, Edinburgh, 2012

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Ministerial Foreword

Improving mental health and treating mental illness are two of our major challenges. We are not unique in facing these challenges and in Scotland we have had much success in promoting rights and recovery, addressing stigma and improving service outcomes. More people are receiving effective treatment and they receive it more quickly than ever before. Increasingly, people have a good understanding of their own mental health and are prepared to talk about things when things are not good. People come from around the world to learn from us.

We are rightly proud of what we have collectively achieved. But though Scotland does well, there is more work to do. This Strategy sets out our objectives for the period to 2015.

Key challenges are to continue the good work that has already been started to deliver on our commitments to offer faster access to specialist mental health services for young people and faster access to psychological therapies. These targets are world-leading in setting expectations for access to mental health services. They demonstrate how, in Scotland, we truly give mental health parity with other health services in what we do as well as in what we say. We have also made good progress on reducing suicide in challenging conditions and must build on that success.

In the coming period, we are making key commitments that demonstrate our desire to increase the pace of change. We will focus on reducing variation in the availability of good quality mental health services such as intensive home treatment and first episode psychosis services. We will build on the prevention agenda, with a greater focus on the first years of life. We will target key connections between mental health and other policy areas such as employment, justice and early years services, where mental health has a large contribution to make.

While these commitments are valuable and necessary, our ambition is greater. We must take a step into the future and think beyond how services are currently structured and delivered.

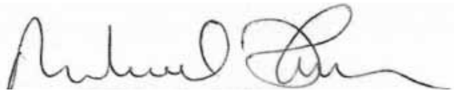
People are already taking greater responsibility for their own health through lifestyle changes designed to produce better health outcomes. They are more likely to seek information for themselves to understand their own mental health and wellbeing and have a greater

desire to control how they access help and support. Self-help, self-referral, self-directed, self-management and peer-to-peer are all concepts that will only grow in importance and which demand a different mindset and approach to service design. The system of the future must develop to embrace and adopt these approaches alongside the more traditional approaches to service delivery, which will also continue to be necessary.

We have learnt how to make improvement by developing a shared understanding of the goal that is to be achieved, using data to understand what is happening at national and local level, identifying early gains to create momentum and confidence, building in improvement support to share and develop learning and putting in place a clear performance and accountability framework. We are able to say when things are working well, but also have the confidence to say when things must be improved.

We have confidence that these are changes that we can make and that when we review progress in 2015 we will evidence a further step forward. Though circumstances are challenging we are ambitious for improvement. We already have a strong consensus in place about the mental health outcomes that we want to achieve and a firm partnership in place between national and local government, other national organisations, the voluntary sector and most importantly with service users and carers. This Strategy is focused on key changes and improvements, but it will be adapted to respond to new challenges as they emerge between now and 2015.

I commend this Strategy to you and ask that you work with us to take forward the commitments set out in it.



Michael Matheson MSP
Minister for Public Health

The Challenge

Mental illness[1] is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. About 1-2% of the population have psychotic disorders, and across Europe 5.6% of men and 1.3% of women have substance misuse disorders. The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 and 20% of those over 80 years of age. In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing[2].

Across Europe, neuropsychiatric disorders are the second largest contributor to the burden of disease (DALYs), accounting for 19% of the total. There is considerable variation across Europe, with mental disorders already ranked highest in many high income Western European countries, but only fourth or fifth in some low income countries due, in part, to the continuing high prevalence of perinatal and cardio-vascular diseases. An important indicator of the disease burden on society and health systems is the contribution of specific groups to all chronic conditions.

Mental disorders are by far the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40% of all Years Lived with Disability.

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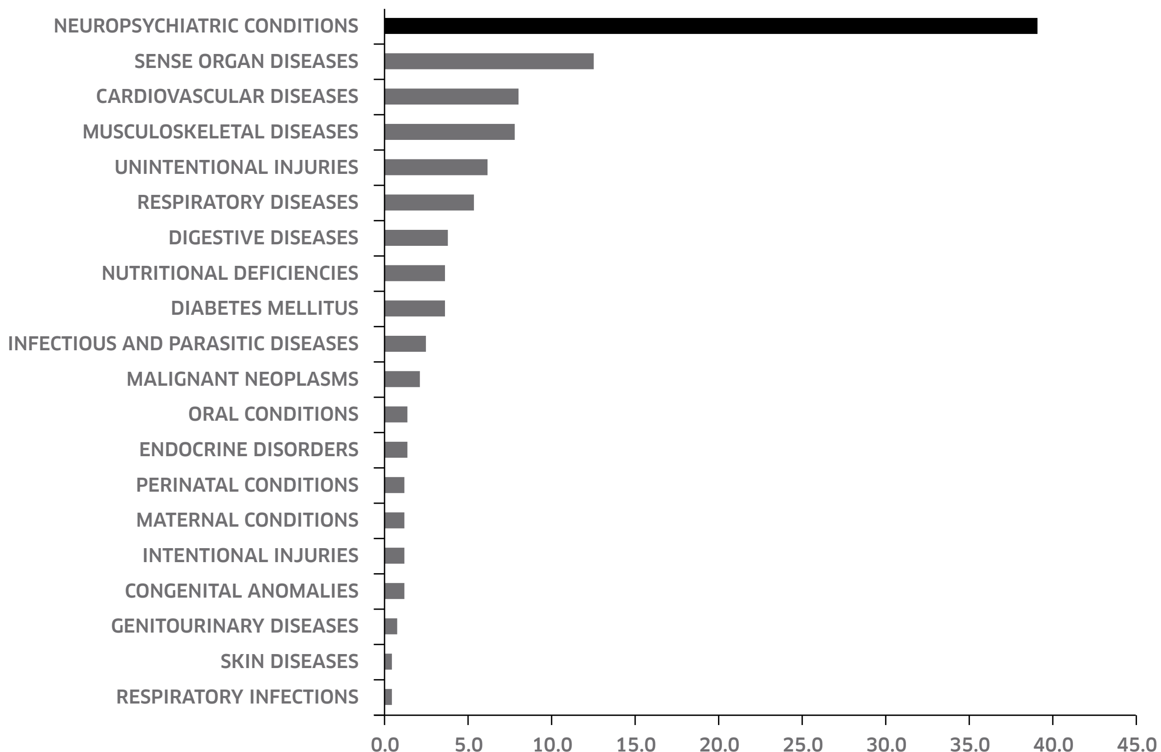
1 Terminology is important but difficult. In this document we use the term 'mental illness' where there is or may be a diagnosis of a particular and defined condition within a document such as *The ICD-10 Classification of Mental and Behavioural Disorders* published by the WHO; 'mental disorder' to refer to the broader category of mental illness, personality disorder and mental illness (which follows the definition in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as well as substance misuse disorders); and 'mental health problems' to refer to the more ambiguous territory which includes those with illness, but also people who may be experiencing challenges to their psychological wellbeing, but who do not have a persisting mental illness or disorder.

2 *Paying the Price – The cost of mental health care in England to 2026* – King's Fund, 2008 available at http://www.kingsfund.org.uk/publications/paying_the_price.html

YEARS LIVED WITH DISABILITY IN THE WHO EUROPEAN REGION



Depression alone is responsible for 13.7% of the disability burden, making it the leading chronic condition in Europe. This is followed by alcohol-related disorders (6.2%) in second place, Alzheimer's and other dementias in seventh (3.8%), and schizophrenia and bipolar disorders in eleventh and twelfth position, each responsible for 2.3% of all Years Lived with Disability[3].

A high percentage of people who receive social welfare benefits or pensions because of disability have, as their primary condition, mental disorders. Data from countries where information is available show that people with mental disorders account for as much as 44% of social welfare benefits or disability pensions in Denmark, 43% in Finland and in Scotland

[3] Figures and graph from *The European Mental Health Strategy*, WHO Europe (forthcoming).

and 37% in Romania. Rates of employment for people with mental health problems in Europe vary between 18-30%. Higher figures for social welfare benefits do not necessarily indicate higher levels of illness, but reflect a combination of reporting arrangements, levels of stigma and discrimination and the different scope of welfare systems across Europe.

Mental disorders are strongly related to suicide. Suicide rates in Europe are high compared to other parts of the world. The average annual suicide rate in Europe is 13.9 per 100,000, but there is a wide variation. In Scotland the most recent figure is for 2010 and was 14.7 per 100,000 (which gives a three-year rolling average for 2008-10 of 15 per 100,000[4]) placing Scotland a little above that average, but in the middle group of European countries. There are reports that suicide rates have been rising in Europe since 2008, with the greatest increases in those countries most affected by the economic recession, but in Scotland figures for suicide have continued to fall[5].

People with mental disorders have a much higher mortality than the general population, dying on average more than 10 years earlier. That gap is widening as health gains have been made more quickly in the general population than for those with mental illness. A reason for this widening gap is the high prevalence of chronic diseases such as cardiovascular disease, cancer and diabetes, and the often poor access and quality of treatment across Europe for such conditions for people with mental illness. Similarly, across Europe people diagnosed with chronic physical health conditions suffer from high rates of depression, often remaining undiagnosed, and this is also associated with higher mortality.

There are now good treatments for many mental disorders and co-morbidities. Suicide can be reduced. However, across Europe the majority of people with mental health problems do not receive treatment, the so-called treatment gap, or experience long delays. It is estimated that even in countries with the most developed mental health systems many people are not diagnosed and do not receive treatment. That is not the case in Scotland and closing this treatment gap has been a key objective of the Scottish Government's work on depression and alcohol misuse – the two conditions least likely to be diagnosed and treated in other countries.

[4] Figures from the General Register Office for Scotland (GROS) at http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/

[5] The figures for 2011 are published by GROS in August 2012 and will have become available after this document has been sent for printing. The data is published at http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/

Achievements

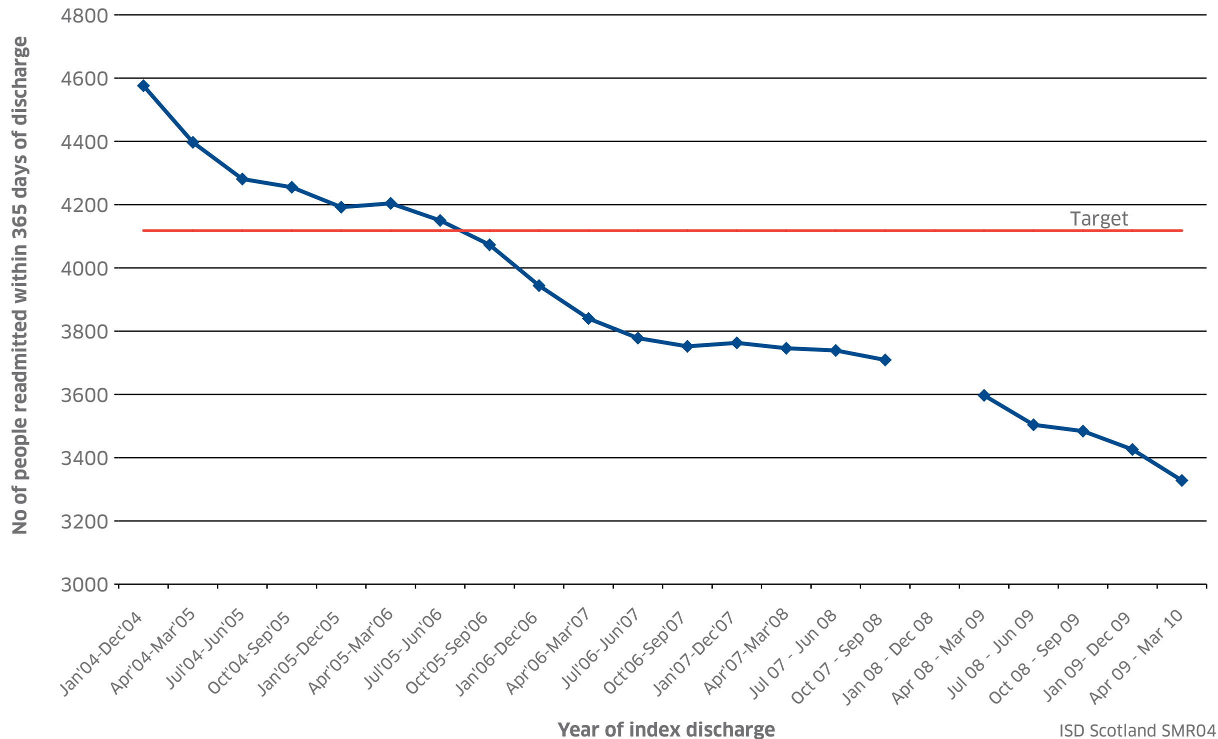
The challenge set out above is sobering and intentionally stark in setting out the scale and range of mental illness and its impact on both individuals and on society as a whole. It is a challenge to which the Scottish Government, working with the NHS, local government, the voluntary sector and service users and carers has responded effectively over time. There is more to do and the challenge remains great, but the Scottish Government has prioritised mental health and worked to give it parity with other health conditions.

Some high-level examples of the improvements that have been made include:

Readmissions – we have seen a steady reduction in the number of people being discharged and then readmitted to services, following work on inpatient and community settings and better discharge planning. Being admitted to an inpatient service has economic and social implications and so reducing readmissions is a necessary quality target. The number of patients who had a psychiatric readmission within one year of a previous psychiatric admission decreased steadily from 4,576 for the year ending 31 December 2004 to 3,426 for the year ending 31 December 2009. The reduction from the baseline figure at December 2004 was 25.1% for those discharged up to December 2009[6].

[6] The period of readmission was for readmissions up to December 2010 and more information is available at http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2011-12-20/2011-12-20-MentalHealth-Report.pdf The numbers of individuals readmitted within 365 days of discharge for Jan 08 – Dec 08 is not available due to data completeness issues during that period.

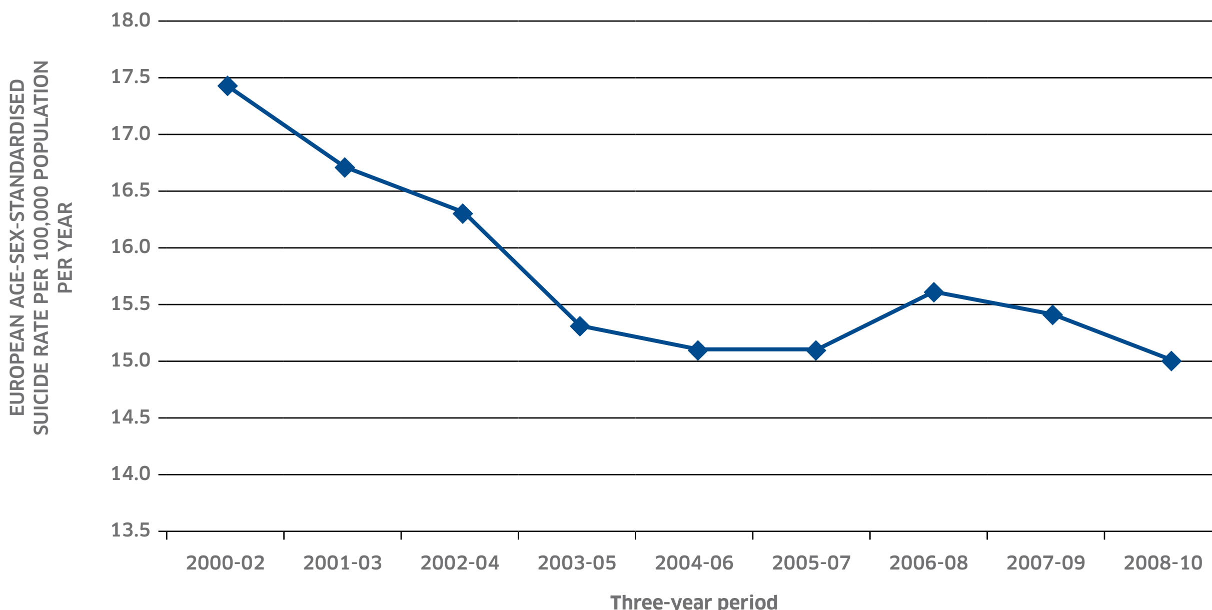
SCOTLAND: NUMBER OF PSYCHIATRIC READMISSIONS (7 DAYS OR MORE) WITHIN 365 DAYS OF DISCHARGE (WITH AN INDEX ADMISSION OF 7 DAYS OR MORE FROM THE ORIGINAL ADMISSION)



Suicide – the number of suicides reduced by 13.8% between 2000-02 and 2008-10. We have also delivered the HEAT target to train at least 50% of all front-line staff in understanding suicide and being able to work safely with people at risk of suicide. The number of suicides in 2009 was the lowest since 1991 and the number for 2010 also one of the lowest. The graph below shows the change over time using three-year rolling averages[7].

[7] More information about delivery against the suicide target is available on the Scotland Performs website at http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/suicideprevention

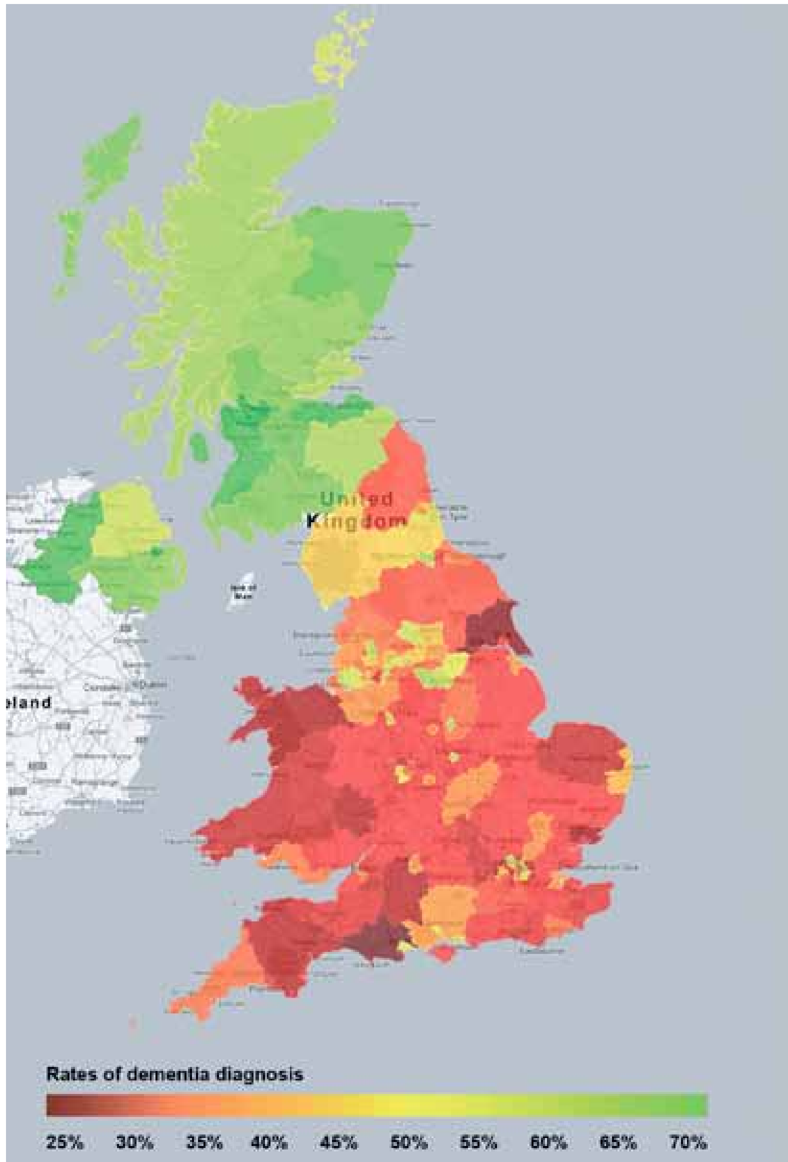
SUICIDE RATE



Source: General Register Office for Scotland

Dementia – based on work taken forward from 2008, NHS Boards in Scotland now have the highest level of diagnosis in the UK and are the most improved. The Alzheimer Society report *Mapping the Dementia Gap: Progress on improving diagnosis of dementia 2010-11* showed that NHSScotland has nine of the top 12 performing health areas across the UK for dementia diagnosis[8]. Faster diagnosis of dementia continues to be a HEAT standard and work to increase diagnosis is continuing. Diagnosis allows access to treatment and support, including for carers. We will say more about our work on dementia later in 2012 when we launch the consultation on the next dementia strategy. The map illustrates the rates of dementia diagnosis across the UK.

[8] The report is available at http://alzheimers.org.uk/dementiamap with information at NHS Board or Trust level across the United Kingdom.



Map data ©2012 GeoBasics-DE/BKG (©2009), Google, Tele Atlas

Access to Psychological Therapies – we have introduced a HEAT target to deliver faster access to mental health services by ensuring access to a psychological therapy within 18 weeks by December 2014. Work with NHS Boards on antidepressant prescribing demonstrates that GPs in Scotland are more likely to be working to clinical practice and guidelines than elsewhere[9]. The gap in prescribing rates between Scotland and England appears to be reducing.

Child and Adolescent Mental Health Services – we are on target to deliver the HEAT target to ensure access to specialist Child and Adolescent Mental Health Services (CAMHS) treatment within 26 weeks by March 2013 and by 18 weeks by December 2014, reflecting a significant service improvement and reduction in waiting times. Data suggests a reduction from over 1,200 waits of over 26 weeks when we began this work to around 300 currently. We have further work in hand that will assure delivery of the target. There has been a 34% increase in the size of the specialist CAMHS workforce between the end of 2008 and March 2012.

What these achievements tell us is that it is possible to make significant improvements in the quality and availability of mental health services and that those improvements produce better outcomes for people with mental illness, their families and our communities. These improvements have been delivered through service improvement, redesign, strong leadership and the hard work of NHS, local government and voluntary sector clinicians and staff. That approach is sustainable even as we face economic challenges and we will commit to a similar or greater rate of improvement over the period of this strategy.

The position in 2012 is very different to the challenge we faced in 2003 when the new mental health legislation was agreed by the Scottish Parliament. At that time Dr Sandra Grant was invited by the then Minister for Health and Community Care to undertake a review of services within Scotland to assess their readiness for implementation of both the terms of the legislation and the expectations that were placed upon it. Her report identified deficiencies in services across Scotland and made a range of recommendations for improvement[10]. We have acted on the basis of what that report found and we continue to seek further improvement.

Commitment 1: The Scottish Government will commission a 10-year-on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014.

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[9] *Factors associated with duration of new antidepressant treatment: analysis of a large primary care database* British Journal of General Practice 2012; DOI: 10.3399/bjgp12X625166

[10] *National Mental Health Service Assessment: Towards Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 Final Report*. Available at http://www.scotland.gov.uk/Publications/2004/03/19084/34431

POLICY CONTEXT

National Performance Framework

This Mental Health Strategy supports the Purpose of the Scottish Government which is to "focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth."[11] This Purpose applies across all the activities and responsibilities of the Scottish Government and creates the overall context for our work on mental health. It is supported by the Strategic Objective for Health which is "Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare"[12] and by 16 National Outcomes, a number of which are directly applicable to the objectives set out in this Strategy, notably[13]:

We live longer, healthier lives.

We have tackled the significant inequalities in Scottish society.

We have improved the life chances for children, young people and families at risk.

Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it.

Our public services are high quality, continually improving, efficient and responsive to local people's needs.

The National Outcomes also mark out the territory for the work of local Community Planning Partnerships in developing and taking forward their Single Outcome Agreements which connect the high-level national objectives with local priorities. This approach was reaffirmed in the Statement of Ambition earlier this year, which reinforced the commitment to delivering demonstrable improvements to people's lives, promoting preventative approaches and to strengthening community engagement and participation in delivering better outcomes[14].

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[11] Available at http://www.scotland.gov.uk/About/Performance/scotPerforms/purpose

[12] Available at http://www.scotland.gov.uk/About/Performance/Strategic-Objectives

[13] Information about each of the National Outcomes can be found at http://www.scotland.gov.uk/About/Performance/scotPerforms/outcome

[14] Available at http://www.scotland.gov.uk/News/Releases/2012/03/statementofambition15032012

Delivering for Mental Health and Towards a Mentally Flourishing Scotland

Scotland's Mental Health Strategy is the successor document to *Delivering for Mental Health*[15] and *Towards a Mentally Flourishing Scotland*[16]. It builds on that work as well as on policy and service improvements taken forward alongside those main policy documents. It reflects the mature development of mental health policy in Scotland in the context of a population that increasingly understands mental health and mental illness, service user and voluntary sector engagement and leadership in taking forward improvement and change, and a Scottish Parliament that recognises the importance of the issue and regularly debates and considers mental health.

Mental health was established as a priority on the global agenda by the World Health Report of 2001 *Mental Health: New Understanding, New Hope*[17], which was endorsed by the World Health Assembly of the World Health Organization (WHO) in 2002. In Europe, in 2005, the Regional Office of the WHO adopted the *Helsinki Declaration and Action Plan* at a special Ministerial Conference held in Helsinki[18]. These Reports and Declarations set an agenda for action to support rights for people with mental health problems and develop community based services. The European Commission launched its European Pact on Mental Health and Wellbeing in 2008[19] and the European Union has now established a Joint Action on Mental Health and Wellbeing starting in 2012[20]. The Scottish Government collaborates with both the European Commission and the WHO Europe office in developing and taking forward mental health policy and improvement.

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15 Available at http://www.scotland.gov.uk/Publications/2006/11/30164829/0

16 Available at http://www.scotland.gov.uk/Publications/2009/05/06154655/0

17 Available at http://www.who.int/whr/2001/en/index.html

18 Available at http://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf

19 Available at http://www.ec-mental-health-process.net/index.html

20 Available at http://register.consilium.europa.eu/pdf/en/11/st10/st10384.en11.pdf

A Health Promoting and Preventative Approach

The Mental Health Strategy is fully consistent with the 2020 Vision:

> **Our vision is that by 2020** everyone is able to live longer, healthier lives at home, or in a homely setting.
>
> We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

The focus on "prevention, anticipation and supported self-management" is central to taking forward mental health policy in Scotland. As indicated above, services in Scotland have already reduced the number of mental health readmissions by around 25%. In this strategy we have a focus on a range of improvements and interventions that are in accordance with the best evidence for return against investment over time, including:

- Early intervention for conduct disorder in children through evidence-based parenting programmes;
- Treating depression in those with long-term conditions such as diabetes;
- Early diagnosis and treatment of depression; and
- Early detection and treatment of psychosis[21].

In addition, there is a strong focus throughout this strategy on actions that people can take for themselves, and with their communities, to maintain and improve their own health. There is a good evidence-base for such approaches, in particular for physical activity.

[21] *Mental health promotion and mental illness prevention: The economic case*, Martin Knapp, David McDaid and Michael Parsonage (editors) Department of Health January 2011. http://www.centreformentalhealth.org.uk/publications/mental_health_promotion_economic_case.aspx?ID=630

WAYS OF WORKING – KEY THEMES

The Quality Strategy

In addition to specific commitments to particular action, we will also be working on a range of themes in respect of improving mental health services and of mental health improvement. These are set in the context of the Quality Strategy[22] and focus on working with people and communities to produce better outcomes.

This Mental Health Strategy fully supports and adopts the **three Quality Ambitions** for Scotland that health and care must be:

Person-centred – which is:

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe – which is:

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective – which is:

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit – and wasteful or harmful variation will be eradicated.

These are not new ideas to mental health, but inform the continuous improvement approach, which aims at delivery of and for consistent and reliable services everywhere. Much of the work that has already taken place in mental health in Scotland exemplifies the objectives and ambition of the Quality Strategy, notably the work in support of the Person-Centred Ambition. A key element of that work is in enabling people to become more involved and active in their own health and wellbeing – which is a key theme of our work on mental health.

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22 *NHSScotland Quality Strategy* – putting people at the heart of our NHS http://www.scotland.gov.uk/Publications/2010/05/10102307/0

Using a person-centred approach to partnership working requires change in how the NHS and its partners develop and deliver services, and approaches to do more to give people greater control and engagement. Similarly, the work to understand how people experience and understand their health and are actively involved in their healthcare experience and decision making, directly links to the work that has begun with service users and their carers in mental health.

We will continue to develop a person-centred approach in mental health and ensure that the learning that has taken place in mental health at a local and national level is fed into the Quality Strategy Person-Centred strand of work, and learn from how it develops in other areas of health and care. There are particular references to work on patient safety in mental health and to clinical effectiveness in the sections below, notably in respect of the access target for specialist CAMHS services and psychological therapies.

Seven Themes for Mental Health

Seven key themes emerged from the consultation on the mental health strategy. None of these ideas are new, but they will have increased emphasis across the mental health and mental health improvement agenda and some have explicit linkages with particular parts of the work programme. The themes are fully consistent with and exemplify the Quality Ambitions and have general application across the mental health work programme for promotion, prevention, treatment, care and recovery.

The themes are:

1. Working more effectively with families and carers

Families and carers can have an important role in providing support to those with mental illness, but can often feel excluded from making the contribution they would like to because of how services are structured or delivered:

The work from Healthcare Improvement Scotland on learning from suicides shows that better work with families can contribute both to safety and to better outcomes[23];

[23] Suicide Reporting System: Learning and Improving Review http://www.healthcareimprovementscotland.org/programmes/mental_health/programme_resources/suicide_reporting_system/learning__improvement_review.aspx

Caring Together: The Carers Strategy for Scotland 2010-15[24] sets out the action that is being taken with partners to provide better support to family members and carers to enable them to offer care and support without coming to harm themselves.

Commitment 2: We will increase the involvement of families and carers in policy development and service delivery. We will discuss how best to do that with VOX and other organisations that involve and represent service users, families and carers.

2. Embedding more peer-to-peer work and support

The work that was taken forward under *Delivering for Mental Health* to establish the first paid peer support workers was successful in creating the role within Scotland. There is a demand to make greater use of the approach, but people need to understand the role and benefits better:

The Scottish Recovery Network (SRN), working with the Scottish Qualifications Authority, have developed a nationally accredited Professional Development Award to assure that the role is of an appropriate quality to add value based on lived experience[25];

SRN are developing a values framework with peer workers to help define and assure the role and have additionally developed the *Experts by Experience Implementation Guidelines* to help ensure considered role development[26];

There is a broader demand for greater use of formal and informal peer support approaches, in addition to the peer support worker role within care teams, and we will seek to build this in to our work more generally.

Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.

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24 Available at http://www.scotland.gov.uk/Publications/2010/07/23153304/0

25 Information about the award is available on the SQA website at http://www.sqa.org.uk/sqa/47021.html

26 A copy of the Guidelines can be requested from http://www.scottishrecovery.net/Resources/experts-by-experience-implementation-guidelines.html

3. Increasing the support for self-management and self-help approaches

The evidence-base for people taking a leading role in managing their own illness over time, and the wider benefits to them that this approach offers, is well established. As outlined earlier, mental illnesses are amongst the most severe long-term conditions:

NHS 24 has developed, piloted and now delivers the Living Life Guided Self-Help Service, under which self-help coaches guide individuals over the phone through a series of self-help workbooks to help them understand some of the reasons why they are feeling low, depressed or anxious[27];

NHS Health Scotland manage the *Steps for Stress*[28] resources which contain practical ways for people to start to deal with stress. This complements Well Scotland[29], the national health improvement website;

NHS Boards continue to develop and deliver self-help services locally, generally for people with common mental health problems, with many of these services being available through primary care, including the provision of self-help materials, access to computerised cognitive behavioural therapy and guided self-help.

This work links directly to the action and commitments on social prescribing which are set out later.

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[27] Information about the services can be found at http://www.nhs24.com/UsefulResources/LivingLife

[28] The website which offers support is at http://www.stepsforstress.org. There is more information about how we intend to develop the use of *Steps for Stress* below.

[29] http://www.wellscotland.info

4. Extending the anti-stigma agenda forward to include further work on discrimination
The work that has been taken forward in Scotland through *see me*[30] is internationally recognised as establishing best practice and has been learnt from and adopted throughout the world[31]:

There is a need to build on this success by developing the work further to focus on the experience of discrimination and exclusion that many people with mental illness experience;

There is also the need to focus attention more directly on stigma and discrimination in health and social care services, which is where service users often tell us they feel the most discriminated against.

Commitment 4: We will work with the management group of *see me,* with the Scottish Association for Mental Health, who host *see me*, and with other partners to develop the strategic direction for *see me* for the period from 2013 onwards.

5. Focusing on the rights of those with mental illness
The Mental Health (Care and Treatment) (Scotland) Act 2003[32], established core principles to apply to mental health services in Scotland and that approach has firmly embedded rights at the heart of practice within services:

The principles of the Act underpin many of the values of inclusion, reciprocity and dignity which are key to effective, person-centred mental health services;

The *Dementia Standards*[33] built on this approach to establish a framework for care and treatment standards for those with dementia and their carers; the standards apply irrespective of who delivers care or treatment, or where care or treatment are delivered and create a common understanding of how the quality of care and treatment should be assessed;

The Scottish Human Rights Commission has established a framework for embedding rights within care and treatment settings and services.

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[30] Available at http://www.seemescotland.org/

[31] *Stigma: An International Briefing Paper*, WHO Europe, 2008 http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/stigma_paper.pdf

[32] The Mental Health (Care and Treatment) (Scotland) Act 2003 can be found at http://www.legislation.gov.uk

[33] Available at http://www.scotland.gov.uk/Publications/2011/05/31085414/0

Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental healthcare in Scotland.

6. Developing the outcomes approach to include personal, social and clinical outcomes

The Scottish Recovery Network[34] was established in 2004 to take forward the recovery model in Scotland; recovery is the idea that individuals and services should look beyond purely clinical outcomes to see the whole person and their social and personal outcomes as equally valid:

In *Delivering for Mental Health* we set out plans to establish the Scottish Recovery Indicator as an approach to refocus services on the wider range of outcomes and objectives; the SRI was launched and used, and has now been refined and re-launched in a more usable format as SRI 2[35];

In the work on access to psychological therapies we are working with NHS Boards to embed the capacity, not just to collect clinical outcomes but to be able to report on them, and do so in a way which encourages monitoring and improvement from the level of individual patients right through to how clinical teams are performing;

Our adult mental health benchmarking indicators and toolkit[36] provide a platform from which service activity and outcomes can be compared between NHS Boards. As further indicators, including outcomes indicators, are developed they will be added to the benchmarking toolkit;

To promote outcomes-focused planning for mental health we have developed the Mental Health Improvement Outcomes Framework[37];

Scotland is one of several nations engaged with the International Initiative for Mental Health Leadership[38] in developing a set of mental health outcome indicators which are considered to be of importance, valid, and feasible, in today's mental health systems. This work will ensure that Scotland remains at the forefront of outcomes measurement in mental health.

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34 Available at http://www.scottishrecovery.net/

35 Available at http://www.sri2.net/

36 More information is available in the final section of this document and at http://www.isdscotland.org/Health-Topics/Finance/National-Benchmarking-Project/mental-health.asp

37 Available at http://www.healthscotland.com/understanding/evaluation/planning/mental-health.aspx

38 Available at http://www.iimhl.com/

7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence-based services

Many people already look to the internet and other new media approaches for help when they are in distress and this trend is likely to increase over time. The NHS in Scotland already offers a range of services through new technologies:

- Since 2008, NHS 24 has offered telephone based Cognitive Behavioural Therapy and Guided Self-Help as a response to depression[39];
- Other NHS Boards provide services such as Living Life to the Full Online, Beating the Blues and Moodgym;
- NHS 24 hosts the NHS Inform service which includes information on mental health and wellbeing[40].

Commitment 6: During the period of the Mental Health Strategy, we will develop a Scotland-wide approach to improving mental health through new technology, in collaboration with NHS 24.

[39] Available at http://www.nhs24.com/UsefulResources/LivingLife

[40] The website is at http://www.nhsinform.co.uk/mentalhealth

KEY CHANGE AREA 1: CHILD AND ADOLESCENT MENTAL HEALTH

Infant and Early Years Mental Health

"The period between pregnancy and 3 years is increasingly seen as a critical period in shaping children's life chances, based on evidence of brain formation, communication and language development, and the impact of relationships formed during this period on mental health. It is therefore also a critical opportunity to intervene to break cycles of poor outcomes."[41]

The Scottish Government is already committed to publishing a Parenting Strategy later in 2012, with a focus on work to support parents to be competent and confident in their efforts to build strong attachments with babies and young children. This will build on existing policy and on the day-to-day activities of midwives, public health nurses, nursery teachers and others. The Scottish Government is also committed to an expansion of the Family Nurse Partnership[42] – a model of delivering intensive support to vulnerable, young first-time mothers – which has been shown to significantly improve a range of outcomes for children. We are already working, through the Early Years Taskforce, to prioritise and invest in interventions for which there is sound evidence of effectiveness.

However, we know that there is more that could be done for those who are most vulnerable. Secure attachment and competent, confident parenting are known to be significant protective factors, conferring confidence, resilience and adaptability. Disorganised attachment in infancy has been linked by both longitudinal and retrospective studies to a number of severe mental health problems manifesting in later life[43]. The importance of early experience in creating the conditions for good or poor mental health cannot be overstated.

Those most in need of help can be either easy or hard to identify depending upon whether the manifesting problems are visible (e.g. young children with very challenging behaviour) or hidden (e.g. babies who may be quietly suffering and anxious because their needs for social interaction through secure attachments are not being met).

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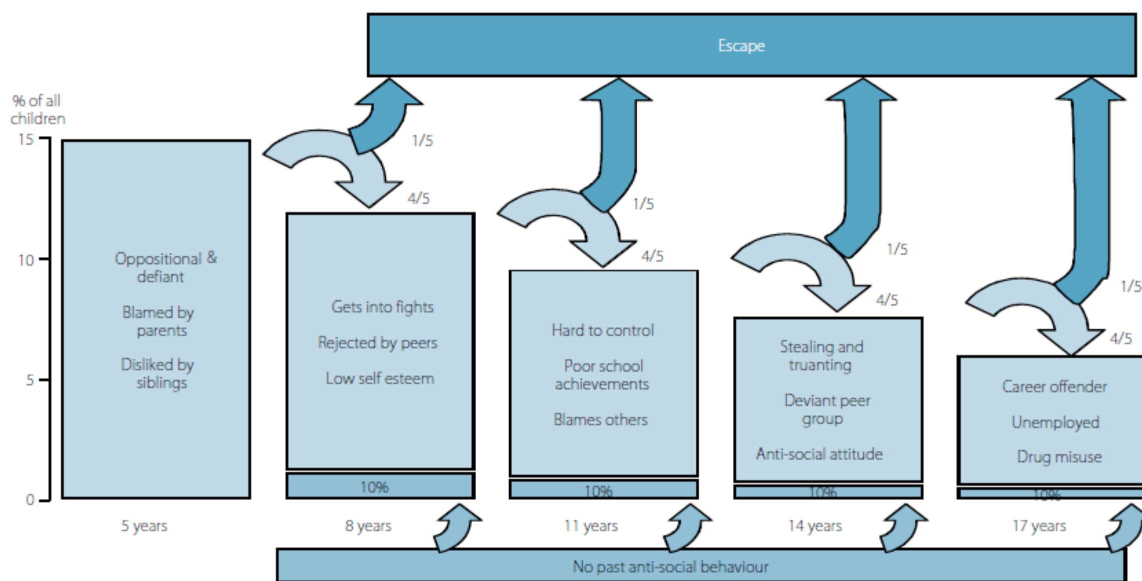
41 *The Early Years Framework*, Scottish Government 2008 available at http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf

42 More information about the Family Nurse partnership work is available at http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership

43 *Attachment, the reflective self, and borderline states*, Fonagy P., Steele M., Steele, H., Leigh T., Kennedy R., Mattoon G., & Target M. (1995) Pp 233-278 in Goldberg, S., Muir, R., & Kerr, J., (Eds) (1995) *Attachment Theory: Social Development and Clinical Perspectives*. Hillsdale, N. J.,: The Analytic Press.

Responding Better to Conduct Disorders

It is normal for young children to display challenging behaviour by being non-co-operative, highly emotional and aggressive at times. Generally, these behaviours peak in the early pre-school years and start to reduce by the time children start school. However, approximately 10% of young children show a different developmental pattern[44]. For these children, their already elevated levels of aggression, non-compliance and emotional distress persist throughout childhood. As the diagram below shows, for many, the pattern endures into, and throughout, adulthood[45].



Source: Scott 2002

Research conducted by Stephen Scott for Home Office, 2002 (unpublished).

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44 *The mental health of children and adolescents in Great Britain* Office for National Statistics, 1999; *Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school,* Paul Bradshaw and Sarah Tipping, Scottish Centre for Social Research. http://spoxy4.insipio.com/generator/en/www.scotland.gov.uk/Publications/2010/04/26102809/0

45 The diagram is sourced from *What Works in Parenting Support? A Review of the International Literature*, Moran P, Ghate D, van der Werwe A: Research Report 574. London: Department for Education and Skills, 2004.

The reasons for these behaviours are complex, but we know that this pattern of behaviour problems is a powerful indicator of risk of long-term negative personal and social outcomes, including school disruption, family stress and dysfunction, mental health problems, loss of employment productivity, social isolation, drug and alcohol problems, as well as crime and antisocial behaviour[46]. A longitudinal study showed that anti-social behaviour at age 13 was predicted by externalising behaviour at age 3[47]. Another study showed that by age 28 those with conduct disorder in childhood were three times more likely to have been convicted of a crime than those with no problems (and 12 times more likely to have spent time in prison)[48].

Evidence-based parenting programmes, such as Triple P and Incredible Years, offer a powerful way of addressing and responding to these early-onset behaviour problems. They are relatively inexpensive and produce long-term benefits to the individual and society. The programmes take a positive and assets-based approach to strengthening parental competencies. For those with early onset disruptive behaviour problems there is over 30 years' worth of top quality research demonstrating the effectiveness of parenting programmes based on social learning theory. The research shows that, after their parents had participated in one of these group-based parenting programmes, roughly two-thirds of the children (with early onset disruptive behaviour) were behaving at a level comparable to that of their peers[49]. Research results have been replicated in randomised control trials by independent research teams in various countries worldwide as well as in Britain[50].

A partnership between the NHS and Glasgow City Council is in the process of making Triple P available to all parents in the city of Glasgow. Hundreds of practitioners, including health visitors, social workers and nurses, have already been trained to deliver the programmes. We believe that we should build on this approach and that a nationally coordinated approach is the best way of maximising efficiencies and ensuring the quality of training and supervision, thereby ensuring that the programmes are delivered in accordance with the research evidence.

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46 *The development of offending and antisocial behaviour from childhood: key findings from the Cambridge study in delinquent development*, Farrington DP, J Child Psychol Psychiatry 1995 36:929-64, 1995.

47 *Very early predictors of conduct problems and crime: results from a national cohort study*, Murray J, Irving B, Farrington DP, Colman I, Bloxson AJ, J Child Psychol Psychiatry 2010, 51:1198–1207

48 *Financial cost of social exclusion: follow up study of anti-social children into adulthood*, Scott S, Knapp M, Henderson J, Maughen B., British Medical Journal 2001;323:191.

49 *Treating Children With Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child, and Teacher Training*, Webster-Stratton, C., Reid, J.M., and Hammond, M. 2004. Journal of Clinical Child and Adolescent Psychology.

50 *Randomised Controlled Trial of a Parenting Intervention in the Voluntary Sector for Reducing Conduct Problems in Children: Outcomes and Mechanisms of Change*, Gardner, F. and Burton, J., Journal of Child Psychology and Psychiatry 2006 47:11. 1123-1132.

Commitment 7: In 2012 we will begin the process of a national roll out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour. We will include more information about the delivery of this commitment in our Parenting Strategy which will be published in October 2012.

Responding Better to Attachment Issues

Secure attachment is a basic human need of all infants but not one which is always met. An infant whose attachment becomes disorganised can experience high levels of stress and anxiety, without necessarily showing outward displays of distress which would signify to their care-giver or the other adults in their support system that something is wrong.

We know about the importance of attachment and we also know a bit about what interventions are effective to address attachment issues in individual cases. Where the key challenge lies, is in designing and developing good systems which combine raised levels of general awareness, a capacity to identify enhanced need and a capacity to respond appropriately and effectively when enhanced need has been identified. In order to address this 'hidden' health need of the present, and improve the mental health and wellbeing of our future population, we need to do three things. We need to do more to improve the general understanding of the issue of attachment, we need to improve the skills and awareness of those who come into contact with infants so that attachment problems or potential problems are recognised and where possible addressed, and we need to improve access to specialist support such as parent infant psychotherapy where this is indicated as necessary.

We are committed to gaining a better understanding of how the range of elements, outlined above, fit together to make up a good infant mental health service system. To do this we intend to examine the range of services and models of delivery currently in operation in Scotland and elsewhere and to learn from the latest available evidence about what systems are effective. We shall also focus attention on specific areas of innovative practice – for example, following, with interest, the progress of the New Orleans Intervention Model – being delivered and evaluated in Glasgow by NSPCC in partnership with Glasgow City Council and NHS Greater Glasgow and Clyde. The New Orleans Intervention Model was developed in the USA and is a cutting-edge way of intervening with abused and neglected pre-school children[51]. This is a potential prototype for a new way of working nationally.

[51] More information about the work the NSPCC is taking forward is available at http://www.nspcc.org.uk/what-we-do/the-work-we-do/priorities-and-programmes/physical-abuse/new-orleans-intervention-committee/new-orleans_wda86270.html

Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children's services workforce. We shall also improve access to child psychotherapy (a profession which specialises in parent infant therapeutic work) by investing in a new cohort of trainees to start in 2013.

Looked After Children

Research carried out in the UK and elsewhere consistently shows that looked after children have significantly poorer mental health than the rest of the population[52]. Work with this particular group is often made more complex by the strong feelings which can be evoked in care-givers and professionals by children who are struggling to cope with and come to terms with a personal history of trauma, including abuse and neglect.

In recent years there have been many positive developments, both in relation to an increase in direct therapeutic services for this population and an increase in the indirect mental health support available. An example of the indirect support is the basic mental health training which has been made available to all those working with or caring for looked after children and young people[53]. In addition, NHS Boards are required to assess the mental health needs of all looked after children for whom they have a responsibility[54].

There is still work to do to improve the way in which Child and Adolescent Mental Health (CAMH) services, local authorities and third sector providers work together to address the mental health needs of this population. Services work best for children where NHS Boards are able to deliver training, and also opportunities for professionals to discuss particular concerns about an individual child or young person in care, where work has been done to develop a shared understanding of thresholds (the signs and symptoms of distress and/or mental illness which make a specialist CAMHS assessment or intervention necessary), where good professional relationships between individuals from different agencies have been allowed to build up over time, and where there is confidence that new referrals for assessment will be given appropriate priority. In accordance with *Getting it Right for Every Child* principles we

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[52] *Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households*, Ford, T., Vostanis, P., Meltzer, H. and Goodman, R., British Journal of Psychiatry 2007, 190, pp. 319-325.

[53] *Delivering for Mental Health*, Scottish Executive, 2006 available at http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[54] *Looked After Children and Young People; We Can and Must do Better*, Scottish Executive, 2007 available at http://scotland.gov.uk/Publications/2007/01/15084446/0

shall continue to encourage high-quality, individually-tailored, multi-agency approaches for this vulnerable group[55].

Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.

Learning Disability and CAMHS

We know that access to mental health services for children with a learning disability is better in some parts of Scotland than in others. This work is complex and challenging, with combinations of learning and developmental disorders as well as mental illnesses giving rise to a wide range of presentations, uncertainties about diagnosis and difficulties in identifying effective treatment regimes which are sustainable over time. Different approaches to service delivery are also taken in different parts of Scotland. We have recently produced a report to support service development which will be made available and issued to NHS Boards, and we will work with clinicians to take forward key actions identified from the report.

We are collecting data, through the CAMHS Balanced Scorecard, on the numbers of children with learning disability gaining access to mental health services in different parts of the country. This will help us towards a better understanding of the variance and help NHS Boards to take appropriate action, where necessary, to improve access in the short term.

Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become, or lead to, prototypes for future testing and evaluation.

Access to Specialist Child and Adolescent Mental Health Services

Much work has been undertaken nationally over the past three years to improve access to specialist CAMHS by reducing the time patients wait between referral and treatment. This followed the setting of a HEAT target which states "no patient shall wait longer than 26 weeks between referral and treatment for specialist CAMHS by March 2013". An additional target of 18 weeks by December 2014 has now been set to bring the target into line with other access time targets and the access to psychological therapies target.

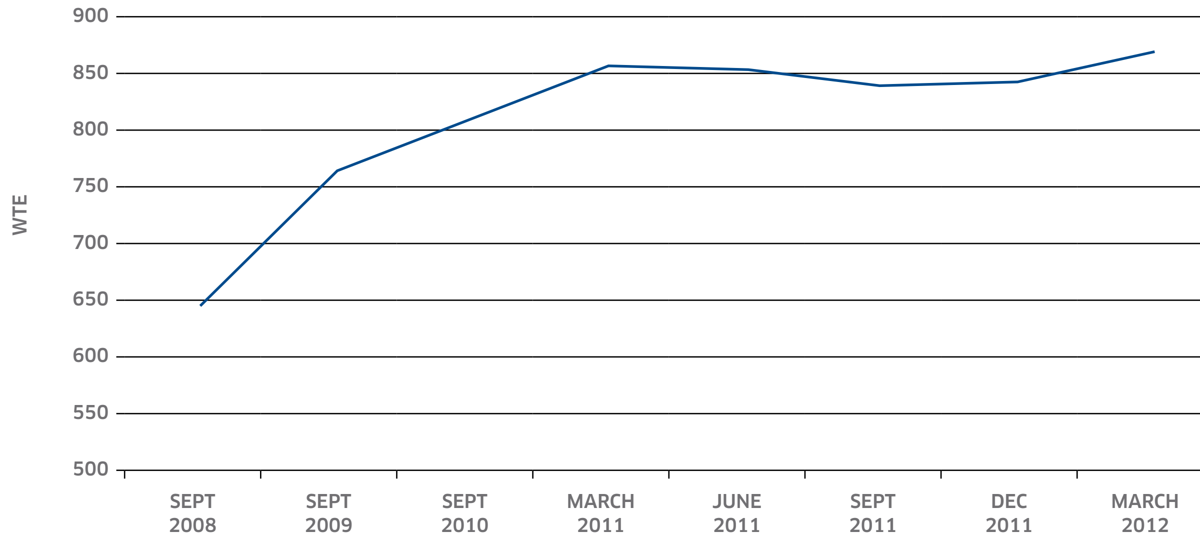
[55] More information about the GIRFEC approach is available at http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

We are on track to deliver the HEAT target, reflecting a significant service improvement and reduction in waiting times. Data suggests a reduction from over 1,200 waits of over 26 weeks when we began this work to around 300 currently, and with further work in hand that will assure delivery of the target. The target is intended to reduce waiting times and improve access to CAMH services overall, but it does not remove the role of clinicians in deciding when a child needs to access a service more quickly. Where a child or young person is assessed as needing to access a service urgently, they will be seen more quickly, sometimes the same day.

Changes have been achieved in a number of ways. Firstly there has been a focus on growing the specialist CAMHS workforce which has increased by over 34% in less than four years from 645.3 whole time equivalents (WTE) in September 2008 to 868.9 (WTE) in March 2012 (see graph below). Secondly, we have worked on capturing data to measure CAMHS waits, which is due to be published for the first time in August 2012 by ISD. There has also been a significant amount of service and patient pathway redesign work undertaken, which has ensured a more efficient and effective use of resources.

The growth in the total whole time equivalent (WTE) for the CAMHS workforce, September 2008 through to March 2012 is shown in the graph below.

TOTAL CAMHS WORKFORCE



Note: Numbers exclude trainees
Source: Child and Adolescent Mental Health Service Workforce Database.

Commitment 11: We will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets.

CAMHS Admissions to Adult Beds

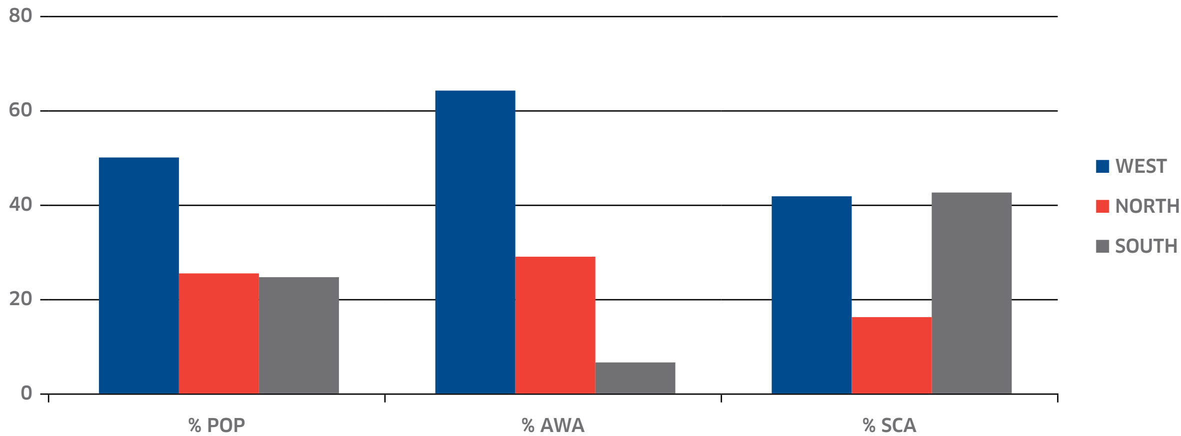
A decision to admit a young person to an adolescent unit will be made only if admission is deemed the only safe and appropriate option available for the patient. It is important therefore that beds are available when required. In order to ensure that this is the case two approaches are being taken nationally. Firstly, a decision of the North of Scotland NHS Boards to build a new 12-bedded unit in Dundee to replace the current six-bedded unit will increase the bed base from 42 to 48 beds, and improve the quality of the estate. Secondly, a new model of care and treatment has been introduced. This new approach to addressing the issue of capacity has seen the development of CAMHS intensive 'hospital at home' type service delivery in a number of NHS Board areas.

The new approach used emphasises the child's strengths and uses the expertise within the family and the local community to maximise the support available – the theory being that a small change in a child's familiar environment will be more significant in their recovery than a larger change in a setting alien to them. When provided in conjunction with practices such as proactive discharge (planning discharges from the date of decision to admit) and flexible approaches to in-reach and out-reach work, a number of benefits have been demonstrated. Some admissions are avoided altogether. Many are significantly shortened. Where evaluation and research has been undertaken, good patient outcomes have been demonstrated[56].

The benefit to the system as a whole, is that new capacity is created. In the areas where the new approaches are most advanced this has been demonstrated to have had the effect of significantly reducing the need for unscheduled and temporary admissions of under 18s to adult psychiatric hospital beds.

[56] *The Effectiveness of a Community Intensive Therapy Team on Young People's Mental Health Outcomes*, Simpson, W., Cowie, L., Wilkinson, L., Lock N., & Monteith, G., 2009, Child and Adolescent Mental Health available at http://www.playfieldinstitute.co.uk/research/reports/effectiveness_of_community_intensive_therapy_team_camh_2010.pdf

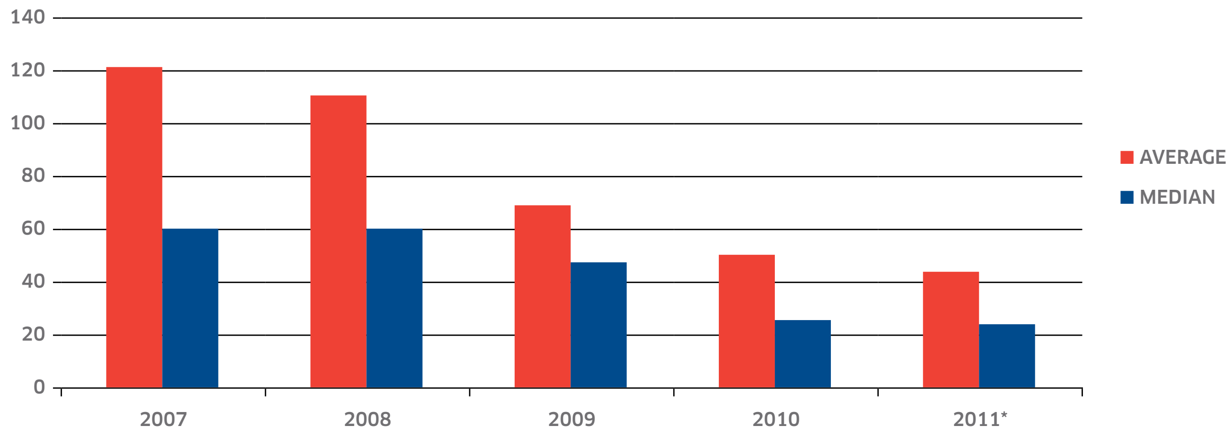
TABLE TO DEMONSTRATE REGIONAL VARIANCE IN UNDER 18 ADMISSIONS TO ADULT WARDS (AWA) AND TO SPECIALIST CAMHS UNITS (SCA) APRIL - SEPT 2011



Source: ISD SMR04 returns

Focusing on the South of Scotland demonstrates the variance and the potential benefits of newly created capacity, arising from the new model. In a recent six-month period it was shown that the South of Scotland had 25% of the population but only 5% of admissions to adult wards. During the same period almost half of all admissions to CAMHS specialist units occurred in the South, though this is also the product of shorter admissions, increasing the number of young people accessing the service as is shown in the following graph.

SOUTH OF SCOTLAND
LOTHIAN CAMHS INPATIENT UNIT
AVERAGE AND MEDIAN LENGTHS OF STAY IN DAYS (2007-2011)



Source: NHS Lothian PIMS
*Data for Jan-May only

This graph shows a dramatic reduction in lengths of stay during the five-year period 2007-11. While there have been changes elsewhere in Scotland, they have been less dramatic and we will be undertaking further work focused on variance, with the objective of delivering similar benefits to those which have been delivered in the South and East of Scotland Regional Planning Area.

A small number of young people in Scotland with very complex needs are admitted to adult forensic services or specialist services in England. As use of the CAMHS inpatient estate continues to develop, we will consider how the varied and complex needs of this group of young people can best be met.

Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.

Child and Adolescent Mental Health Indicators

A set of national mental health indicators for children and young people in Scotland has been established. This complements the mental health indicator set for adults. It was launched formally by NHS Health Scotland in November 2011, with a follow-up web publication[57]. The children and young people's mental health indicators cover both the state of mental health (mental wellbeing and mental health problems) and the associated contextual factors.

The indicators provide for the first time, a means of assessing and monitoring the mental health of Scotland's children and young people over time, and will enable the development of the first national mental health profile for children and young people (aged from pre-birth to 17 years). Updated every four years, the profile will result in a greater understanding of the current and changing picture of mental health within this population, and the factors that influence it.

[57] The publication and further information can be found at www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx

KEY CHANGE AREA 2: RETHINKING HOW WE RESPOND TO COMMON MENTAL HEALTH PROBLEMS

Common mental health problems, such as depression and anxiety, can be both severe and enduring, but the response they will generally require is different from that for illnesses such as schizophrenia. However, in many ways the systems for providing care and treatment can look very similar. We need to examine and challenge that model.

The themes above, and commitments set out throughout this Strategy promise a system where therapies are more readily available, but also where there is a wider range of responses, including social prescribing, self-help and peer-to-peer work. People already have access to more information themselves and are increasingly able to self-refer to services or to seek support for themselves. These approaches build capability and make choices, and that degree of control and mastery is itself health-producing.

This marks a move away from the model where, uniformly, the doctor diagnoses and treats illness, to a wider range of responses which includes that approach, but also includes approaches where people will be identifying problems for themselves and seeking help or taking action, and where families and friends are more likely to say something or offer support. Information and support will be more widely available, whether from healthcare professionals or from the web.

This is not a utopian vision and these new ways of working will not be for everyone, whether because of personal choice or for reasons linked to illness. Services as we know them will continue to be necessary as part of a mental health system.

This is a change which will accelerate over the next period of time and services and approaches need to adapt quickly.

Faster Access to Psychological Therapies

The Scottish Government is already committed to delivering faster access to psychological therapies for those with mental illness or disorder. We have already seen improvements in service performance across Scotland since the HEAT target was set. Patients and clinicians have long identified access to therapies as a key service improvement that would better meet their needs and expectations in getting access to world-class clinical care, both for those

with severe and enduring mental illness and for those with more common illnesses such as depression and alcohol addiction.

Delivering faster access is a significant and complex challenge. The objective is that by 2014 the standard for referral to the commencement of treatment will be 18 weeks, irrespective of age, illness or therapy. No other country in the world has set such a wide ranging and comprehensive target within a publicly-funded healthcare system.

The programme to take forward this work is delivered locally, but supported nationally. To deliver the target we have had to undertake the following work:

- We are developing national and local information systems and data to record performance and progress against the target; this has required us to specify and define the target and what should be recorded, as well as creating the capability to record data to a high standard over time;
- We have offered guidance through the *Matrix*[58] on what treatments are effective for which illnesses and conditions; the HEAT target covers all types of evidence-based therapy for all types of mental illness or disorder, as well as allowing for work where the evidence-base is underdeveloped or not available at this time;
- The Matrix also stresses that services must provide adequate psychological therapies supervision for staff delivering psychological interventions, to ensure patient safety and the delivery of evidence-based care; the evidence also shows that supervision improves the quality of outcomes and the efficiency of service delivery;
- With NHS Education Scotland (NES), we are working to assess and develop workforce capacity; this is not just about psychology staff, but ensuring that a range of staff including psychologists, nurses, allied health professionals and doctors are equipped to deliver therapies, at a range of levels, as part of their clinical practice;
- We are working to ensure that systems are designed to make the most effective use of current resources by removing duplication, unwarranted variation and waste;
- We are building processes into the work to gather information on clinical outcomes; while it is important that we are able to offer faster access to services, it is equally important that what we offer produces clinical benefit.

[58] The *Matrix* is available at http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix/the-psychological-therapies-matrix.aspx

While data systems are still developing and we are continuing to resolve issues with recording and reporting systems, good progress is being made across NHS Boards in Scotland which gives us confidence that the target will be achieved on time. More information on the target and the work to support its implementation is on the NHS ISD website[59].

Local service redesign informed by evidence is central to delivery of the target. For example, mental health services historically have tended to have high rates of people not attending appointments. One service reduced its Did Not Attend rate from 21% to 7.5% by making changes which gave patients more choice over appointment times. Another service reduced the amount of time spent in allocation meetings by 312 hours, giving an extra 312 hours to see patients just by changing its processes for allocating patients to staff. Work being taken forward by NHS 24 to deliver therapies and guided self-help by telephone is increasingly being accessed by people who self-refer to the service. In each case these improvements contribute to the objective that people in distress get to see the right person as quickly as possible.

Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014 the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.

Equality of Access to Services

Some people can experience more difficulty than others in accessing mental health services to meet their needs. This can be because some groups are less likely to try to access services, for example due to stigma, or because there are gaps or lack of capacity in some services.

We need to understand who is accessing services to identify where there might be unmet need or where additional preventative action could be taken. Consistent recording of data about ethnic background and other information, for example, gender, sexuality and disability provides us with information about whether services are delivered in a way that meets people's specific needs.

Commitment 14: We will work with NHS Boards and partners to improve monitoring information about who is accessing services, such as ethnicity, is consistently available to inform decisions about service design and to remove barriers to services.

[59] Available at http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies.asp

Social Prescribing and Self-help

The work on access to psychological therapies is just one part of creating the well-functioning mental health system. In parallel with this, NHS Boards and their partners offer access to information and advice, self-help approaches, some of which may be online or through NHS 24, bibliotherapy, counselling and other accessible low-intensity treatments, including exercise, to meet the needs of people experiencing psychological distress.

The evidence-base for a wider range of approaches to tackle common mental health problems like depression is already established. Many people would prefer to 'do something' to improve their mental health than to receive a treatment. We also know that the recovery of people with more severe mental illnesses also benefits from access to services that support physical activity and social integration. The poor life expectancy of those with mental illness is as much or more driven by poor physical health and health behaviours as it is by their mental illness.

A standardised assessment tool and a pathway for brief advice and brief intervention have been developed for use by primary care teams, to assess and improve levels of physical activity in the community. Though we know activity has physical and mental health benefits, currently only 39% of the adult population in Scotland achieve the minimum guidelines of 30 minutes five times per week of physical activity. NICE describe Brief Intervention for Physical Activity as highly cost effective, at £20-£440 per quality adjusted life year (QALY)[60]. These tools and pathways are being integrated into existing Keep Well pathways. eLearning modules on Health Behaviour Change including "Raising the Issue of Physical Activity" have been developed and can be used by any health professional.

We do not think the challenge here is primarily about the range of local services and facilities. The challenge is more about connecting people to such opportunities and addressing the reasons why they might not access them. Our focus is on things that people and communities can do for themselves, which are particularly valuable given the additional benefits that people derive from taking control of their own health and wellbeing. However, people may not access services for the following reasons: they may not know about them; they may not think they are for them; or they may be uncomfortable or nervous about going for the first time.

[60] For commonly-used methods to increase physical activity, http://www.nice.org.uk/PH2

Primary care and particularly General Practitioners have a key role to play in this work. Often they are the best placed to signpost a person successfully to such a service. They have a good understanding already of their patients and what might work for them. Toolkits and reviews have been produced previously to show the benefits and give guidance on social prescribing approaches. We will ensure that this information is easily available. One example is Developing Social Prescribing and Community Referrals for Mental Health in Scotland[61]. Similarly the Links Project Report[62], based on work in Glasgow and Fife, showed how General Practices can make better use of community resources to help and support the people they are working with. It was notable that in many cases, up to 50% in Glasgow, the resources being referred to were for addiction or mental health. In some cases it is necessary for practitioners to connect people to local community and voluntary sector services to assist people to access activities for the first time, and to develop confidence and skills to do so on an ongoing basis.

Commitment 15: We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find[63]. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.

One of the 22 commitments delivered under *Towards a Mentally Flourishing Scotland* was the development and publication of *Steps for Stress*[64]. *Steps for Stress* is a short booklet which provides an easy guide to understanding common mental health problems and providing advice on things that people can do for themselves or services such as debt advice that they can access to gain support.

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[61] Available at http://www.scotland.gov.uk/Resource/Doc/924/0054752.pdf

[62] *Links Project Report: developing the connections between General Practices and their Communities* http://www.scotland.gov.uk/Publications/2012/05/1043/0

[63] Available at http://www.aliss.org/

[64] Available at http://www.scotland.gov.uk/Publications/2009/05/06154655/0

The booklet is supported by a website that has additional content and links[65] and a relaxation CD is also available. Since 2009 more than 420,000 copies of the booklet and almost 970,000 CDs have been handed out. We have recently agreed to allow the Northern Ireland Assembly to produce their own local version of the resource.

We intend to take this approach forward in a number of ways to make best use of the existing resources and materials. One component of this will be to provide and share learning for local health improvement and voluntary sector staff, in how they can use the materials in their locality, and how they can work with people who are using the materials. A second element will be to link the resource more directly to the ALISS project so that people can easily identify local opportunities to access help and support.

Commitment 16: NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use *Steps for Stress* as an early intervention approach to address common mental health problems.

[65] Available at http://www.stepsforstress.org

Mental Health and Alcohol

There are strong links between depression and drinking above recommended guidelines. The SIGN Guideline – *The management of harmful drinking and alcohol dependence in primary care*[66] – explains how hazardous drinking and alcohol dependence present in many ways, one of which may be through depression.

Alcohol Brief Interventions (ABIs) are part of the Scottish Government's wider strategic approach to tackling alcohol[67]. In 2008, an NHS health improvement HEAT target was introduced, based on the SIGN Guideline, requiring NHS Boards to deliver ABIs within the following three priority settings – primary care, A&E and antenatal. To date, over 272,000 ABIs have been delivered. Many of these interventions have been delivered in primary care settings. We believe there is value in clearly aligning the work in place to diagnose and respond to depression, with the delivery of brief interventions to reduce people's alcohol consumption.

For 2012-13 ABI delivery has become a HEAT standard. NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed ABIs in the three priority settings. In addition, they will continue to develop delivery of ABIs in wider settings, which may include specific mental health settings.

NES is supporting the development of a standardised training and certification programme in Motivational Interviewing which will be of relevance across all tiers of service in relation to alcohol misuse and wider health behavioural change issues. Training is also being delivered in core behavioural and cognitive behavioural therapy skills for relapse prevention and recovery management.

Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care.

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[66] *SIGN 74* is available at http://www.sign.ac.uk/guidelines/fulltext/74/index.html

[67] *Alcohol Framework for Action* (2009) http://www.scotland.gov.uk/Publications/2009/03/04144703/0

Mental Health and Debt

In 2010-11 the Scottish Citizens Advice Bureau (CAB) received over 90,000 new debt enquiries and over 15,800 new debt cases. There is evidence of a link between debt and mental health problems, and research shows that suicide risk is raised for virtually all mental health problems and substance abuse. CAB advisers reported that some clients experiencing debt were also indicating signs of stress and anxiety. CAB identified a need for further training on mental health awareness and suicide awareness for advisers, and training for supervisors to enable better support of client advisers following a distressing contact.

Earlier this year, the Scottish Government funded Samaritans to undertake joint work with CAB to produce two e-learning modules to develop the service which clients with mental health problems receive from CAB. The first module covers suicide risk awareness, recognising signs of suicidal intent and providing first level response and support to clients and is aimed at paid staff and bureaux volunteer advisers across Scotland. The second module is for use by CAB line managers and supervisors to support advisers after they have handled a distressing contact.

Trauma

The relation between trauma and mental illness is complex. Across the lifespan trauma is a relatively common phenomenon, and many people have experience of single life-threatening events, or longer-term traumatic circumstances, without suffering significant psychological harm. However, some do suffer harm and that harm, while rooted in the psychological trauma, may manifest in a variety of mental health problems including depression, addiction or physical symptoms. There are clear linkages to the work on distress set out later, as well as to the work to improve access to psychological therapies.

While there is a growing recognition of the significance of trauma, clinicians and others may be reluctant to engage with it because of the concern of causing further harm, or of not being able to offer an appropriate response which meets the needs of the person. We need to address that deficit and improve the general service response to trauma.

The Rivers Centre in NHS Lothian has been commissioned to investigate the issue of staff awareness of trauma-related mental health disorders in primary care. The work will begin with engagement with a number of GP practices in NHS Lothian with different experience and circumstances. A consultation process will follow with the Royal College of General Practitioners and with representatives of NHS Education for Scotland (NES).

The objective of this work is to develop an approach designed to raise the awareness of primary care practitioners of post traumatic disorders, facilitate best practice management of post traumatic disorders and improve identification of available local resources and services for onward referral. This approach will be piloted in the same GP practices as are involved in the first-stage study. The pilot data will be analysed, modifications to the training package will be made in consultation with the Royal College and with NES, and, if appropriate, a wider roll-out plan will be designed.

NES will continue to develop and deliver a range of training courses to support staff working across the tiers of the stepped care system, including psychoeducation for complex trauma, trauma-focused cognitive behavioural therapy and Working with Dissociation in Survivors of Trauma.

The Scottish Government is also supporting the UK Psychological Trauma Society to develop and support a national learning network for trauma practitioners and services working in Scotland.

Commitment 18: We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network.

Distress

Over recent years there has been a greater recognition of a group of disorders, illnesses and behaviours which present particular challenges to services and to families. Particular examples are eating disorders and self-harm. The common characteristics are that they are behaviours that involve risk to the individual and which others find frightening or upsetting; they are associated with self-stigmatisation and guilt leading to avoidance and disengagement; generally individuals are regarded as having capacity, and so there is an element of voluntariness which produces confusion about interventions; they present in primary care and A&E and other non-specialist settings; and they tend to begin early in life, but can be fatal or have a continuing impact.

The current model of service delivery is treatment approaches that tend to focus on the behaviours, not the underlying cause (except in some cases where trauma or personality disorder is identified), alongside treatment of co-occurring illness issues, notably depression,

anxiety and addictions. In some cases these treatment approaches are effective and successful, but often that is not the case and the behaviours are chronic. There is a preference in primary care to refer to secondary care for 'specialist' mental health treatment, but also often a recognition by primary care practitioners that this is unsatisfactory. Families and carers are able to act as advocates, but often feel disempowered to help.

People within this group may have frequent contact with crisis and healthcare services and a subset have regular attendances at A&E. Some will also have regular contact with the police or with social work services, but the challenges they present are very similar. At times they may seek or request help, but they are likely to disengage or to fail to take up appointments. There is no single treatment or intervention which is appropriate and referrals to specialist mental health or addiction services are often unsuccessful. There is an interaction with the work on Adult Support and Protection which may also offer new opportunities for different ways of approaching the challenge and co-ordinating the statutory sector response.

The Scottish Government has been undertaking recent work with NHS Tayside and partners, including families, focusing on this group following on from a group of suicides in 2010. Developing ideas from that work include moving the focus from the behaviours to focus more on the underlying distress. The thinking is that doing so would offer a more human, caring response that acknowledges what is going on with the person and which is less likely to produce a stigmatising and excluding response, with the effect that more people will come forward for treatment or engage with services. It could also give family members and others a better basis for offering care and support and enable us to mobilise a wider range of treatment and community supports. Initial discussions with service users and others suggest that further work to develop the approach would be welcomed.

Commitment 19: We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test this in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.

Mental Health of Older People

There has been a significant focus on the mental health of older people through the work on dementia. The next stage of work on dementia will be consulted on later this year and there is a commitment to produce an updated strategy in 2013. However, more older people experience illnesses such as depression and anxiety than experience dementia and there is a need to better respond to their needs. More than any other group, older people are less likely to have illness diagnosed and less likely to receive treatment, though prescribing data since 2000 would suggest that this is improving and the mental health needs of older people are increasingly recognised.

In 2010, as part of the work on better access to psychological therapies, the Scottish Government established a working group to focus on the mental health needs of older people. That working group reported in December 2011 and made recommendations for service development based on seven key principles[68]:

Seven Principles of Good Psychological Care for Older People

1. A psychologically and age-aware workforce for all services.
2. Specialist older people's psychological services are based on need not age.
3. Access for older people to general non-age-related services where appropriate.
4. A matched care approach is used that meets the needs of older people.
5. Sufficient numbers of highly-trained staff are available to undertake low and high-intensive therapy, plus training, research and service development.
6. Trained staff will have reserved and protected time to undertake such work.
7. There will be ongoing clinical support, clinical supervision and reflective practice opportunities.

The report identified the need to make improvement across the system, from highly specialist therapeutic approaches to better community and self-help approaches that support and maintain people's wellbeing in later life. This is consistent with the recommendations that

[68] *The Challenge of Delivering Psychological Therapies for Older People in Scotland* Report of Older People's Psychological Therapies Working Group, December, 2011.

were produced by the reference group for Mentally Healthy Later Life[69], flowing from the commitments in *Towards a Mentally Flourishing Scotland* to explore what is needed to support wellbeing in later life. The indications are that in a number of local authority areas preventative approaches have been prioritised under service redesign initiatives being taken forward under the Change Fund[70]. As with the adult population, we know that addressing common mental health problems such as anxiety and depression alongside co-occurring long-term conditions improves clinical outcomes and reduces the likelihood of admission to hospital or institutional care.

Commitment 20: We will take forward the recommendations of the psychological therapies for older people report with NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population.

In addition, the Scottish Government is currently consulting on the integration of adult health and social care, with a particular focus in the first instance on improvements in services and support for older people[71].

Commitment 21: We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people's mental health as part of the work to take forward the integration process.

Mental Health of those with Physical Illness

In *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, the Institute of Medicine identified as its first overarching recommendation that: "health care for general, mental and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body."[72] In *Long-term conditions and mental health: the cost of co-morbidities*, the Kings Fund found that people with

[69] Mentally Healthy Later Life Reference Group – *Recommendations to inform Scottish Government's action plan to promote mentally healthy later life in Scotland* (2010) NHS Health Scotland available at http://www.wellscotland.info/guidance/tamfspolicy/laterlife/index.aspx

[70] More information about the Change Fund is available at http://www.scotland.gov.uk/Topics/Health/care/reshaping/changefund

[71] More information about health and social care integration is available at http://www.scotland.gov.uk/Topics/Health/care/IntegrationAdultHealthSocialCare

[72] *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, IOM, page 11.

long-term conditions who also had co-morbid mental health problems such as depression and anxiety had increased healthcare costs and poorer clinical and other outcomes[73]. Recent research in Scotland supports these conclusions and argues for new approaches to care and treatment to enable clinicians to offer better support to those with co-morbidities, particularly in deprived areas[74].

This academic and clinical research evidence is in accord with what patients often tell us, that they feel that their treatment is fragmented. There is an ongoing need to address co-morbidities with a particular focus on identifying and responding effectively to depression. The indications are that clinicians in primary care in Scotland have been very effective in closing the treatment gap for patients with depression, but further work is needed in all settings to tackle this challenge.

The Living Better Project – a learning collaboration between a number of partners including the Royal College of General Practitioners in Scotland – identified key lessons for staff working with people with long-term conditions who also had common mental health problems[75]. It developed training interventions both for professionals and for patients and addressed issues to do with stigma by promoting activity in a way that plays down the connection to mental illness, and focused on positive wellbeing and people's potential strengths as individuals and as a group. Similarly, work with the Thistle Foundation in Craigmillar in Edinburgh gave us insight into how local community services can engage with General Practitioners. GPs became more confident about referring to services if they got feedback from those services about how patients benefited. As part of that programme the Thistle Foundation provided GPs with data on improvements on depression scores over time. Seeing benefits in clinical terms encouraged GPs to make greater use of the service and also kept it at the front of their mind.

NES will continue to support work to produce learning resources for staff working with patients with physical health problems, particularly long-term conditions, which will help them to understand the link between physical and emotional issues and deliver more holistic and effective care.

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[73] Available at http://www.kingsfund.org.uk/publications/mental_health_ltcs.html

[74] *Multimorbidity: redesigning health care for people who use it* available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60482-6/fulltext

[75] The final report is available at http://www.ltcas.org.uk/news-and-events/news/2012/03/final-report-of-the-living-better-project-is-now-available/

Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long-term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.

KEY CHANGE AREA 3: COMMUNITY, INPATIENT AND CRISIS SERVICES

A well-functioning mental health system has a range of community, inpatient and crisis mental health services that support people with severe and enduring mental illness. There has been considerable redesign of mental health services across Scotland, continuing the long-term trend of moving from largely inpatient services to services where care and treatment is delivered mostly in the community. Within the broad direction of change towards developing more services based in the community, we know that there are wide variations in pace of change, delivery, and models of services.

As information about mental health services has been developed over the past few years, there is increasing scope to use data – across teams, services, local areas and internationally – to understand variation and use the information to plan and implement change. There are examples across Scotland of NHS Boards using such data to improve the quality of care and treatment, improve the efficiency and effectiveness of services, and to make strategic decisions about how services should be configured. We intend to develop our understanding of how service structure and design produce better outcomes.

Intensive Home Treatment Services and Crisis Prevention Approaches

Some mental health problems can be episodic in nature, with people experiencing stable periods with few symptoms, and periods of crisis with intense symptoms. A number of NHS Boards have developed home treatment services to care for people in their own homes during the acute phases of severe mental illness. Two reports, *The Scottish Crisis Resolution/Home Treatment Network Service Mapping Report*[76] and *A Review of Crisis Resolution Home Treatment Services in Scotland*[77], highlight the range of models that have been developed in Scotland but also indicate the difficulty in making comparisons across the models to understand which deliver the best outcomes.

[76] The report is available at http://www.evidenceintopractice.scot.nhs.uk/media/147569/scrhtt%20network%20service%20mapping%20report.pdf

[77] The report is available at http://www.qihub.scot.nhs.uk/media/264761/crisis_resolution_home_treatment_report%20final%20november.pdf

Intensive Home Treatment Teams – Edinburgh CHP

Available 24/7, these multi-professional teams provide a rapid response, intensive specialist assessment, treatment and risk management in a community setting. They focus on people who might otherwise require hospital admission. They have had a significant impact in quality terms:

- A 32% decrease in admissions and readmissions allowing closure of 25 beds in December 2008 and 12 beds in the Summer of 2009. NHS Lothian now has the lowest number of acute beds *per capita* in Scotland: 13 per 100,000 population.
- Average length of stay reduced by six days.
- Average occupied bed days reduced from 89% to 77%.
- Service user feedback is routinely positive, with 87% of respondents reporting clinical improvement, 43% feeling recovered at discharge and 96% feeling safe during their episode of treatment. People value the level and quality of support, avoidance of hospital admission and improved recovery facilitated by home treatment.[78]

The Mental Welfare Commission in their report *Intensive Not Intrusive*[79], into intensive home treatment services in Scotland found that individuals who had received a service, and also carers, valued the service highly. They found that most mental health services were able to demonstrate how intensive home treatment had reduced the use of inpatient beds, with many demonstrating fewer admissions and shorter spells in hospital where admission had been necessary. However, they also noted that intensive home treatment is not equally available across Scotland and made the recommendation that NHS Boards should monitor the uptake of intensive home treatment to ensure equality of access and to continue to evaluate services.

The *Mental Health Pathway Efficiency and Productivity Report*[80] also considered the role of crisis resolution and intensive home treatment teams. It concluded that while the overall evidence for the cost-effectiveness of the approach was mixed there were also likely to

[78] More information is available at http://www.qihub.scot.nhs.uk/media/264764/ihtt%20mhas%20review%202010%20amended%20final.pdf

[79] Copies of all Mental Welfare Commission reports are available at http://www.mwcscot.org.uk/

[80] The report is available at http://www.qihub.scot.nhs.uk/media/266122/mh%20pathway%20efficiency%20and%20productivity%20report%20(2).pdf

be significant quality and efficiency savings attached to preventing crisis occurring in the first place. As there is evidence that psychiatric crisis is often preceded by a social crisis, integrated, responsive health and social care services are vital.

Further work is needed to identify the key components of crisis prevention services, but the likely elements include:

- Routine use of relapse and crisis contingency planning for individuals who have experienced more than one acute episode;
- Integrated (cross heath and social care) and person-centred care planning;
- Effective involvement of families, friends and carers; and
- Timely responses by specialist services when an individual or their carers highlight the occurrence of early warning signs.

A further idea that is creating interest in Scotland is of a crisis safe house, safe haven or sanctuary. Crisis houses offer intensive short-term support to help resolve a crisis in a residential rather than hospital setting. There is no single model for a crisis house, but they are often run by third sector organisations and can provide a key location for undertaking peer-to-peer support. They also have a clear function and linkages to statutory services. We will be interested to see how this idea develops over the coming period and will take forward discussions with interested parties.

Commitment 23: We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHSScotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services.

First Episode Psychosis

Early detection of psychosis and intervention for first episode psychosis provides better outcomes for individuals and financial savings for the NHS and wider public sector. Early intervention teams provide intensive support and treatment for people who have had a first episode of psychosis, and aim to reduce relapse and readmission rates, and improve clinical and social outcomes such as returning to employment, education and training. The

Mental Health Pathway Efficiency and Productivity Report[81] also identified potential savings from early intervention teams, and used benchmarking data on psychiatric bed usage by individuals aged 18-24 years in Scotland to illustrate where there might be scope for improvement in service delivery.

Commitment 24: We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option.

Quality of Community Services

To underpin the work to understand variation across services and particular models of service provision, we need to further develop indicators of quality across community services. Information on reducing readmissions to inpatient services provides part of the picture as it is dependent on having effective community services and discharge planning in place.

Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services.

Inpatient Services

As community services have developed, the number of psychiatric beds has reduced across Scotland. There is considerable variation in how beds are used across Scotland, in terms of the primary diagnosis of patients, the numbers of admissions and the average length of stay. There has also been recent development of specialist services, e.g. significant investment in the forensic inpatient estate.

We want to better understand the use of acute, Intensive Psychiatric Inpatient Units and crisis services. We also want to consider the balance of services between the overall general inpatient provision and specialist provision, including where there is pressure to develop additional specialist provision. In undertaking this work we are clear that it is intended to support future local and regional decisions on redesign to improve outcomes and efficiency and that any decisions on local restructuring will be made by NHS Boards.

[81] See note 80

The National Forensic Network is supported by the Scottish Government with the aim of developing protocols to assist in patient movement throughout the secure estate, maximising the use of the forensic estate and creating sustainable services for specific patient populations with specialist needs. The Forensic Network has developed standards for low security and community services and will work with other local services to continue to improve standards and equity of access to specialist interventions.

Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland.

Patient Safety

As well as understanding the balance between community and inpatient services and how they can deliver the best outcomes, we want to ensure that services are safe. We have introduced the Scottish Patient Safety Programme in Mental Health (SPSP-MH) The SPSP-MH will be a four-year programme with an overall aim of reducing the harm experienced by individuals in receipt of care from mental health services. It will start with a focus on adult psychiatric inpatient units and forensic inpatient units, including admission and discharge processes.

Whilst there is clear evidence that harm is experienced by people using mental health services, there is currently no method in place within Scotland, other than for suicide, for reliably measuring the levels of that harm occurring. Therefore work will progress as part of the first phase to develop an approach to reliably measuring levels of harm in mental health services. Similarly, initial scoping into the subject area revealed limited evidence about what interventions will reduce harm in mental health. Therefore the programme will start with an initial one-year phase of testing interventions and development of a future approach.

Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health.

Health Improvement for People with Severe and Enduring Mental Illness

As explained above, people with mental disorders have a much higher mortality than the general population, dying on average more than 10 years earlier. The Scottish Government

made a commitment to take forward work on the physical health of people with mental illness in *Delivering for Mental Health*. We said:

> 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[82].

We produced guidance on how NHS Boards could ensure good work between primary and secondary care in providing good quality physical health services to people with severe and enduring mental illness, to build on the QOF (Quality and Outcomes Framework used by GP practices) points, and to ensure that we got full value from them[83]. The guidance made seven main recommendations with the key themes focusing on awareness raising, removal of barriers to accessing services, and the requirement to evidence improvement over time. It created a framework for local services to develop their local approaches.

NHS Greater Glasgow and Clyde works with primary care through the Primary Care Interface Group. The Interface Group took forward work to ensure that there was good recording of diagnosis in GP mental health registers and the matching process increased the percentage of people recorded on GP registers with a secondary care diagnosis of psychosis from 68% to 90%. GPs welcomed having access to better information which continues to be updated regularly. This increased the number of physical health reviews being taken forward, and we tracked performance on this across Scotland as one of the areas we focused on in twice yearly NHS Board area visits in 2008 and 2009.

This work to improve physical health is also supported by work in secondary care settings. Physical health improvement is built into the Scottish Recovery Indicator, ensuring practice in mental health services relates to the factors which can help recovery[84]. Service providers are asked how they support people's physical healthcare. Service users are asked how the service takes account of their physical health needs. Similarly, the Releasing Time to Care inpatient programme, which is designed to increase the amount of time that professional nursing staff

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[82] See note 53 for reference to Delivering for Mental Health.

[83] A copy of the report *Mapping and review of physical health improvement activities for adults (16-65) experiencing severe and enduring mental illness* is available at http://www.healthscotland.com/documents/4806.aspx

[84] See note 35 for reference to Scottish Recovery Indicator.

spend in therapeutic activity with patients, encourages a focus on physical health[85]. Early work from the Releasing Time to Care work is showing increases in some areas in activity such as walking groups, exercise induction and preparation for sleep.

Various health improvement activities that are effective in the general population can be appropriate for those with severe and enduring mental health issues. We do know there are real barriers and challenges for this work but surveys and feedback show that it is important to service users. To gain maximum benefit, individuals are likely to require additional education and support to participate, sustain involvement in, and benefit from, health improvement activities. A combination of motivational and behaviour change interventions, alongside appropriate pharmacological treatments, appear to provide the best results in terms of both health gain and adherence to health improving activities.

Commitment 21 of *Towards a Mentally Flourishing Scotland* was that NHS Health Scotland would review the evidence-base for health improvement activities for those with severe and enduring mental illness and work with NHS Education for Scotland to build knowledge and skills in the workforce[86]. The review demonstrated that those with severe and enduring mental health problems can gain health improvement benefits from participation in health improvement activities (smoking cessation, weight management and physical activity)[87]. These are evidenced to be successful as long as the activity is tailored to the individual, and the professionals involved have increased knowledge and awareness of issues surrounding the individual's mental and physical health, are aware of the benefit and impact of combination therapies, and ensure the most appropriate support mechanisms are in place.

Clozapine is the 'gold standard' antipsychotic for patients with treatment resistant schizophrenia. Unfortunately it is associated with a range of side-effects, some of which can have a profound effect on a patient's ongoing physical health. Work has been undertaken to develop NHSScotland Clozapine Physical Health Monitoring Standards and these Standards will be taken forward through awareness raising, the development of appropriate prompts and the use of local clinical audits.

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[85] More information about Releasing Time to Care can be found at http://www.evidenceintopractice.scot.nhs.uk/leading-better-care.aspx and an early evaluation of impact at http://www.evidenceintopractice.scot.nhs.uk/media/126433/lbc%20and%20rtc%20briefing%20paper%20sept%202010.pdf

[86] See note 16 for reference for *Towards a Mentally Flourishing Scotland*.

[87] See note 83 for reference to the review report.

Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine.

Employability

We know that being in the right work is good for a person's health and improves their quality of life and wellbeing. This is also true for people with a mental or physical health condition. Remaining in, or returning to work quickly, aids recovery and more people gain health benefits from being in work than are negatively affected by it[88]. However, people with mental illness are less likely to be engaged in work than the general population or those with other health conditions, with one review identifying that 79% of people with serious, long-term mental health problems are not in employment[89]. Improving and increasing access to employment for those with mental illness is challenging, but necessary and achievable.

We have already seen success in the use of recovery-orientated practice and person-centred practice in services with the development of the Scottish Recovery Indicator[90]. This approach has been well supported by *Rights, Relationships and Recovery* focused on nursing practice[91]. Employability is also embedded and integrated into the work that enables service users to develop personalised Wellness Recovery Action Plans[92]. These approaches demonstrate how services, service users and those who support them can orientate themselves towards work.

A key component of this change process is to reinforce this message of the importance of employment in promoting and maintaining health and for Community Mental Health Teams to more effectively incorporate vocational information and activity into care plans. This is a cultural as well as a technical challenge. NHS Lothian and NHS Lanarkshire are training

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88 *Vocational Rehabilitation What works, for whom and when?*, Waddell G., Burton A.K., Kendall N.A.S., 2008, London available at http://www.dwp.gov.uk/docs/hwwb-vocational-rehabilitation.pdf

89 *Disability and employment in Scotland: a review of the evidence-base* Riddell S., Banks P. and Tinklin T. Scottish Executive, 2005, available at http://www.scotland.gov.uk/Publications/2005/01/20511/49760

90 Information about the SRI 2 is available at http://www.sri2.net/

91 The most recent information about *Rights, Relationships and Recovery* together with a link to the original document is available at http://www.scotland.gov.uk/Topics/Health/health/mental-health/RRRmentalhealth/

92 More information about Wellness Recovery Action Plans is available at http://www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html

occupational therapists to be aligned with Community Mental Health Teams to lead this role. In other places this role may be taken on by a dedicated support worker. NHS Tayside and NHS Fife are developing an electronic resource in partnership with work agencies to help staff signpost to resources. A community of practice has also already been established[93] and employability training made available to health professionals through NES[94]. AHPs in mental health are being encouraged to lead the way in promoting timely access to effective vocational support for service users through informed signposting and implementation of evidence-based models of practice.

There is an evidence-base that shows that, with the right kind of help, people with serious mental health problems can successfully get and keep work. This applies irrespective of individual characteristics such as clinical history or previous employment. A Cochrane systematic review found that those with severe mental illness who received supported employment were two or three times more likely to be in competitive employment at 12 months[95]. The evidence demonstrates that "place then train" models are much more effective than traditional approaches such as vocational training and sheltered work in successfully getting people into work[96]. A 12-month study on the impact of supported employment for those with mental health issues also found that those who entered work used significantly less mental health services[97].

"Place then train" focuses on competitive employment as a primary goal and is open to all those who want to work. It has demonstrated strong employment-related outcomes for individuals with long-term mental health problems and has an evidence-base that extends outside the US where it originated, across to Europe and the UK. The most well-established

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93 Materials which support this community of practice are available at http://www.knowledge.scot.nhs.uk/work/groups-and-projects/mental-health-and-forensic-ahp-network.aspx)

94 The materials are available at http://www.employabilityinscotland.com/toolkits/capacity-building/employability-training-for-health-professionals

95 *Vocational rehabilitation for people with severe mental illness*, Crowther R., Marshall M., Bond G.R., Huxley P., the Cochrane Library, 2010, available at http://summaries.cochrane.org/CD003080/vocational-rehabilitation-for-people-with-severe-mental-illness

96 *The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial*, Burns T., Catty J., Becker T., Drake R., Fioritti A., Knapp M., Lauber C., Tomov T., van Busschbach J., White S., Wiersma D., The Lancet, 2007, 370 1146-1152 available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61516-5/fulltext

97 *Impact of supported employment on service cost and income of people with mental health needs*, Schneider J., Boyce M., Johnson R., Secker J., Slade J., Grove B., Floyd M., Journal of Mental Health 2009 18(6) 533 available at http://informahealthcare.com/doi/abs/10.3109/09638230903111098

method of "place then train" in mental health is Individual Placement and Support (IPS). IPS has been shown to be more effective the more closely it follows these eight principles:

1. It aims to get people into competitive employment
2. It is open to all those who want to work
3. It tries to find jobs consistent with people's preferences
4. It works quickly
5. It brings employment specialists into clinical teams
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. It provides time unlimited, individualised support for the person and their employer
8. Benefits counselling is included[98].

There are already good examples of the "place then train" model being implemented in Scotland[99]. The WORKS is an NHS Lothian vocational rehabilitation service for people living in Edinburgh that supports people with mental health conditions to stay in work, return to work, or gain work for the first time. It provides ongoing practical and emotional support that can include on-the-job support to manage a mental health condition, advice about informing employers about a mental health condition and other tailored support for as long is required. It also offers employers advice around good working practices, including disability discrimination legislation and reasonable adjustment.

Commitment 29: We will promote the evidence-base for what works in employability for those with mental illness by publishing a guidance document which sets out the evidence-base, identifies practice that is already in place and working, and develops data and monitoring systems. Change will require redesign both within health systems and the wider employability system to refocus practice on more effective approaches and to realise mental healthcare savings.

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98 More information is available at http://www.centreformentalhealth.org.uk/employment/ips.aspx

99 *Realising work potential. Defining the contribution of allied health professionals to vocational rehabilitation in mental health services*, 2011, Scottish Government, available at http://www.scotland.gov.uk/Publications/2011/12/16110149/0; *Towards Work in Forensic Mental Health National Guidance for Allied Health Professionals* available at http://www.forensicnetwork.scot.nhs.uk/allied-health

KEY CHANGE AREA 4: OTHER SERVICES AND POPULATIONS

Mental Health and Offending

Within forensic services the Care Programme Approach (CPA) is used to manage the risks posed by restricted patients (patients who are subject to special restrictions applied by the court, because of the risk posed because of a mental disorder). The School of Forensic Mental Health has created a number of training modules focusing on risk assessment and delivered training to create capacity to deliver psychological therapies for mentally disordered offenders.

The *Report of the Commission on Women Offenders*[100] identified mental illness and personality disorder as key contributors to women's offending and to the likelihood of prison as a disposal. The report identified the need to improve the treatment and support offered to women with borderline personality disorder, the need to develop better approaches for short-term prisoners to allow for interventions to start in prison and continue into the community, faster access to psychological therapies and a better capability within police, healthcare, prison and social work staff to understand the interaction between mental disorder and offending.

In its response, the Scottish Government made a series of commitments to continue to work to improve mental health services to address these challenges[101].

Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a 'mentalisation' approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh.

Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.

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[100] The report is available at http://www.scotland.gov.uk/About/Review/commissiononwomenoffenders/finalreport-2012

[101] The response is available at http://www.scotland.gov.uk/Resource/0039/00395486.pdf

As indicated above, over the period of this Strategy we will also build on existing work to improve access to mental health services, including the HEAT target to reduce waiting times for access to psychological therapies. The focus on people who experience distress, and the complex connections with eating disorders, depression, self-harm, domestic violence, substance misuse, personality disorder and depression is particularly relevant to the work with women offenders.

In addition to this work, which has a particular focus on women offenders, we will also take forward other work focused on offenders. We have already committed to extending the current forensic work in NHS Lothian which supports justice staff working with sex offenders who have personality disorders, to include work with serious violent offenders.

We are also aware that there has been relatively limited use made of Community Payback Orders with a mental health condition. These orders were introduced under the Criminal Justice and Licensing (Scotland) Act 2010 with the intention of allowing for treatment in particular cases, to accompany a non-custodial sentence[102]. They are likely to be particularly appropriate for some people with personality disorders or developmental disorders, where treatment within the legal framework could potentially give quite different long-term outcomes.

Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.

Neurodevelopmental Disorders

In the consultation on this Strategy we set out our view that the provision of specialist mental health services and associated supports for people with a range of neurodevelopmental disorders could be improved. The term 'neurodevelopmental disorders' encompasses a range of conditions with features specific to each diagnosis but in common they can impact on social functioning and behaviour, sometimes quite severely, irrespective of the level of intelligence of the individual. Autism spectrum disorder (ASD) and Aspergers syndrome, attention deficit hyperactivity disorder (ADHD), and Tourettes syndrome and chronic severe tic disorders are among the neurodevelopmental disorders most frequently seen through childhood and into adulthood.

[102] More information about Community Payback Orders is available at http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/examples/payback/CPO

While developmental disorders are not uncommon – the prevalence of ASD in the general population is around 1% – there is a small number of people with ASD within Scotland who have particularly high levels of need, which makes providing their care that bit more complex. The response to the consultation confirmed that this view is shared and that there is a desire and need to deliver improvement which must start with addressing levels of awareness and skills amongst health and other professionals. This challenge crosses traditional boundaries between health and social care services and requires more work to make the linkages between this Strategy and the Scottish Strategy for Autism[103] work for individuals and their carers.

Similarly there is work needed to improve diagnosis of and response to ADHD. Work within NHS Lothian has established that people with ADHD are increasingly presenting to adult mental health services, but there are inconsistencies within mental health services in how this is responded to. ADHD is also known to be linked to higher rates of offending and we will make the linkage with justice services.

Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.

Veterans

The Scottish Government has supported development and provision of specialist mental health and community outreach services for veterans. The Scottish Government funds the NHS-commissioned service delivered by Combat Stress at Hollybush House, which offers a wide range of specialist services to meet the needs of veterans with a mental health problem. Combat Stress is redesigning its service to provide 32 places for veterans resident in Scotland on a six-week intensive Post Traumatic Stress Disorder course, in addition to delivering treatment to veterans as either an inpatient, outpatient or, where appropriate, in the community. Community outreach services run by Combat Stress have been developed to respond quicker and better to veterans' mental health needs and to improve access to NHS services. Two regional teams operate across the East and West of Scotland, with the Scottish Government funding the East Team.

[103] The Strategy is available at http://www.scotland.gov.uk/Publications/2011/11/01120340/0

Veterans First Point is a ‘drop-in’ service for veterans based in the Lothians, providing support and advice covering a range of areas such as health, social, employment and education, with signposting where appropriate to other relevant agencies for further help and support. The service was evaluated positively by Sheffield University as one of six UK community mental health pilots and was the overall winner at the Military and Civilian Health Partnership Awards 2011.

Commitment 34: We will continue to fund the Veterans First Point service and explore roll-out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer-to-peer activity for veterans with mental health problems.

SUPPORT ACTIVITY

The Scottish Government's Quality Strategy aims to put NHSScotland at the forefront of world healthcare through delivery of the highest quality, person-centred, clinically effective and safe-care. This Strategy describes how we aim to take that vision forward in mental health. Our aspirations are high, but the progress we've achieved to date shows we are well placed to make further improvement. However, to deliver world-class mental health services, it is not enough just to set aspirational visions and aims. We also need to create the right conditions for change and to support services and individuals to make the specific improvements.

We set out above the seven key themes which will underpin how we deliver services. This section looks at how we will support the work of improving services.

We will:

Ensure staff have the skills to deliver effective and person-centred interventions. This work is primarily led nationally by NES and includes the current programme of work to increase the number of people trained and supervised to deliver evidence-based psychological therapies;

Ensure staff treat everyone with dignity and respect, supporting them on their unique journey to recovery. This has been a key focus of the Scottish Recovery Network and is a key aspect of an integrated approach to improvement work in mental health;

Ensure our processes are designed to deliver effective, evidence-based interventions. Current programmes designed to support this change work include the Integrated Care Pathways programme, the work currently in place across NHS Boards to align the delivery of psychological therapies against The Matrix and the work of the Scottish Patient Safety Programme in Mental Health;

Ensure our processes are designed to do the right thing reliably and efficiently. Reliably delivering interventions which reduce harm is a key aim of the Scottish Patient Safety Programme. Both the efficiency and productivity work and the systems redesign work attached to the mental health 18 weeks access targets have a focus on doing things more efficiently through reducing unwarranted variation, duplication and waste.

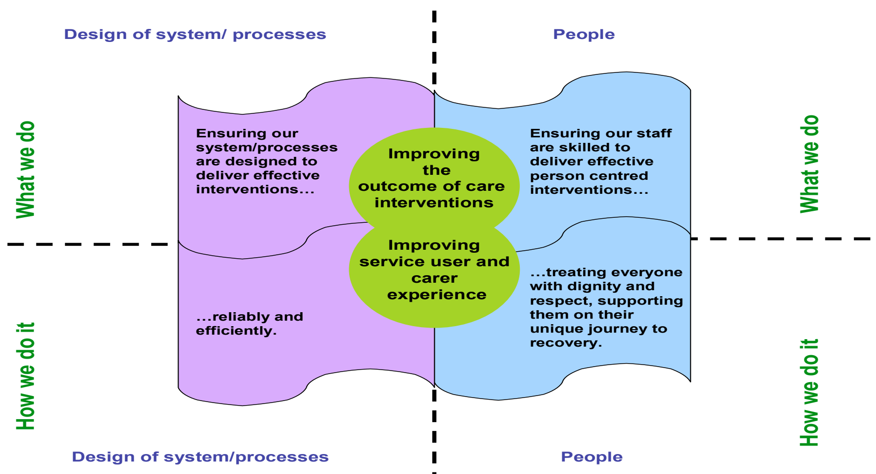
To meet the current financial challenges, whilst maintaining and improving the quality of care delivered, we need to make progress in all four domains at the same time. Just focusing on one issue will not be enough and central to this will be the work to redesign pathways of care, making sure that we reliably do the right thing at the right time in the most efficient way.

Further, underpinning all of this work needs to be a focus on information, both quantitative and qualitative. We need information to tell us how well our system currently works and where the opportunities are for improvement. We also need information to tell us whether the changes we are making are actually delivering improvements.

Finally, none of this will happen without effective leadership at all levels creating the right conditions for change and supporting services to make the specific improvements.

The following diagram shows how these link together to ultimately deliver improvements in clinical/care outcomes and improvements in the experience of individuals using our services.

The Improvement Jigsaw – an overall framework for improving the quality of mental health services in Scotland



Using information to review all of the above and
ensuring effective leadership that creates the
conditions for change and supports the work of improvement

Delivering the above is not the responsibility of just one part of the system, it will require all parts to work together in partnership to create and sustain a context that enables ongoing improvement in care to be a day-to-day reality. The Scottish Government, NHS Boards, local authorities, the third sector, academics, service users and carers all have their part to play in supporting the delivery of world-class mental health services.

Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.

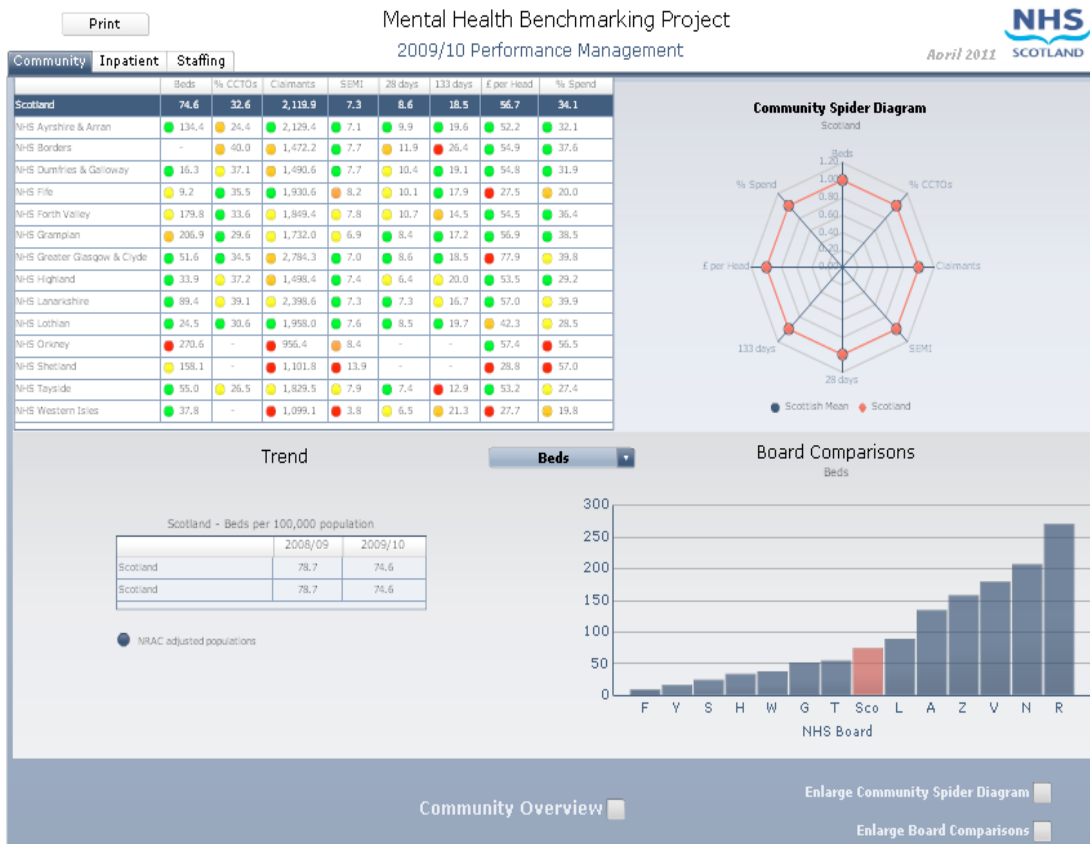
Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to co-ordinate, monitor and performance manage progress on the national commitments outlined in this Strategy. In doing this we will build on the successful experience of managing the implementation of the Dementia Strategy.

In support of this commitment we will:

- Continue to conduct twice-yearly mental health performance reviews with each NHS Board, where local progress on delivering improvements is reviewed;
- Provide ongoing support for the use of continuous quality improvement approaches across mental health services by:
  - Funding and supporting Healthcare Improvement Scotland to deliver the Scottish Patient Safety Programme for Mental Health.
  - Producing a toolkit to support services and clinical teams to diagnose and deliver productivity and quality improvements across community mental health teams.
  - Putting in place a learning support network for individuals involved in using quality improvement methods to deliver faster access to mental health services whilst maintaining or improving quality of care.
  - Ensuring clarity on how any new improvement programmes nationally interface with the existing work.

Continue to develop the Adult Mental Health Benchmarking project to provide a tool to aid in the improvement of mental health services in Scotland by using a range of comparative information to compare key aspects of performance, identify gaps, identify opportunities

for improvement and monitor progress. The Mental Health Benchmarking Toolkit has been created to facilitate this aim[104].



	Beds	% CCTOs	Claimants	SEMI	28 days	133 days	£ per Head	% Spend
Scotland	74.6	32.6	2,119.9	7.3	8.6	18.5	56.7	34.1
NHS Ayrshire & Arran	134.4	24.4	2,129.4	7.1	9.9	19.6	52.2	32.1
NHS Borders	-	40.0	1,472.2	7.7	11.9	26.4	54.9	37.6
NHS Dumfries & Galloway	16.3	37.1	1,490.6	7.7	10.4	19.1	54.8	31.9
NHS Fife	9.2	35.5	1,930.6	8.2	10.1	17.9	27.5	20.0
NHS Forth Valley	179.8	33.6	1,849.4	7.8	10.7	14.5	54.5	36.4
NHS Grampian	206.9	29.6	1,732.0	6.9	8.4	17.2	56.9	38.5
NHS Greater Glasgow & Clyde	51.6	34.5	2,784.3	7.0	8.6	18.5	77.9	39.8
NHS Highland	33.9	37.2	1,498.4	7.4	6.4	20.0	53.5	29.2
NHS Lanarkshire	89.4	39.1	2,398.6	7.3	7.3	16.7	57.0	39.9
NHS Lothian	24.5	30.6	1,958.0	7.6	8.5	19.7	42.3	28.5
NHS Orkney	270.6	-	956.4	8.4	-	-	57.4	56.5
NHS Shetland	158.1	-	1,101.8	13.9	-	-	28.8	57.0
NHS Tayside	55.0	26.5	1,829.5	7.9	7.4	12.9	53.2	27.4
NHS Western Isles	37.8	-	1,099.1	3.8	6.5	21.3	27.7	19.8

Scotland - Beds per 100,000 population

	2008/09	2009/10
Scotland	78.7	74.6
Scotland	78.7	74.6

The toolkit is structured to provide a balanced view across the Quality Strategy domains of Efficient, Effective, Person-centred, Safe, Equitable and Timely. The first release of the toolkit contains information on 19 indicators across the first five Quality Strategy domains. Future releases of the toolkit will contain additional indicators and will populate the remaining Timely domain.

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104 More information about mental health benchmarking and the mental health benchmarking toolkit is available at http://www.isdscotland.org/Health-Topics/Finance/National-Benchmarking-Project/Mental-Health.asp

SUMMARY OF COMMITMENTS	Person-centred	Safe	Effective
Commitment 1: The Scottish Government will commission a 10-year-on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014.			
Commitment 2: We will increase the involvement of families and carers in policy development and service delivery. We will discuss how best to do that with VOX and other organisations that involve and represent service users, families and carers.			
Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.			
Commitment 4: We will work with the management group of *see me,* with the Scottish Association for Mental Health, who host *see me*, and with other partners to develop the strategic direction for *see me* for the period from 2013 onwards.			
Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental healthcare in Scotland.			
Commitment 6: During the period of the Mental Health Strategy, we will develop a Scotland-wide approach to improving mental health through new technology, in collaboration with NHS 24.			
Commitment 7: In 2012 we will begin the process of a national roll-out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour. We will include more information about the delivery of this commitment in our Parenting Strategy which will be published in October 2012.			

SUMMARY OF COMMITMENTS	**Person-centred**	**Safe**	**Effective**
Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children's services workforce. We shall also improve access to child psychotherapy (a profession which specialises in parent infant therapeutic work) by investing in a new cohort of trainees to start in 2013.			■
Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.			■
Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become, or lead to, prototypes for future testing and evaluation.			■
Commitment 11: We will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets.	■	■	■
Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.	■	■	■
Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014 the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.	■	■	■
Commitment 14: We will work with NHS Boards and partners to improve monitoring information about who is accessing services, such as ethnicity, is consistently available to inform decisions about service design and to remove barriers to services.	■		■

SUMMARY OF COMMITMENTS	Person-centred	Safe	Effective
Commitment 15: We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find[63]. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.	■		■
Commitment 16: NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use Steps for Stress as an early intervention approach to address common mental health problems.	■		■
Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care.	■		■
Commitment 18: We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network.	■		■
Commitment 19: We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test this in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.	■	■	■

SUMMARY OF COMMITMENTS	**Person-centred**	**Safe**	**Effective**
Commitment 20: We will take forward the recommendations of the psychological therapies for older people report with NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population.	■		
Commitment 21: We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people's mental health as part of the work to take forward the integration process.	■		■
Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long-term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.	■		■
Commitment 23: We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHSScotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services.		■	■
Commitment 24: We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option.	■		■

SUMMARY OF COMMITMENTS	Person-centred	Safe	Effective
Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services.			
Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland.			
Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health.			
Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine.			
Commitment 29: We will promote the evidence-base for what works in employability for those with mental illness by publishing a guidance document which sets out the evidence-base, identifies practice that is already in place and working, and develops data and monitoring systems. Change will require redesign both within health systems and the wider employability system to refocus practice on more effective approaches and to realise mental healthcare savings.			

SUMMARY OF COMMITMENTS	Person-centred	Safe	Effective
Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a 'mentalisation' approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh.			
Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.			
Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.			
Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.			
Commitment 34: We will continue to fund the Veterans First Point service and explore roll out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer-to-peer activity for veterans with mental health problems.			

SUMMARY OF COMMITMENTS	Person-centred	Safe	Effective
Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.			
Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to co-ordinate, monitor and performance manage progress on the national commitments outlined in this Strategy. In doing this we will build on the successful experience of managing the implementation of the Dementia Strategy.			