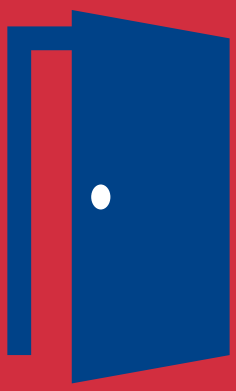

THE TRANSFORMATION OF ADULT MENTAL HEALTH CARE IN SCOTLAND:

LEARNING FROM THE PAST TO SUPPORT INTEGRATION REFORM

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6. SERVICES HAVE THE RIGHT STAFF, WITH THE RIGHT SUPPORT AND TRAINING, TO MEET IDENTIFIED NEEDS

obligations on health boards and providers to ensure that, where an order is in place for a person to be detained under the Act, care is provided in a secure setting that is appropriate for their level of need.

A NEW POLICY FRAMEWORK FOR MENTAL HEALTH

The National Programme for Improving Mental Health and Well-Being: Action Plan 2003-2006 became the foundation of the Scottish approach. It has been noted that this was the rst national programme which looked beyond service delivery to include commitments to promoting the understanding of mental health and wellbeing and its determinants among the general population.[15]

The 2006 delivery plan - Delivering for Mental Health - set the direction for mental health services, including speci c targets for improvement such as a 10% reduction of readmissions within 7 days from 2006 to 2010. This plan was refreshed in 2010.

RIGHTS, RELATIONSHIPS AND RECOVERY: THE REPORT OF THE NATIONAL REVIEW OF MENTAL HEALTH NURSING IN SCOTLAND

The rst national review of mental health nursing resulted in the 2006 report Rights, Relationships and Recovery (RRR) and a delivery action plan. The report was released during a period in which mental health was a political priority.

The actions flowing from this review embedded a values-based, service user led, whole systems and recovery-oriented approach to mental health nursing.[16]

Recovery has been a core philosophy of the service user movement since the late 1960s, and challenges the ideas of illness and wellness. Recovery is unique to the individual person and it changes over time. It involves social connectedness, hope, optimism about the future, identity, meaning in life and empowerment.[17] It rejects the idea of recovery as being symptom-free.

The 2006 review report described recovery as one of the fundamental values of mental health nursing, which would focus on ‘Promoting recovery and inspiring hope – building on people’s strengths and aspirations. Increasing capacity and capability to maximise choice.’

Nurses themselves were deeply involved in the development of RRR and their views incorporated in the actions flowing from the review. This included a particular focus on recovery, and solidi ed an understanding in Scotland of what a recovery approach means for nursing practice.

The challenges set forward in RRR were embraced by mental health nurses.

all health and social care services is still some way down the track: “What we have right now is lots of people who share buildings. But in terms of getting a shared ethos, we’re miles away from that.”

Another person noted that “Within our community services, the relationships are there, we just need to foster and develop them, make the connections where needed.”

The people RCN Scotland spoke with were in general agreement that integration represents an opportunity for mental health, however a number also raised their concern that mental health services will fall down the agenda as integration moves forward. One particular quote is indicative of a broader feeling:

“That process [of learning to work together] happened in the late 90s, but it looks like we’ll be having the same move again. In the NHS, we’re having to make cuts, we’re having to make services more discrete in what we’re doing. We have to be more creative about how we develop our services. But other folk will see that [the NHS is] still in the peak position, and they will see mental health as an area we can impact on, particularly in terms of the health care support worker level.”

The rst integrated strategic plans developed by Scotland’s 31 integration authorities provide some indication of their intention for future services. Around half of the plans do not outline speci c intentions for mental health services. A number set forward their plans for redesign or relocation of mental health wards; while only a minority have a mental health focus or look to shi services more broadly. Within that minority, most look to enhance the use of recovery approaches by their mental health services.

A recent paper from the Scottish Government’s Chief Nursing O cer Directorate and NHSScotland’s Mental Health Nurse Leads describes the new challenges for mental health nursing in the current era.[30] They note that mental health nurses are well placed within this new context ‘“to emerge as key leaders and they are equipped to rise to the challenges and harness the opportunities that integration brings for the people of Scotland’.

The paper sets forward four main priority areas for action:

1. Mental health nurse leadership, governance and

"Are we treating people with mental health issues in the same way as we're treating people with general physical health conditions? That's something that I'm acutely aware of as we go forward."

The Mental Health Foundation's recent review of mental health services in Scotland[38] makes clear the need to continue with progressing the direction of travel over the last 10 years, and further transforming services and support to better involve people in decisions about their care, and address inequality. RCN Scotland intends for this paper to be read in this context. While there are actions which

KEY ENABLERS OF TRANSFORMATIONAL CHANGE: LESSONS FROM THE EXPERIENCE OF MENTAL HEALTH NURSES

change is taking place. Success will mean a shared vision and goals for what is to be achieved through the reform.

However, change is di cult and, as noted elsewhere in this paper, there will be resistance from some sta and service users. Sta from di erent backgrounds need to nd common ground and “managers need to be strong in dealing with individual practitioners who don’t want that to

which is designed around the individual needs and prioritised actions of the person receiving care.

This was one of the most signi cant changes to take place in mental health services over the last several decades. In nursing, RRR formalised a new approach to mental health nursing, and many of the areas for action within RRR have seen improvement.

The recovery approach is radically person-centred. Embedding personal recovery into services is a shi 'to practice that is built on equal partnership, hope-promoting and facilitating self-determination' which requires 'a transformation of services, practices and the paradigm within which they are delivered.'[42]

When discussing mental health nursing a er RRR, both nurses and partner professionals felt that the change had been embedded into practice. This reflected what RCN Scotland previously heard from mental health nurses in 2010 – they too felt that it had rede ned mental health nursing and supported better, more person centred approaches.[43] They also felt that the review raised the pro le of mental health nursing and helped nurses to aspire to excellence and put patients at the centre of care.

A psychiatrist noted that "At the core of [recovery] is having shared goals and shared views, and I think nursing has always been good at that… It's about culture and putting goals into action".

Nurses discussed the importance of developing shared aspirations together with people, and the right of people to be fully involved in decisions about their care. Some felt there is still more to be done in embedding recovery into how all sta approach and think about an individual's care and support.

Every person's recovery is di erent and the services required to support this recovery will look di erent across time. As a member of a crisis team noted, "we have a short period of time with a person; how do we get to the point… where they're comfortable and you're comfortable that they don't need you anymore?"

Moving services towards a person-centred, recovery focus is an ongoing process, and change

"I think there's a long way to go… in terms of empowering the patient and the carer," felt one person, suggesting one reason for that is: "I think professionals like me are very good at hiding behind our professional identity."

Enabling people to get involved at a strategic level

It is also crucial that service users are involved as collaborators in design and planning, to ensure services meet their needs.

The reform and implementation of change in mental health services included the active involvement of service users. In recognition of the need to embed person-centeredness into mental idgo48-45.mn (ve)5i ve-03 (h)3-1.4eidgve-03 (h (m)7.4 (41238 TD3h(l)39s))-9.1 v5eidgo46-03 (i)8 6m(

of integrated health and social care. To work in practice this will require team cohesion, forged through the negotiation of relationships and traditional cultural boundaries between professions and services.

The integration of teams of di erent nursing roles and other health and care sta requires everyone to better understand each other's roles and where these cross over. In mental health, team working is now seen as essential to provide the right care for people: "It's the foundation of what we do," noted one psychiatrist, because the long-term nature of many people's mental health conditions means that, having a team that works together, helps with continuity for "trust and recovery. It o en takes time."

Nurses and other health professionals reported good working relationships between members of the multidisciplinary mental health team, including psychiatry and other nursing roles. However, it did take time for this transition to take place and there was some reluctance from sta .

For example, in one area when the clinical expertise in the old mental health hospital was moved across to the district general hospital and integrated with other services, "nobody thought it would work… that it would be total chaos." However, when the end result was improved patient care, sta changed their minds.

Addressing professional silos and tribalism upfront is important. Most people noted that boundaries are particularly noticeable when sta rst begin working in integrated teams – "there is a vying for position and a vying for a role", and that this can be a barrier to e ective integrated working.

where changes to services mean sta move from an acute setting out into the community, there's a need for service managers to be aware that there will be some resistance to be addressed: "How do we support people when the boundaries are crossed? We have to be really conscious of professional boundaries".

Multidisciplinary teams need to be designed to be supportive and closely connected. Professionals working in the community – and particularly lone workers – need to be linked into a broader team to share good practice and seek advice and support. Regular team huddles or similar initiatives can strengthen this working relationship.

A theme in many people's comments was how risk shapes professionals' decisions about a person's care. People receiving care in the community will for the most part be self-managing their health conditions and health and social care professionals should be working collaboratively with the person to assess risk, understand it and support safe, positive risk-taking. 'Promoting safety and risk enablement' is one of the 10 ESCs which have become embedded in mental health practice.

Community psychiatric nurses (CPNs) need to be able to make di cult decisions which allow the person they are working with to stay home and recover, but a number of the people RCN Scotland spoke with noted that it can be challenging to make that decision when there is the risk that something can go wrong, and where the expectation of families, media and others is that admission to hospital would be the safest and best option.

People talked about how to enable positive risk through shared decision making with the person they are working with. "I think there's an art in positive risk taking, which is developed over a number of years by a crisis practitioner", one noted.

Managing risk was described by several people in terms of process. At an individual level, this includes agreeing and documenting decision-making in partnership with the person and their carer. At a strategic level, those leading services need to ensure that sta working in the community are enabled to take risks. This included developing a supportive infrastructure around sta in the community, including ongoing clinical supervision as well as opportunities to share and reflect on practice with other professionals.

Potentially, community health services can

CPNs today require a wide range of skills and

Developing knowledge about mental health conditions was seen as a priority for older adult and other settings. One nurse described how issues with communication and understanding can arise where sta (both nursing and other sta) have poor knowledge of mental health conditions. Another noted "I'm not a cardiac nurse but I can recognise the signs of a heart attack – it should be the same with mental health problems in general wards".

There are past instances of Scotland's NHS rolling out a programme of training which supports other sta to better understand mental health problems. Training in suicide prevention for primary care and A&E sta was a commitment within Delivering Mental Health and has supported sta with the skills and competencies to assess and respond to the needs of people at high risk of suicide. For example, by understanding the level to which the person has made a plan, and any preparations they might have made, a nurse in A&E will be able to set out the best course of action.

Current sta ng challenges

At a 2015 mental health summit, participants discussed the sta ng issues which are being felt at every level of the mental health system. They felt that the prioritisation of acute services means early intervention is being unmet. Participants described how integration could improve connections between community services and primary care for mental health service users and "create a common vision based on a common set of principles. It can also be an opportunity to enable di erent parts of the system such as social care, community mental health teams, and primary care to provide the necessary services to people and ensure that care is inclusive". [50]

People who RCN Scotland spoke with also raised the current sta ng di culties faced by mental health services. There was a very strong sense that people working in services – whether NHS, local authority or the third sector – are very stretched.

Reasons for this include insu cient increases in NHS sta ng, reduced funding, di culty in recruiting, and an aging workforce. Mass retirement of experienced nurses will particularly increase issues around supervision and support of newer nursing sta . As one person noted: "the generation that's coming in behind us: who's going to train them? Who's going to support them? How do we retain that aging mental health nursing workforce?"

Leaders in health and social care services will need to consider how to further develop mental health nursing as an attractive career option as well as providing training and succession planning.

It was noted that, where services are short sta ed, what is postponed is the routine preventative care for people who are not in an acute state. For example, in one area it was reported that the CPNs are now unable to provide their regular scheduled visits to local care homes due to sta ng shortages. It was also reported as not uncommon that a person with dementia is admitted to hospital because the social care package or respite they require is not available.

A number of people described new initiatives which were planned and implemented without the associated extra capacity required to deliver them. "We've taken on the work, but not the sta ", said one nurse.

7. INTEGRATED CARE PATHWAYS ENABLE PEOPLE TO ACCESS THE LEVEL OF SUPPORT THEY REQUIRE

The implementation of reform of Scotland's mental health care services shows us that joined-up thinking is required to make care pathways smooth, logical and safe. As broader health and social care services make this transition, planners need to ensure that services are designed and connected, to enable people to access the care and support they need – including hospital care.

It is important to ensure that new models work for the people accessing them. The Scottish Government is currently funding a range of tests of change across

inpatient facilities to ensure the protection and promotion of people's rights; the reported outcomes are broadly positive, and reflect the work of hospital sta to provide care which is appropriate, safe and in line with best practice.[53]

A number of people felt that the biggest change in practice for them during the closure of the large mental health institutions was a shi from an "admit to assess" approach to "assess to admit", meaning that the default location of care is in the community, and admission used only where alternatives are not available or appropriate.

Inpatient services must be available where and when people need it. As one person noted, currently a person can still "come in on an informal basis for treatment and assessment… you don't want to get to the point where you need to be detained to get a bed in a hospital."

As most people now access services in the community, the people requiring inpatient care are likely to have very complex mental health and social needs. Hospital bed numbers are "dwindling and dwindling and access to those beds is becoming a bit more acute in that you need to be acutely ill to get into a bed". It was noted that a large proportion of inpatients in mental health hospitals are now o en young adults in crisis and/or with substance misuse problems, as older people increasingly receive care in other settings.

Several nurses reported their concern that there are o en still barriers to accessing appropriate community-based care for people living with very severe and enduring mental health problems – particularly where their condition is exacerbated by inequalities, and for people in rural and remote areas. Some who work in inpatient settings described di culties in accessing and referring people to the specialist community services that can meet their immediate and long term needs. This can sometimes result in the nurse being unable to discharge the person in their care. One nurse gave the example of people with personality disorders who require specialised packages which are o en unavailable or di cult to access.

Recognising the contribution of the third sector

Several people emphasised the importance of including the third sector in providing support, care and resources for recovery. Excellent local relationships between multidisciplinary community mental health teams and third sector services were reported and it was noted that mental health nursing has a real strength in connecting and networking with the third sector, both formally at a service level and through informal connections between teams and individuals.

When discussing the need to develop community capacity, a number of people noted that it has been the third sector, in many cases, that has stepped into this gap in the market to provide the needed support for many people who had previously been hospital inpatients, including housing associations, day services and advocacy.

A number of people were concerned that, particularly with reduced local authority budgets, the third sector is struggling to meet demand. Some noted their concern that the voice of the third sector has not been heard in the local integration of health and social care, and that this will have an impact on continuity of care and planning.

8. THERE ARE SERVICES AVAILABLE FOR PEOPLE NEEDING CARE IN THE COMMUNITY IN TIMES OF CRISIS

As mental health services were moved to the community, an emerging problem was the gap between acute and community services, which could make it di cult for people to access the specialist support they needed when they experienced a sudden change in the severity of their condition. In Scotland and elsewhere, unscheduled care and crisis teams were formed to help bridge this gap.

An e ective community based health system will provide pathways back into acute care as well as access to higher-level care in the community. People noted that joined-up thinking is a necessity in order to develop well clari ed pathways for people in crisis to get help.

Well integrated crisis and unscheduled care teams were highlighted by a number of people as a success story of the current mental health approach in Scotland, which emerged in the move of services to the community. As one nurse noted, "The aim of the crisis service was to give people choice, which they never had before – you were either a community patient in a community mental health team or an inpatient, there was nothing in between".

In particular, a number of people discussed how the development of crisis or unscheduled care teams alongside the community mental

CONCLUSION

RCN Scotland believes that there are lessons to be learned for the people leading newly integrated health and social care services from the experience of people working in adult mental health services in Scotland. The strongest messages that RCN Scotland has heard from members and others are about prioritising relationships and people.

As one nurse said, “It’s always about teamwork,

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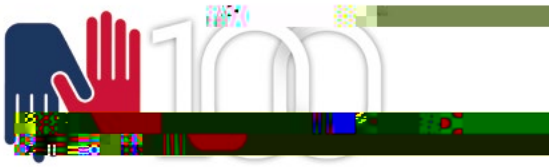

Royal College of Nursing

Scotland

42 SOUTH OSWALD ROAD,
EDINBURGH, EH9 2HH

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