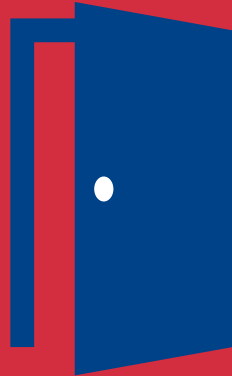# THE TRANSFORMATION OF ADULT MENTAL HEALTH CARE IN SCOTLAND:

LEARNING FROM THE PAST TO SUPPORT INTEGRATION REFORM

ACKNOWLEDGEMENTS

FOREWORD

Mental health services in Scotland have undergone radical change over the last three decades, with a shift from long-term care provided in large institutions, to care delivered mostly in the community by multidisciplinary teams.

Transformation of mental health care did not follow a simple pathway of progression – it wasn't easy, consistent or linear.[1] It did, however, develop in two broad stages: the extensive closure of large psychiatric institutions in the 1980s, and the strengthening of a rights and recovery approach since 2000.

This fundamental, yet protracted, change may sound familiar to those who are involved the transformational changes underway in Scotland today in how health services are designed, delivered and measured. As integration and other reform processes gather speed, there are lessons to be learned from the experience of Scotland's changing approach to mental health care over recent decades.

To explore those lessons, RCN Scotland has undertaken a detailed policy analysis and a review of literature on the reform of Scotland's adult mental health system. It has spoken with practitioners to explore their lived experience of the change and their voices are shared throughout this paper.

This paper is designed to help decision makers as they plan for mental health and other services in an integrated future. The lessons for enabling change, which it lays out, will not be new or surprising to many. However, in the midst of change, it is often easy to lose sight of what is already working well, and the enablers are a reminder of what needs to take place, from the perspective of people who have experienced a period of significant change first-hand.

The transformational change which is explored in this paper has taken decades, and there are still challenges for the mental health care sector. However, we now broadly see a system where community-based care is the default or preferred option, and in which a legal and policy framework supports care on the basis of what best meets the preferences, needs and situation of the person receiving care.

RCN Scotland hopes that this paper will spark thought and conversation on what needs to be in place to make transformational change a reality for Scotland's newly integrated health and social care services.

Theresa Fyffe
Director, RCN Scotland

EXECUTIVE SUMMARY

With a strong drive in Scotland towards person-centred, integrated health and social care in the community, RCN Scotland believes there are lessons to be learned from the past experience of transformational change in mental health services.

Adult mental health nurses were central to this transition in mental health care and, in the development of this paper, RCN Scotland undertook one-to-one interviews with nurses and other partner professionals, and reviewed literature on the reform of Scotland's mental health system.

Through these conversations, RCN Scotland identified some key enablers of transformational change for those planning and leading integrated services, learning from the experience of mental health nursing.

These enablers are an important reminder of the immense effort required – particularly at a local level – to embed the transformational change which comes as a result of national reform.

1. CHANGE IS WELL LED, MANAGED AND FUNDED

Change takes time, and those responsible for leading services in a period of change need to make sure that their vision for the future is shared. It was clear to the people RCN Scotland spoke with that reform works best where leaders work collaboratively with people who are providing services on the ground. People also felt that investing additional resource during the period of transition supports better implementation of change and ensures that high quality, safe care continues to be delivered by a skilled workforce.

2. HEALTH AND WELLBEING ARE DEFINED BY THE INDIVIDUAL

Each person who uses health and social care services is unique and should be able to determine their own goals and outcomes for health and wellbeing. The role of services should be to enable the person to have real choices, make informed decisions, set and achieve goals, and live what they define as a meaningful life.

A radical shift to rights-based, person-centred care has transformed mental health services in Scotland. The move towards a recovery approach in mental health practice can offer important lessons in how to bring about cultural change within wider integrated services over the coming years.

3. PEOPLE USING SERVICES ARE INVOLVED BOTH IN DECISION-MAKING ABOUT THEIR CARE AND AT A STRATEGIC LEVEL

The personal health and life outcomes the person receiving care has prioritised should inform how care is planned and provided. At a strategic level too, the voices, needs and experiences of people that are using services, and their families and carers, must be heard. Those leading newly-integrated services must work with people using services to develop services and support that work for them – across the NHS, local authority, third and independent sectors.

4. REAL RELATIONSHIPS ARE DEVELOPED AS THE FOUNDATION OF EFFECTIVE TEAMWORK

To develop strong multidisciplinary and multi-agency teams, leaders need to address tensions between staff and avoid silo thinking while supporting role identity. The key to this is keeping the person receiving care at the centre of all care planning and provision.

5. AN ENVIRONMENT IS CREATED WHICH ENABLES PEOPLE TO TAKE RISKS PROACTIVELY

Those leading services need to ensure that community-based health and social care staff have the skills and are confident to work collaboratively with service users to support safe, positive risk taking. Leaders need to model this in their own decision-making. Supporting positive risk taking will include ensuring that professionals have ongoing clinical supervision and opportunities to share and reflect on practice.

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

Moving services from hospital to community care requires extensive workforce preparation, including education, team support, supervision and ongoing learning. Leaders should identify and invest in their workforce according to identified need. Occupational development and human resources departments are crucially important for getting this right.

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

The result of reform should be a more seamless and effective care experience for service users, which enables them to access appropriate levels of care by using existing, and developing new, services and models of care. Those planning services should ensure that all parts of the system – including acute and non-statutory services – are incorporated in this new vision. In mental health, there is now a presumption that wherever possible, care will be delivered in the community. For example, there has been a shift from an "admit to assess" approach to "assess to admit", shifting the place of decision making away from hospital.

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

People who are living at home or in a homely environment need to be able to access a higher level of care when they need it. When unscheduled care needs arise, teams of highly-skilled staff in the community can provide short-term interventions and more person-centred rapid response, which can prevent unnecessary hospitalisation. These models should be designed to a nationally-agreed standard, but on the basis of local population need.

A HISTORY OF MENTAL HEALTH SERVICE TRANSFORMATION IN SCOTLAND

Before diving into the lessons learned from the experience in mental health services, there is value in understanding the changes that have been undertaken at a strategic and service level over the last thirty years. Key drivers contributing to the success of mental health reform in Scotland included 'increasing optimism about the ability to treat, rather than contain, people with acute and chronic mental health conditions, coupled with a belief that long-term institutional care had detrimental effects.'[2]

From the second half of the 20th Century, the mental health care landscape shifted slowly but surely towards health care delivered in the community. From the 1980s, mental health bed numbers dropped dramatically. Between 1983/84 and 2013/14, the number of people who were resident in mental health inpatient facilities fell by about a third.[3, 4]

Throughout the 1990s, calls for change in Scotland's policy direction for mental health were increasing from professionals, notably nurses, and from a growing service user movement.[5] Criticism of the lack of formal mental health policy in Scotland by the Scottish Grand Committee instigated the Westminster Government to develop and publish a Framework for Mental Health Services in Scotland in 1997.[6] For the most part, this strategic framework simply consolidated the existing approach in Scotland.

MILLAN COMMITTEE REVIEW

In the first decade of the 21st century mental health policy and legislative frameworks for mental health were transformed in Scotland. Devolution acted as a catalyst for change in mental health policy, and change was aided by other factors including a burgeoning service user activist movement, public impetus and good will for change. At the same time, publication of statistics showing Scotland's high suicide rate highlighted poor mental health in the country, sparking media attention, public outcry, and a sense of urgency. [7]

Open dialogue between the Scottish Government, service users and those working in the mental health system ensured the relevant people were 'on board' with reforms.[8] It also provided an opportunity for the new parliament to demonstrate their commitment to public participation and was a motivation for change.[9]

The 2001 Millan Committee review on reform of Scottish mental health legislation set out new directions for mental health in Scotland, going beyond its initial remit as a law review. The Committee emphasised the need for more community based services, and respect for human rights in mental health, including improving service user and carer involvement in decision making. 'This approach gained significant support across all interest groups and was the foundation for an ongoing consensus about mental health priorities and objectives.'[10]

Key mental health policy and legislation changes following the review created the structure for a new Scottish mental health system and recent evidence shows continuing broad support for the strategic national approach taken.[11]

A NEW MENTAL HEALTH ACT

Many of the mental health nurses RCN Scotland spoke with felt that the contextual change which had the biggest impact on their career was the 2003 Mental Health (Care and Treatment) (Scotland) Act and other legislation developed in response to the Millan review.

Before this time, the main piece of legislation relating to mental health was the 1984 Mental Health (Scotland) Act, a consolidating Act which re-enacted its 1960 predecessor and amendments. The 2003 Act differed in that it laid down a set of guiding principles, to 'set the tone of the Act and guide its interpretation'.[12] These principles emphasise the need for community based care with a focus on service users' rights and service user involvement, and the Act has been described as broadly progressive.[13]

A recent review found that the Act has been successful in meeting some early expectations in advancing the rights of service users, has stimulated innovation and supported greater user involvement and representation.[14] The review noted that the promotion of advance statements is an area where work is still needed.

One nurse particularly noted the impact of the principle of reciprocity within the Act, which put

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 first 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 specific 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 first 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 solidified 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.[18] Nurses RCN Scotland has spoken with, who were working in the system at the time of RRR, reported that while this wasn't a new approach, it did embed rights and recovery approaches into ways of working.

By the time the strategy was refreshed in 2010, actions which had been completed included the development of a national framework for training in recovery-based practice, as well as a number of national frameworks and development activities.

Any transformation of services will take time to become embedded into practice, and many of the comments nurses and others have shared with RCN Scotland today are echoes of those raised by participants in an RCN Scotland mental health nursing event held in 2010.[19] Shared themes across the 2010 and 2016 conversations include: building on the successes of RRR; supporting multidisciplinary working by addressing tribalism across health and social care disciplines and providing opportunities for learning exchange; and ensuring mental health nursing has a voice in wider reform processes.

SPECIALIST MENTAL HEALTH SERVICES IN SCOTLAND TODAY

The mental health care system in Scotland has received positive international attention. In a general sense, it is characterised by high levels of agreement about the path the Government should be taking with respect to mental health.[20] It has been noted that, in comparison to other countries, 'the mental health system is more consultative, more involving of consumers, less hierarchical and more open to new ideas.'[21]

Multidisciplinary team working has become the norm in mental health care in Scotland, and community mental health teams are usually made up of community mental health nurses, alongside different professionals such as psychiatrists, clinical psychologists, allied health professionals, pharmacists and social workers. There is agreement

among mental health professionals that people's care is best coordinated and provided by a multi-professional team.

Where a person's mental health condition is acute or long term and they require support beyond that provided by generalist services and primary care, they are supported by specialist community teams in their home; access specialist hospital units for acute admissions; or receive long-term care in small residential units.

As noted in our 2014 Frontline First report, however, 'Though the reduction in mental health inpatient beds and admissions suggests that more people are being treated at home, we have not seen the concerted shift in resources and investment in the community workforce needed to underpin this.'[22] As of 2015, only a third of total NHS spend for general psychiatric services was on community based services.[23]

There has also been a continued underinvestment in the mental health workforce in comparison to other areas of health care. RCN Scotland members are feeling the squeeze of staffing shortages, as mental health nursing numbers have not grown at the same rate as the wider nursing workforce.

Nursing numbers in Scotland declined to a low in 2012 and are only just recovering now.[24] However, while Scotland has 4.3% more nursing staff in post now than when nursing numbers were at their lowest, there are only 1.7% more adult mental health nursing staff.[25]

The aging nursing population will increasingly become a problem for mental health services, and a looming mass retirement of experienced nurses will particularly increase issues around clinical supervision and support of newer nursing staff.

MENTAL HEALTH CARE WITHIN OTHER HEALTH SERVICES

While this paper focuses specifically on nursing in specialist mental health services, for most people general practice is the contact point and point of referral for initial access to mental health services. Primary care staff also provide mental health care and support, and indeed consultations for mild to moderate mental health problems account for a third of GPs' time.[26]

Treatment for mental health conditions within general hospitals has become more common over the last 15 years, while in the same period treatment in specialist mental health units has fallen.

39% of people with a main diagnosis of a mental or behavioural disorder who have been admitted to hospital in the last five years will have received treatment solely within a non-psychiatric specialty, while another 8% will have received both psychiatric and other treatment.[27]

NHS Scotland's Information Services Division notes that while at first glance this increase in care in general hospital settings might imply that care has simply been shifted across from mental health facilities, more detailed analysis tells a different story. The increase is due to changing demographics in Scotland, in particular the country's aging population. People treated for a mental health condition in a general hospital are more likely to be older. The two most common main diagnoses for treatment in general hospitals are 'mental disorders due to substance abuse' and 'organic mental disorders' (for example, dementia or delirium).[28]

INTEGRATION OF HEALTH AND SOCIAL CARE

In health and social care, there has been a slow but progressive shift in the way services are designed, delivered and measured. This change has been away from traditional concepts of care delivery to people, and a strengthening of rights based approaches in which care is planned and provided in partnership with people.

Involving people in decisions about their own health care and support, and basing those decisions on personal outcome preferences, is key to this, as is delivering care at home or as close as possible to home. The integration of health and social care in Scotland has been designed to move services further towards person centred decision making.

The Health Foundation notes that making person-centred care 'business as usual' requires 'fundamental changes to how services are delivered and to roles – not only those of health care professionals, but of patients too – and the relationships between patients, health care professionals and teams…. It requires effort, but it certainly is possible.'[29]

To implement the transformational change which will come as a result of the integration of health and social care, those planning and leading services will need to enable staff ownership of and involvement in making change happen.

The mental health practitioners that RCN Scotland has spoken with feel that true integration across

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 first 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 specific 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 shift 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 Officer 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 professional regulation within Health and Social Care Partnerships
2. Contributing to the nine Health and Social Care Outcomes with a particular emphasis on reducing health inequalities
3. Delivering pre and post registration Mental Health Nursing education and training in a new context of Health and Social Care Partnerships
4. Championing and assuring the delivery of evidenced based, excellent mental health nursing care in Scotland.

There are several Government work streams underway at present that will influence the future shape of adult mental health services. A new 10-year mental health strategy is due in late 2016 and priorities in the draft strategy include a focus on prevention and early intervention, parity between mental and physical health services and realising the rights of people with mental health problems. A Community Mental Health Nursing Career Development Framework is also due to be published soon, which will describe the role of mental health nurses within integrated community services.[31]

CHALLENGES FOR THE FUTURE

The most recent national report on the mental health of adults in Scotland found that 'modest progress is being made in terms of improving mental health and the conditions that underpin or undermine it'.[32] However, addressing the root cause of poor mental health remains a challenge for Scotland and there continues to be inequalities in mental health outcomes by age, gender, and deprivation.[33]

People whose lives are affected by social inequality are more likely to have poor mental health and to use mental health services.[34] The gap in mental wellbeing between the most and least deprived areas in Scotland has widened since 2008/09.[35]

Living with a severe and enduring mental health condition is itself a factor of inequality; the mortality rate for people who are in contact with mental health services in Scotland is three times higher than for the rest of the population.[36] Scottish Association for Mental Health (SAMH) report that this is often due to inaccessible, poor quality treatment.[37]

Both mental health and mental health services have improved in Scotland, but there is still much more to do to achieve parity of esteem with physical health, and to ensure people with mental health problems can access the services they need. A number of mental health nurses RCN Scotland spoke with were concerned, as one person said,

"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 can be taken to enhance mental health services and ensure they are central to the development of integrated services in the future, there are also learnings we can take from the past and present experience in mental health which can improve reform of services more broadly.

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

1. CHANGE IS WELL LED, MANAGED AND FUNDED

Scotland's nursing staff understood and bought into the mental health reform policy drivers and felt on board for the journey. The successful RRR nursing strategy was developed and implemented, for example, in partnership with nursing staff on the ground. The end result was that new ways of working are now business as usual.

This was echoed by the findings of the Kings Fund, who reported that 'High-quality, stable leadership is needed to manage change, handle unexpected demands and results, and ensure vertical integration of expertise, both within the organisation and among voluntary and independent providers.'[39]

Leaders in health and social care services need to trust that people providing services know how to improve care, and should work jointly with care staff to make those improvements. The people RCN Scotland spoke with talked about the need for leaders to have a conversation with staff and make what one person described as "a psychologically safe environment to sit down and talk" about how change is progressing.

Several people felt that resourcing of change management can be the critical factor in whether reform works or not. A robust change management approach, with staff engagement, helps staff to move in step with the reform.

Effective change management also means ensuring that, regardless of what decisions are made, people can still get the services they need. This is a significant factor behind professional resistance to change. People felt that safety, for a particularly vulnerable client group, must be above all other considerations: "We need to make sure our patients are safe" and have timely access to adequate numbers of "consultants and nurses and occupational therapists that can benefit" them.

Beyond this, strong and autonomous professional leadership was generally seen as one of the most important enabling factors for change. Leaders and managers should work with staff to ensure that they are on board, address concerns and make clear why change is taking place. Success will mean a shared vision and goals for what is to be achieved through the reform.

However, change is difficult and, as noted elsewhere in this paper, there will be resistance from some staff and service users. Staff from different backgrounds need to find common ground and "managers need to be strong in dealing with individual practitioners who don't want that to happen." Those who are leading change have a responsibility to understand the underlying reasons for this resistance, and to manage this.

People felt that delivering on the vision of integration will take more funding than has been made available so far. As the transformation of mental health progressed, there was investment in the process of change. In many areas, the deinstitutionalisation of mental health services was underpinned by additional pump-priming investment which allowed new models to be up and running before the institutions were closed.[40]

A number of people noted that, while moving care into the community is worthwhile, it should be undertaken in order to deliver better and more person-centred care, not to save money. Indeed, when care moves from acute to community settings, costs are not necessarily reduced. In the transition of mental health services to the community in England, 'Although the initial investment was quite considerable, and although the costs of community settings are usually lower, in the long run improvements of quality usually drain those costs quite considerably.'[41]

This was supported by some nurses RCN Scotland spoke with, who provided examples where providing quality care in a community setting has proven more expensive than the equivalent care in a hospital, particularly where the person has challenging behaviour.

2. HEALTH AND WELLBEING ARE DEFINED BY THE INDIVIDUAL

To deliver on the vision of integration, Scotland's health services must, in the future, deliver care

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

This was one of the most significant 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 shift '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 after 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 redefined mental health nursing and supported better, more person centred approaches.[43] They also felt that the review raised the profile 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 staff approach and think about an individual's care and support.

Every person's recovery is different and the services required to support this recovery will look different 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 continues today. One person highlighted current work in their area to move away from services defined by age to those defined by the skill set and experience required to care for an individual. For example, while older people's mental health teams are experienced and skilled in dementia care, a person over the age of 65 with a diagnosis of schizophrenia requires care which is specific to their condition and needs, and may be more effectively provided by the community mental health team.

3. PEOPLE USING SERVICES ARE INVOLVED BOTH IN DECISION MAKING ABOUT THEIR CARE AND AT A STRATEGIC LEVEL

Relationships and collaborative working

Designing and delivering care around the needs and preferences of people accessing services has been, and continues to be a focus of mental health services in Scotland. Many nurses talked about the importance of working collaboratively with people with severe and enduring mental health problems, and building a positive relationship.

This is particularly important in a community setting, where professionals must engage in a respectful and positive way and work in partnership with the service user, "because if you don't do that the patient doesn't open the door. They have a choice, they don't have to open the door." This is significantly different from the past, when patients had less choice and were less involved in their care planning, with care being 'done to' rather than with a person.

Working in partnership with people means nurses and other professionals need to really understand their individual life and life assets; to think about "what pre-existing skills [does the person] have? Why are they not using them? What's going on in their life around them?"

Many nurses described their relationship with service users as what keeps them in mental health nursing. In several comments there was a theme of travelling together: "The joy of mental health nursing is that you take a journey with your patient" one person felt, while another noted that "it's a two way street" – relationships are the key and "you have to give a bit of yourself".

However, several people felt that while there has been excellent progress in developing relationships and recovery approaches, there is still further to go in ensuring services safeguard and support service users' rights. Health services in Scotland have made moves to better embed patient rights into how services are provided, including through the rights and responsibilities of service users described in the NHS Scotland Charter of Patient Rights and Responsibilities[44] and use of the Scottish Human Rights Commission's PANEL approach (participation, accountability, non-discrimination and equality, empowerment and legality).[45]

Many nurses felt there is work still to do.

"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 health practice, NHS Education for Scotland developed the 10 essential shared capabilities supporting person centred approaches (10 ESCs) collaboratively with people who used mental health services. This resource supports health professional's learning and development in person centred, rights and values based approaches to working with people.[46]

Training and learning on the 10 ESCs was delivered to mental health nurses as a result of RRR and evaluation has shown that this values-based approach has had a positive impact on relationships between staff, patients and carers.[47]

Alongside this, there was a strong sense from the people RCN Scotland spoke with that, while there has been a strategic focus on carer involvement and some improvement at a service level, there is a need for a continued focus on this and for people delivering care to continue challenging themselves. An example of this is when the carer's loved one is an older person with challenging behaviour; one nurse asked: "How dare we presume that we know better" about what is best for a person, than their long term spouse?

There has been an improvement in how staff think about service user involvement, but embedding this into practice requires constant work and reflection. Several people discussed their own ongoing efforts at a strategic level to improve shared care planning, for example to replace traditional management plans that "tell patients what they can't do... I'm doing a piece of work at the moment looking at – how do we get patients involved in writing their own care plan? How do we get them to agree to that care plan and actually own it? And how do we then share it with other agencies and people they come in contact with?"

There was a feeling from some people that despite its aims, a person-centred approach appears to be lacking from the integration process now underway. One reason for this barrier that was highlighted by several people was a lack of continuity of planning and information sharing across NHS, third sector and local authority services.

Building community with people living with severe and enduring conditions

Nurses that RCN Scotland spoke with talked about the challenge of helping people who had lived in hospital for a long time to develop new community connections. A number of people noted that, while the move of services to the community was positive, for many former inpatients it was also a loss of community and home, and often in the initial stages led to marginalisation and isolation. As one person noted, in many cases people "had been in hospital for 20, 30, 40 years and all of a sudden were being asked to move into the community where they weren't near family, or maybe didn't have any family".

In this context, mental health and care and other community services had to help develop new forms of community. Sometimes these new ideas came from reflection on what has worked in the past.

For example, one nurse described a strong sense of loss that was felt by former residents at the closure of their large, institutional mental health hospital. While the closure was a positive change, "people aren't objective when they know what worked for them in the past... They lamented the loss of the hospital because it was their community and home." In recognition of that fact, the mental health team secured land from the local authority to develop a garden to grow and sell produce, replicating the old gardens of the mental health hospital, which was self-sufficient and fed by its gardens. The new garden, like the old, created a sense of belonging: it "reinvented something people missed, in a new way."

4. REAL RELATIONSHIPS ARE DEVELOPED AS THE FOUNDATION OF EFFECTIVE TEAMWORK

Addressing professional boundaries

Multidisciplinary and multi-agency working to provide care in the community is an aspiration

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 different nursing roles and other health and care staff 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 often 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 staff.

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, staff changed their minds.

Addressing professional silos and tribalism upfront is important. Most people noted that boundaries are particularly noticeable when staff first 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 effective integrated working.

Joint working across health and social care

The relationship between mental health nursing in the community and social care was seen by people as very positive. This, however, took time and concerted relationship building, led by senior management.

Several people described a profound cultural difference between local authority and NHS services at all levels, including in how decisions are made by management. For example, one person noted that while the partnership model in the NHS means staff are involved in decision-making, in social care this is often not the case. They questioned how this might play out in integrated settings.

They also spoke about the different pressures faced by health and social care and how this can

lead to friction between staff in different services. The resolution to this was seen in the balance of role definition, areas of expertise, and relational working. "For example, if we were in an integrated team and we have our social care colleagues there, at a certain level we'll think 'Well, what part of your job can I do? In what part of the job is there overlap that we can actually share?'" There is a need for all members of the multi-professional team to understand and respect the unique contribution of professional skills that each brings.

In general, it was felt that in comparison to other services, mental health is much further along the journey of multidisciplinary working: "I know we are moving into integration now, but a lot of areas of work have had integrated pathways for a long, long time in mental health".

There was a sense from some that mental health staff could be champions of integration. "I think mental health is quite good at working collaboratively, but we have a lot of hearts and minds to win over with our acute [general] colleagues", one person said.

5. CREATING AN ENVIRONMENT WHICH ENABLES PEOPLE TO PROACTIVELY TAKE RISKS

Supporting lone workers and enabling risk taking

Moving care to community settings means employers need to develop appropriate supervision and support for lone workers who are likely to be providing care for people with complex health and support needs.

A problem experienced by the mental health nursing cohort in the transition from acute to community was the lack of experience of lone working of many nurses, who had previously been in team environments on hospital wards. Some struggled with this new working context and needed extra support, supervision and development to enable them have the skills and confidence to work effectively on their own. This included the formal structure and team support of a lone worker scheme.

For example, one person described her own experience in the transition, noting that as a nurse "I liked the security of the hospital setting". Her personal lesson from the experience was that,

where changes to services mean staff 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 difficult 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 staff working in the community are enabled to take risks. This included developing a supportive infrastructure around staff 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 inadvertently replicate institutional settings[48] by keeping people within their books while they are in a period of recovery. Positive risk taking includes

being aspirational about the care being provided, and seeing discharge as the endpoint from the moment a person is referred.

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

The delivery of community mental health services has required the development of new roles as well as upskilling of the existing workforce. Developing the workforce of the future within integrated health and social care services means having the right people with the right education working in the right model, and "this is going to take time". Those leading reform need to recognise that change is difficult and that people will respond in different ways.[49]

Support from occupational development and human resources is crucially important for ensuring that the workforce is prepared, the transition is smooth and risks are managed.

Where staff take on roles in new or changed services, there is a need for intensive clinical supervision and support to ensure they have the skills, training and access to the broader network they need to do their job well. This becomes particularly critical where staff move from a ward-based environment to lone working in the community. Those planning services need to consider how clinical supervision will be provided, and what investment is required.

People felt that where planning for reform included an investment in additional staffing, processes and new models of care developed more effectively.

Developing all of this is likely to require pump priming of funds to avoid a shortage of appropriate staff over the period of change.

Developing new skills and areas of expertise

It was felt that CPN roles have become increasingly more attractive as they have developed. "It's very interesting because when I came into psychiatry, hospital nursing was seen as the thing to do," one noted, "...and I think there was a huge swing to the community. Certainly I've worked with a lot of nurses over the years whose main aspiration was to get out of hospital and go out into the community".

CPNs today require a wide range of skills and competencies to provide specific interventions, assessment, medication management, caseload management, and to work effectively with a multidisciplinary and multi-agency team. Several people noted that developing this workforce has required huge investment in continuing professional development, supervision and also in time for staff to practice new skills.

It was noted that as there is not a Specialist Practice Qualification to become a CPN – as there is for Health Visitors and District Nurses – it can be more difficult to ensure this workforce receives the full range of training they need to deliver care in the community, both general training and to deliver specific interventions.

Psychosocial therapies have become one of the most important tools used by community mental health nurses to treat people. A number of people raised psychosocial therapies as a significant change in practice and had a variety of thoughts on how this has changed mental health nursing.

Most felt that the increasing focus on psychosocial therapies has enabled more effective, positive and personalised nursing care. "I think there's a much broader therapeutic approach used by nurses now. Even when CPNs came in, they were thought of as the people who went to people's houses and made sure they got their depo [sic]. But now it's much more therapeutic, it's much more about recovery, and it's much more about the whole individual."

It was felt by a number of people that increasing training in cognitive behavioural therapy (CBT) must be a focus for community mental health teams today. Several people raised different challenges in developing CBT practice, including providing appropriate supervision and also giving staff the space and time to practice CBT.

There was also a feeling from some that, while CBT is an effective and evidenced approach, it must be used only in balance with other nursing interventions and support, and is not appropriate for all people – particularly for people living with severe inequalities or with poor health literacy.

In the future, it will be important to ensure that people have access to: a range of services that meet their level of need in a timely and appropriate way; and skilled professionals to provide the required level of care.

There are advanced nurse practitioner (ANP) roles developing in mental health which will ensure that, in the future, there is additional expertise in the community, for people with higher levels of need or with deteriorating health. However, "A problem we're having here – and it's the same as with the doctors – is that there is a pool of people who can do it [advanced practice], but once you reach the end of that pool, then what?" There is a need to develop succession planning and training, and to identify and train skilled practitioners among nursing staff, to grow the ANP workforce for the future.

As mental health services moved into the community, registered nursing roles changed, but so did other key care roles. People described to RCN Scotland the new significance of the health care support worker role in the initial stages. For many former residents in inpatient facilities, a health care support worker was their key contact and principal carer.

Today, health care support workers are a critical part of the mental health support infrastructure in the community. They work within multidisciplinary teams and have access to a wide range of assets to which they can connect service users in support of their recovery. As with nurses, access to ongoing clinical supervision and multidisciplinary support, as well as appropriate continuing professional development, enables health care support workers to confidently practice as lone workers in community.

Ensuring the right skills are in the right place

As a large proportion of care for people with severe mental health problems is provided in physical health settings, it is essential that people working in these services to have the skills and resources they need to recognise and provide appropriate care for – and link to specialist mental health support for – people who are experiencing mental illness or distress.

A number of nurses told RCN Scotland that they felt what matters is that the right skills are in the right place. People who are living with mental health problems will sometimes need the support of expert mental health nurses, but more often people will be working with other staff – including nurses in general hospitals, care homes and district nursing teams.

A number of nurses were concerned about the lack of mental health expertise and support available to older adult services, including care homes. Some felt that progress was being made and joint working was developing locally.

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 staff (both nursing and other staff) 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 staff to better understand mental health problems. Training in suicide prevention for primary care and A&E staff was a commitment within Delivering Mental Health and has supported staff 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 staffing challenges

At a 2015 mental health summit, participants discussed the staffing 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 different 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 staffing difficulties 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 insufficient increases in NHS staffing, reduced funding, difficulty in recruiting, and an aging workforce. Mass retirement of experienced nurses will particularly increase issues around supervision and support of newer nursing staff. 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 staffed, 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 staffing 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 staff", 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 Scotland, last year announcing a £15 million increase in funding for mental health services, including additional funding for child and adolescent mental health services and a Mental Health Innovation Fund.[51] The Fund looks at new models for service delivery, particularly in primary care.

Models of care should be designed to meet local needs, but follow a national direction of travel.[52] From a service user's perspective, pathways should be clear and well signposted.

The continuing importance of inpatient services

The move of many mental health services to the community has changed acute mental health inpatient facilities and the kind of mental health care delivered within them. The Mental Welfare Commission conducts visits of mental health

inpatient facilities to ensure the protection and promotion of people's rights; the reported outcomes are broadly positive, and reflect the work of hospital staff 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 shift 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 often 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 often 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 difficulties 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 often unavailable or difficult 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 difficult 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 effective 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 clarified 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

health teams has allowed the circumvention of hospitalisation, by providing excellent and integrated intermediate services. These teams are made up of staff with an advanced skill set and different training to identify and take action when someone's condition is deteriorating.

There are a number of the Scottish Government's current priority areas of work with links to unscheduled care, including: the National Clinical Strategy; tests of change in out of hours primary care and with primary care transformation funding; the Chief Nursing Officer's reviews of district nursing and advanced practice; and emerging models of intermediate care in community settings, such as hospital at home.

Local development of solutions

In mental health, unscheduled care and crisis resolution teams evolved as part of the movement of care from institutions to the community. They provide an excellent example of a model for integrated care in the community which connects to other acute, primary and social care services.

A crisis service 'provides a brief intervention service to patients suffering from acute mental health distress as an alternative to hospital admission, with a maximum target response time of four hours. It offers a gatekeeping function to beds through intensive interventions to support patients in their own environment. The service should be provided twenty-four hours a day, seven days a week. It features a multi-disciplinary (multi-agency) approach to delivering a service to its geographical area'.[54]

Each team looks different and is designed around local need. They do have shared characteristics, including: user representation and involvement; good connections with other areas of health and social care, including third sector providers; successful prevention of hospital admission and reduced acute bed use; and in most cases, 24/7 provision of care.

Teams are often multidisciplinary and may include psychiatrists, health care support workers, social workers, occupational therapists and psychologists. However, some are staffed mostly by nursing and led by senior decision-making nurses. An example of this is the service in NHS Borders which is staffed entirely by nurses and support workers with clinical leadership from two consultant psychiatrists.

These teams operate across metropolitan and rural areas, and how service users access crisis teams works differently depending on the area. Some allow direct contact from people in crisis or

their families; many only take referrals from other services – in particular, from GPs or emergency departments; and sometimes the community mental health team will provide crisis team contact details to their service users as a go-to emergency contact. The crisis team will intervene for a time-limited period – for example up to six weeks – and provide referrals to relevant services on discharge.

Local needs and assets drive the design of crisis and unscheduled care teams. In Edinburgh, a 1995 report Research into Mental Health Crisis Services for Lothian was the result of in depth consultation with service users and defined 'a crisis' as an individual experience which does not necessarily require hospital admission but does require an immediate response. When a crisis team was developed in Edinburgh a decade later, this and further consultation informed their decision making.[55]

In Glasgow, crisis teams were formed in 2001 as part of a broader agenda around modernising mental health, and funded as part of the transition of care to the community. Funding was provided upfront to develop the services ahead of the closure of hospital wards. The service – which is provided by CPNs with the support of on-call psychiatric medical staff – has been effective and has been credited with reducing use of general adult psychiatry beds across Glasgow hospitals.[56]

In contrast, Moray's out-of-hours and emergency mental health care is provided by a mental health ANP team based in the hospital at Elgin.[57] In a rural area, keeping people out of hospital is a necessity. With only 20 acute beds available, staff need to be very robust in their decisions about formulating safe alternative plans so that people can return home the same night.

Successes

Mental health crisis and unscheduled care teams have been very successful in their aim of providing high quality care at home to avoid hospitalisation.

A 2011 review by NHS Tayside of Scottish health boards' different arrangements for crisis resolution in the community found that while the models, referral pathways and team structures look different in each area, they have all been successful in reducing admissions and keeping them down, and have reduced bed usage demand through earlier discharge from inpatient wards.[58]

More generally, the review found that while crisis teams would never replace all admissions, what mattered was 'to maximise the opportunities to

offer people appropriate treatment at home'.

In 2010, NHS Lothian reported such measurable impacts of their crisis service as: a 32% decrease in admissions and readmissions, along with a six day reduction in average length of stay; and routinely positive service user feedback, with 87% of respondents reporting clinical improvement, 43% feeling recovered at discharge and 96% feeling safe during their episode of treatment. People accessing the crisis service valued the level and quality of support, avoidance of hospital admission and improved recovery facilitated by home treatment.[59]

Similarly, when the Intensive Home Treatment Team was piloted in NHS Forth Valley in 2005, an evaluation found that the service provided a safe and accessible alternative choice to inpatient care and that service users had high levels of trust and appreciation of the service.[60] The pilot also delivered improved results from a service perspective, with a 20% reduction in mental health ward occupancy during the eight month pilot period and up to 70 people having an early discharge because of the service.

The success of mental health crisis and unscheduled care services has been dependent on a high level of pre-planning around how the service would be introduced, and the engagement of all critical stakeholders in the acute mental health pathway. In the cases provided in the Tayside review, none had complete buy in from the very beginning, but did have enough good will to work effectively.

The reviewers make two points about this. Firstly, more time and effort was invested in planning and strong leadership in the establishment phase, in comparison to the norm. Secondly, 'CRHT [Crisis Resolution Home Treatment] services at the beginning were in a slightly precarious position. They could not afford to fail (or at least fail very often) to manage people in crisis effectively. Otherwise referrers and others would have resorted back to inpatient admission and pulled the carpet from under the CRHT Service. They had

to get it right pretty much straight away and pretty much consistently.'[61]

In 2005, the Scottish Government recognised the importance of mental health crisis services with the provision of additional funding[62], and in 2006 national standards for crisis services were developed. These standards were under review at the time of writing.

Issues
There would be value in future work to explore how effective crisis and unscheduled care services have been in delivering better care and keeping people at home. While generally the sense is that where crisis services are in place, they have improved care pathways, there are some issues to be examined.

In some cases there is a need for better understanding by the broader team of the role of crisis services and why crisis team members might make a decision that admission is warranted for clinical need or safety reasons. This was raised in a 2014 Healthcare Improvement Scotland review which noted the need for clarity on when and why crisis team members make the decision to admit people to an acute hospital, and for a more robust role for crisis teams in discharge.[63]

The same review noted that community mental health staff provided 'examples of how they believed the handover to the crisis team could result in a breakdown in continuity of patient care due to the crisis team's unfamiliarity with the patient background and needs.'

Another issue raised by the people RCN Scotland spoke with is how to ensure crisis services are able to deliver care to the right people. One nurse in a strategic role noted that other health and social care agencies which do not operate out of hours will refer inappropriately to the crisis team in absence of a more appropriate service – for example, where a person is in distress or an older person is experiencing delirium.

CONCLUSION

Scotland's mental health services, and related policy and legislation, have shifted over recent decades from a focus on institutional care towards community services delivering holistic and person centred care which is designed in collaboration with the service user, to meet their own goals for health and wellbeing. The development of this change was highly collaborative, with leaders opening up dialogue with people who have lived experience of poor mental health, carers and families, and health and social care professionals.

As nurses and others were engaged in this change, and their experience and advice reflected in how services were redesigned, they felt a real sense of ownership of the process. The shared approach to mental health care and support was embraced by professionals and, as RCN Scotland members and partner professionals have reported, the values of recovery-oriented care and support for people's rights are still at the heart of mental health practice today.

However, mental health services face ongoing issues in Scotland, many of which have been highlighted by the recent Mental Health Foundation review of mental health services in Scotland. RCN Scotland has not explored these in detail, but two issues that were highlighted in the conversations they had with members and other stakeholders were an ongoing underinvestment in the NHS mental health workforce, and in the funding of third sector care and support services. Addressing this and other disparity between mental and physical health care must be a focus of the Scottish Government's new Mental Health Strategy, due in late 2016.

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, it's always about collaboration, it's always about people. You can have as many systems as you like but it's about people working to a common goal and putting the patient at the centre."

Care which is designed around the individual, holistic needs of a person is a challenge to traditional ideas about the purpose of health services. One person's idea of a healthy and purposeful life may differ greatly from another's. This is the foundation of the recovery approach in mental health. It is also embedded in the strategic direction of the Scottish Government, and in pockets of innovation across Scotland's physical health services. However, there is some way to go to make this 'business as usual' for the professionals working across all of Scotland's health services.

Leaders in newly integrated services have an enormous task ahead of them in bringing together different professionals and providers, tackling professional boundaries and developing person-centred and community based services. However, the experience of mental health reform in Scotland shows that thoughtful investment and partnership with the people who use and provide local services can deliver change which is meaningful and lasting.

REFERENCES

[1] Helen Gilburt. 2014. Mental health services transformation in London (speech). Kings Fund. Retrieved from http://www.kingsfund.org.uk/audio-video/helen-gilburt-mental-health-services-transformation-london

[2] The Kings Fund. 2014. Service transformation: Lessons from mental health. Retrieved from http://www.kingsfund.org.uk/publications/service-transformation

[3] ISD. May 2015. Mental Health Hospital Inpatient Care: Trends up to 31 March 2014. NHS Scotland

[4] Royal College of Nursing UK. 2014. Frontline first: RCN report on mental health services in the UK

[5] Smith, Freeman and Sturdy. 2008. The social and cognitive mapping of policy: the mental health sector in Scotland. Knowledge and Policy http://www.pol.ed.ac.uk/__data/assets/pdf_file/0004/16978/O1_Final_Report_Scotland_health.pdf

[6] Loudon, J. & D. Coia. 2002. The Scottish scene. Psychiatric Bulletin, 26, 84-86. http://pb.rcpsych.org/content/pbrcpsych/26/3/84.full.pdf

[7] Smith-Merry, J. 2010. Working paper: Transformation of a mental health system – the case of Scotland and its lessons for Australia. Menzies Centre for Health Policy. Retrieved from http://sydney.edu.au/medicine/public-health/menzies-health-policy/publications/jsmpaper280311.pdf

[8] Ibid

[9] Cairney, P. 2008. 'Has devolution changed the 'British policy style'?' British Politics, 3: 350-372.

[10] Forti, A. 2014. 'Mental Health Analysis Profiles (MhAPs): Scotland'. OECD Health Working Papers, No. 74, OECD Publishing.

[11] Mental Health Foundation. 2016. A review of mental health services in Scotland: Perspectives and experiences of service users, carers and professionals

[12] Scottish Association for Mental Health. 2004. The New Mental Health Act – What's it all about? A Short Introduction [online]. Retrieved from http://www.scotland.gov.uk/Publications/2004/01/18753/31686

[13] Haydecker, R. 2010. 'Public policy in Scotland after devolution: convergence or divergence.' POLIS Journal. Vol.3, Winter 2010

[14] Mental Health Foundation. 2016.

[15] Forti, A. 2014

[16] Scottish Government. 2006. Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland: Delivery Action Plan. Edinburgh: Scottish Government. Retrieved from http://www.gov.scot/Publications/2006/04/18164814/13

[17] Bird V, Leamy M, Le Boutillier C, Williams J, Slade M. 2014. REFOCUS (2nd edition): Promoting recovery in mental health services. Rethink Mental Illness

[18] Chief Nursing Officer's Directorate and NHSScotland Mental Health Nurse Leads. 2016. A New Era for Mental Health Nursing in Scotland. Edinburgh: Scottish Government

[19] Feedback from 80 mental health nurses participating in RCN Scotland event 'Our Profession, Our Practice: Responding to Change in Mental Health Nursing' 25 March 2010

[20] Smith-Merry, J; Sturdy, S; and Freeman, R. 2010. 'Indicating mental health in Scotland. Report to the European Commission'. KnowandPol Orientation 2, phase 2 report. Louvian-la-Neuve: Universite Catholique de Louvain.

[21] Ibid

[22] Royal College of Nursing. 2014. Frontline first: RCN report on mental health services in the UK

[23] ISD Scotland. 2016. Mental Health Benchmarking Toolkit 2014/15. Edinburgh: Scottish Government

[24] RCN. 2016. Unheeded warnings: health care in crisis: The UK nursing labour market review 2016. London: RCN https://www.rcn.org.uk/professional-development/publications/005779

[25] ISD Scotland workforce statistics, full tables available http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1725#1725

[26] Cited Forti, A. 2014

[27] ISD. 2016. Hospital inpatient care of people with mental health problems in Scotland: Trends up to 31 March 2015. Edinburgh: Scottish Government

[28] Ibid

[29] Health Foundation. 2014. Person Centred Care Made Simple. London: Health Foundation

[30] Chief Nursing Officer's Directorate and NHSScotland Mental Health Nurse Leads. 2016

[31] Chief Nursing Officer's Directorate and NHSScotland Mental Health Nurse Leads. 2016

[32] ScotPHO. 2012. Scotland's mental health: adults 2012. Edinburgh: NHS Health Scotland

[33] ScotPHO. 2015. Scottish mental health profiles for adults: summary report. Edinburgh: NHS Health Scotland

[34] Audit Scotland. 2012. Health Inequalities in Scotland. Edinburgh

[35]The Scottish Government. 2015. Long-term Monitoring of Health Inequalities

[36]ISD Scotland. 2016. Mental Health Benchmarking Toolkit 2014/15. Edinburgh: Scottish Government

[37]SAMH. 2011. What's it worth now? The social and economic costs of mental health problems in Scotland. Scottish Association for Mental Health

[38]Mental Health Foundation. 2016

[39]The King's Fund. 2014

[40]The Kings Fund. 2014

[41]The Kings Fund. 2014

[42]Slade, M; Amering, M; Farkas, M; Hamilton, B; O'Hagan, M; Panther, G; Perkins, R; Shepherd, G; Tse, S; and Whitley, R. 2014. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry. Vol 13, Issue 1

[43]Feedback from 80 mental health nurses participating in RCN Scotland event 'Our Profession, Our Practice: Responding to Change in Mental Health Nursing' 25 March, 2010, Glasgow

[44]NHS Scotland. 2012. The Charter of Patient Rights and Responsibilities

[45]Scottish Human Rights Commission. Webpage: What is a human rights based approach? Viewed October 2016 http://www.scottishhumanrights.com/careaboutrights/whatisahumanrightsbasedapproach

[46]NHS Education for Scotland. 2012. 'Introduction to the resource'. The Ten Essential Shared Capabilities. Retrieved from http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/publications-and-resources/publications-repository/10-essential-shared-capabilties-supporting-person-centred-approaches.aspx

[47]Lamza, C and Smith, P. 2014. Values-based training for mental health nurses. Nursing Practice. Vol 110 No 15

[48]Kings Fund. 2014

[49]Kings Fund. 2014

[50]Scottish Liberal Democrats. 2015. Report of Outcomes: Mental Health Summit

[51]Scottish Government. (20 November 2012). 'Media Release: Mental health investment'. Retrieved from http://news.scotland.gov.uk/News/Mental-health-investment-127a.aspx

[52]Kings Fund. 2014

[53]Mental Welfare Commission. Webpage: Local visit reports http://www.mwcscot.org.uk/publications/local-visit-reports/

[54]Mitchell, J. 2015. Paper in Response to Commitment 23 and 25 of the Mental Health Strategy. Scottish Government

[55]Web

[56]Cited NHS Lanarkshire. 2013. Modernising Mental Health Services in Lanarkshire [Board paper]. Retrieved from http://www.nhslanarkshire.org.uk/boards/2013-board-papers/Documents/June/Modernising-Mental-Health-Services--June-2013-Board.pdf

[57]RCN Scotland. 2015. Nurse Innovators - Case Study - Leading the way for mental health https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-nurse-innovators-case-study-leading-the-way-for-mental-health

[58]Williamson, P and Marshall, L. 2011. A Review of Crisis Resolution Home Treatment Services In Scotland. NHS Tayside. Retrieved from http://www.qihub.scot.nhs.uk/media/264761/crisis_resolution_home_treatment_report%20final%20november.pdf

[59]Williamson and Marshall, cited in Scottish Government. 2012. Mental Health Strategy for Scotland. Retrieved from http://www.gov.scot/Publications/2012/08/9714/8

[60]Coutts et al. 2006. Providing Alternatives to Inpatient Care: the Intensive Home Treatment Team Pilot in Forth Valley. The Mental Health Review Vol 11 Issue 3

[61]NHS Lanarkshire. 2013. Modernising Mental Health Services in Lanarkshire [Board paper]. Retrieved from http://www.nhslanarkshire.org.uk/boards/2013-board-papers/Documents/June/Modernising-Mental-Health-Services--June-2013-Board.pdf

[62]Delivering for Health. 2005. Scottish Executive

[63]Health Improvement Scotland. 2014. 'Findings and recommendations from a review of concerns presented to the National Confidential Alert Line: NHS Tayside'. Scottish Government. http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=df4d853f-572c-43a6-aa7b-716a3ac60ecc&version=-1

Royal College of Nursing
Scotland

42 SOUTH OSWALD ROAD, EDINBURGH, EH9 2HH

NOVEMBER 2016