SUPPLEMENT

to

A Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028

25 05 2023

Document Version Control

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Contents

This supplement adds to the 2017-2023 Adult Mental Health Strategy and the subsequent 2023-2028 Refresh in providing additional or new information on the roles and functions of the wider mental health complex and the additional focus on Digital / eHealth.

1. Introduction

This supplement to the 'Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028' provides, or adds to, information on services not included in the original strategy for adult mental health services 2018-2023, reflecting the expanded scope that now takes account of the wider complex of mental health services.

The following table shows how the chapters in the Supplement map across to the Strategy Refresh.

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2. Public Mental Health

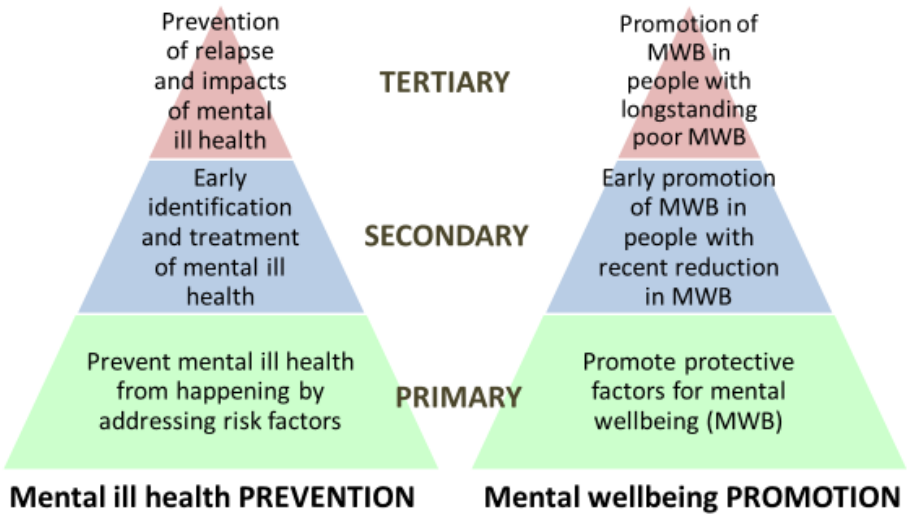
The term 'public mental health' means taking a systematic approach to working towards the best mental health possible for the whole population. This includes addressing both the root causes of poor mental health and strengthening the factors that boost positive mental wellbeing, in active partnership with relevant communities.

It seeks to address the social, environmental and individual determinants of mental health and:

- improves population mental health through the promotion of mental wellbeing, prevention of mental health problems and improving the quality of life of those experiencing mental ill health
- reduces inequalities in mental health
- reduces the health inequalities of those experiencing mental health problems

This should be done using a proportionate universalism approach, which addresses whole population mental wellbeing promotion and provides additional targeted support for high risk groups proportionate to the level of need.

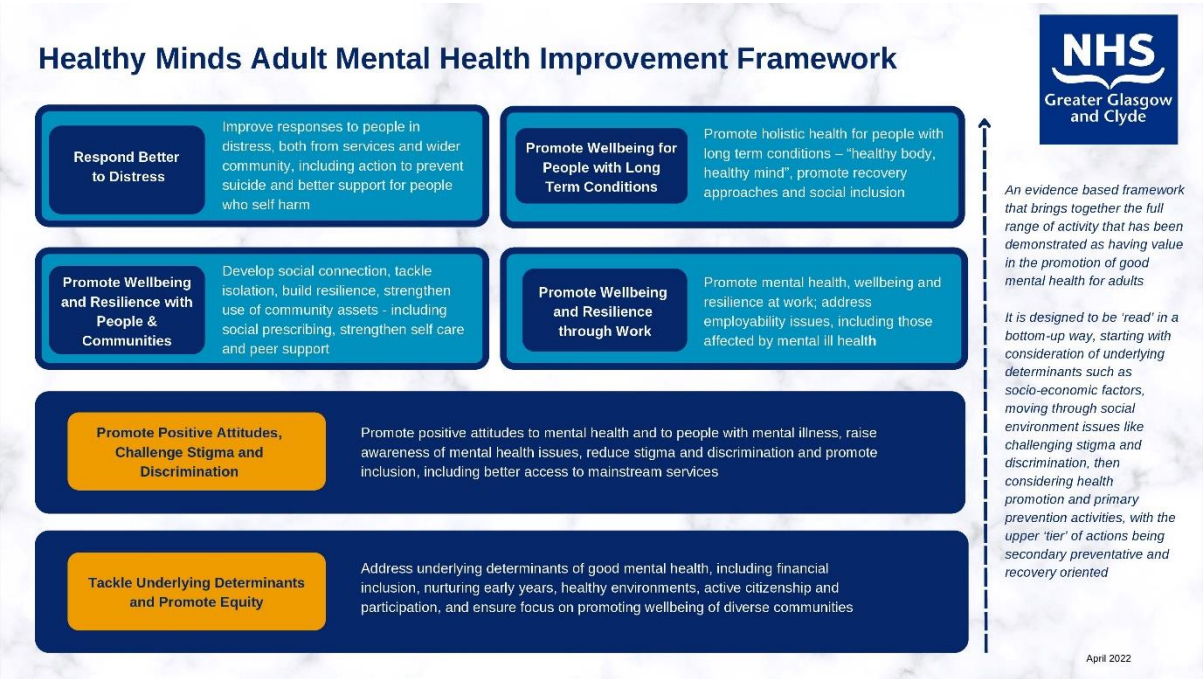
Splitting action into prevention and promotion, including primary, secondary and tertiary, helps to map out existing work and priorities for future focus.

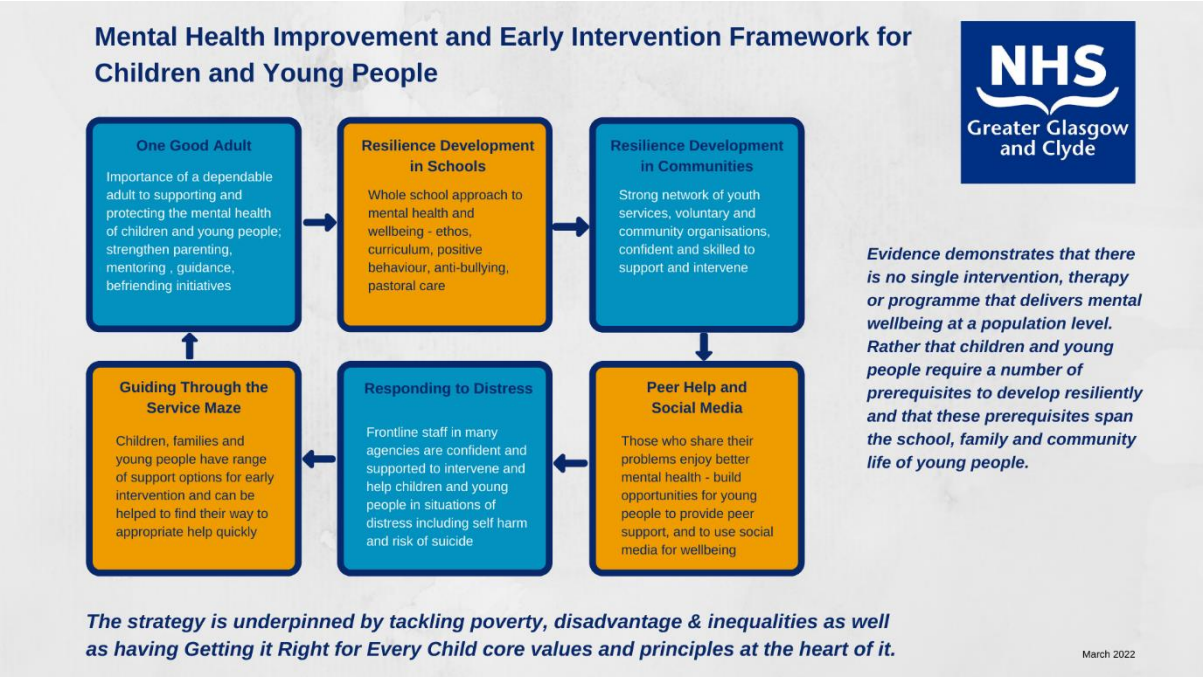


Mental wellbeing promotion and mental ill health prevention are considered and described across the life course, examining the main protective and risk factors at different stages of life and what can bolster or mitigate these factors.

2.1. Frameworks for action

The key elements of a public mental health approach are summarised both for adults and children and young people in separate evidence based strategic frameworks[1,2].





2.2. Children and Young People

The majority of mental health problems will develop before age 24 with 50% of mental health difficulties established by age 14. Mental health and wellbeing is declining in children and young people, with the COVID-19 pandemic having a disproportionately negative impact on this group, especially older young people.

2.3. Inequalities

Mental health is not experienced equally across the population, with higher risk of poor mental health in specific groups. These inequalities are driven by the wider determinants of mental health: poverty, employment, education, housing, social capital etc. Groups who experience stigma and discrimination such as BAME, LGBTQ+ and people with disabilities, are also more likely to experience poor mental health. The pandemic has had a disproportionately negative impact on those who already had higher risk of poor mental health.

2.4. Finding the right help at the right time

There is a wide spectrum of mental health support needed from preventative to acute distress response. Finding and accessing the right support at the right time is imperative to supporting good mental health and early or acute intervention when needed.

2.5. Training

Raising awareness and developing skills within the workforce and wider society around mental health continues to be a priority.

2.6. Partnership Working

Many of the opportunities and mechanisms for action and change sit out-with the NHS's direct control: e.g. in communities, Local Authorities and Third Sector and it is important to influence change through encouraging partners to view and consider issues through a public mental health lens.

3. Older People's Mental Health

Older Peoples Mental Health Services provide services and support to Older People (typically aged over 65), with moderate to severe mental health illness. Support and services are provided in a variety of settings including in the Community, Care Homes, Acute Hospital Liaison Service (Secondary Care) and In Patient Services in specialist Older People's Mental Health Beds.

Service users primarily access services via referral to an Older People's Community Mental Health Team by their General Practitioner. The Older People's Community Mental Health teams are well established multi-disciplinary teams, with a range of health and social professionals within the teams. These include medical, nursing allied health professionals, (for example Psychology/Psychological Therapists and Occupational Therapy), social work and social care colleagues.

Patients may present with a variety of issues including Functional Mental Health which includes support for conditions such as depression, anxiety, psychosis, or Organic Mental Health needs, which would include people with a potential or diagnosed dementia or cognitive impairment.

3.1. In- Patient Beds

In – Patient Beds fall into two categories; Acute Admission and Hospital Based Complex Care Beds and within this to Organic (i.e. for patients with a potential or actual diagnoses of Dementia or Cognitive Impairment) and Functional (i.e. for patients with conditions such as depression, anxiety, psychosis).

3.1.1. Acute Admission

Patients are admitted to an Acute Admission bed when they are in crises and require the full range of support available in a hospital in patient setting. Patients are admitted to these beds when their illness cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space.

Patients remain in these beds for a short period of time**.** As patients move through their treatment journey, discharge planning will commence and will include an assessment both of their mental health and social care needs.

3.1.2. Hospital Based Complex Clinical Care

The Scottish Government's national guidance for Hospital Based Complex Clinical Care (2015) set out a vision to disinvest from long stay beds by finding alternative strategic commissioning solutions in the community, stating "as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs".

Patients admitted to a Hospital Based Complex Care Bed require care that **cannot be provided in any other setting**, these patients are reviewed every three months and as their care needs change may be discharged from HBCC to another care setting.

3.2. Liaison Services & Support

Our liaison services are aligned with our OPMH Community Teams. There are two different liaison responses; Secondary Care (Acute Hospital Liaison) Care and Care Home Liaison.

3.2.1. Care Home Liaison

The Glasgow City HSCP Care Home Liaison Service offers an effective and time limited response to the challenges associated with increasing demands for complex care beds for residents living with dementia. The service aims to promote a model of person-centred care that takes into account patients' needs, preferences, strengths, drives consistency of service delivery processes; as well as setting out a framework of key performance measures. It also aims to ensure care is delivered in the least restrictive manner. This is achieved through undertaking comprehensive mental health assessments, developing care/interventions plans with the emphasis on preventing and reducing acute admissions to hospitals, and through the reduction of anti-psychotic prescribing. The service also promotes proactive and preventative strategies to managing distressed behaviour through the promotion of non-pharmacological interventions. The service supports care home staff to develop their skills and competencies in mental health and in managing stress & distress behaviour through the delivery of training, which is matched to their skill level of expertise as outlined in the Promoting Excellence Framework. The service is delivered by Community Health Liaison CPNs, Psychiatrists with some resourcing for Clinical Psychology.

3.2.2. People's Mental Health Acute Hospital Liaison Service

The strategic priority of the Older People's Acute Hospital Liaison Service is to improve integration between physical and mental health care in the acute hospital context. A collaborative, multidisciplinary approach is adopted to care and discharge planning with the following aims:

- to improve the overall quality of care;
- reduce barriers to discharge and unnecessary re-admissions;
- to provide smooth transition to appropriate HSCP and third sector services; and
- to increase access to mental health care in underserved groups with high level of need (e.g. older adults with multi-morbidities, long term conditions, cognitive impairment).

Acute Liaison Services have been shown to offer excellent value for money, with improved health outcomes for patients and significant cost-savings for the NHS, namely due to more timely discharges and fewer unnecessary re-admissions, particularly among older patients (see Parsonage and Fossey, 2011).

The Glasgow City HSCP OPMH Acute Hospital Liaison service is a multidisciplinary team comprising of Psychiatry, Clinical Psychology and Nursing staff. Teams are attached to North East, North West Glasgow and Glasgow South localities. Clinical Psychologists within the team provide assessment, formulation & intervention for older people during their admission to acute or rehabilitation hospital wards. They also provide consultation and training to multi-disciplinary colleagues on supporting psychological aspects of patient care (e.g. Psychological interventions in response to Stress and Distress in Dementia and trauma-informed care). The service will assess and treat older people aged 65 years and above who are within an inpatient acute hospital ward; where there is a concern that the individual's mental health needs are impacting their physical health care/treatment or causing a delay to their discharge from hospital.

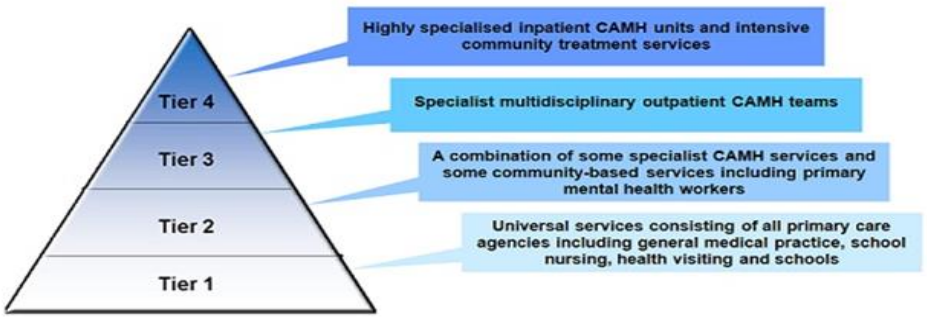
4. Children and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) are multi-disciplinary teams that provide (i) assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, and (ii) training, consultation, advice and support to professionals working with children, young people and their families. CAMHS supports children up to age 18yrs and for targeted group up to age 25yrs.

All children and families should receive support and services that are appropriate to their needs. For many children and young people, such support is likely to be community based, and should be easily and quickly accessible.

Children, young people and their families should also be able to access additional support which targets emotional distress through Community Mental Health and Wellbeing Supports and Services. Community supports and services should work closely with CAMHS and relevant health and social care partners, children's services and educational establishments to ensure that there are clear and streamlined pathways to support where that is more appropriately delivered by these services.

Mental Health supports for Children and Young People are delivered through a Tiered approached



There are eight Tier 3 Community CAMHS teams within NHSGGC spanning the six Health and Social Care Partnerships. These services are supported by a range of Tier 4 Board wide services: Intensive and Unscheduled CAMHS, Forensic CAMHS, Connect Eating Disorders team, and a range of mental health services delivered in to Women and Children's Directorate. GGC hosts the national Child Psychiatry Inpatient unit and the West of Scotland Adolescent Psychiatric inpatient unit.

5. Perinatal Mother and Infant Mental Health

Perinatal refers to the period during pregnancy and up to one year after the baby is born. During this period new and expectant parents (mums, dads, partners) can experience issues with their mental health also known as perinatal mental health problems. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.

Around 1 in 10 women will experience postnatal depression after having a baby. Depression and anxiety are equally as common during pregnancy. Most women recover with help from their GP, health visitor, midwife and with support from family and friends. However severe depression requires additional help from mental health services.

The symptoms of postnatal depression are similar to those in depression at other times. These include low mood, sleep and appetite problems, poor motivation and pessimistic or negative thinking.

Two in 1000 women will experience postpartum psychosis. The symptoms of this illness can come on quite rapidly, often within the first few days or weeks after delivery, and can include high mood (mania), depression, confusion, hallucinations (odd experiences) and delusions (unusual beliefs). Admission to a MBU is advised for most women, accompanied by their baby. Women usually make a full recovery but treatment is urgently necessary if symptoms of postpartum psychosis develop.

5.1. Perinatal Mental Health Service

Scotland's first specialist perinatal mental health inpatient and community service for mothers, babies and their families provides a comprehensive service which consists of:

The West of Scotland Mother and Baby Unit (MBU) is situated in purpose-designed facilities at Leverndale Hospital and is staffed by a multi-disciplinary team of professionals admits women who are experiencing severe mental illness in the later stages of pregnancy or if their baby is under 12 months old. It allows for the joint admission of mothers accompanied by their babies, where the woman requires acute inpatient mental health care and enables mothers to be supported in caring for their baby whilst having care and treatment for a range of mental illnesses including:

- postnatal depression
- postpartum psychosis
- severe anxiety disorders
- eating disorders

The unit offers a wide range of therapies including biological, psychological and psychosocial interventions including interventions to enhance the mother-infant relationship.

The Community Perinatal Mental Health Team (CPMHT) are a specialist multi-disciplinary team service providing care and treatment to women who are pregnant or postnatal and are at risk of, or are affected by, significant mental illness in pregnancy or the postnatal period. They also offer expert advice to women considering pregnancy if they are at risk of a serious mental illness on risk and medication management, and provide a maternity liaison service to all NHSGGC Maternity hospitals.

The service will work in partnership with partners and families, maternity services, primary care (including health visiting and Family Nurse Partnership), adult social services, children & families social services and other agencies, to design, implement and oversee comprehensive packages of health and social care to support people with complex mental health needs.

The Infant Mental Health Service is a specialist community multidisciplinary team who can draw on a range of expertise and experience to offer needs-led support for infants and families. A key aim of the service is to ensure that the voice and experience of the infant is held at the centre of work with families across the health board.

The multi-disciplinary Maternity & Neonatal Psychological Interventions (MNPI) Team will address the common and/or mild to moderate psychological needs of the maternity and neonatal populations by providing in-patient and out-patient assessments and a range of evidence based psychological interventions. The central focus in all of these interventions is to enhance the parent-infant relationship, improve parental and infant mental health and to prevent a range of psychological difficulties (emotional and cognitive) in childhood and later life.

6. Learning Disability

"We believe that people with learning disabilities should be given the right support so that they can live fulfilling lives in the community. This support should always be person centred, preventative, flexible and responsive. People should only be admitted to inpatient assessment and treatment services when there is a clear clinical need which will benefit from hospital based therapeutic intervention. Challenging behaviour, with no identified clinical need, is not an appropriate reason to admit people to inpatient assessment and treatment services."[1]

A learning disability is a significant, lifelong, condition that starts before adulthood. It affects a person's development and means they need help to:

- Understand information
- Learn skills
- Cope independently

Learning difficulties, such as dyslexia, ADHD, dyspraxia and speech & language difficulties are not defined as a learning disability due to the specific nature of their developmental delay.

Policy and practice guidance commonly distinguishes between two reasons why people with learning disabilities may require or be at risk of admission to inpatient assessment and treatment services:

- people who have mental health problems may need assessment and treatment for an acute episode of ill health or, for example, to manage a change in medication under close supervision
- people who have a history of behaviour that challenges (or an unexplained change in behaviour) may need admission for very detailed investigation; sometimes admission is seen as the only option for people who need time away from their usual home

East Renfrewshire is host HSCP for managing specialist inpatient learning disability services with community services directly managed by each HSCP.

7. Alcohol and Drug Recovery Services

The Alcohol and Drug Recovery Service (ADRS) comprises integrated multi-disciplinary teams of health, social care workers, qualified social workers and administrative staff, providing a Recovery Orientated System of Care to adults and young people with drug or alcohol dependency and significant problem substance use.

Services include: alcohol in-patient and community detoxification and supportive medications, opiate replacement therapy, psychosocial support, harm reduction advice and interventions, needle replacement, blood borne virus testing and treatment, access to alcohol and drug Tier 4 services, psychiatry, psychology, occupational therapy, specialist inpatient and outpatient services. ADRS also provides access to a range of commissioned services delivered by third sector partners such as residential, crisis, rehabilitation and stabilization services and community Recovery Hubs, and recovery communities.

[1] Designing an Effective Assessment and Treatment Model, NHS Greater Glasgow and Clyde 2018

ADRS staffing comprises NHS and local authority comprising: health, qualified social worker, social care and admin.

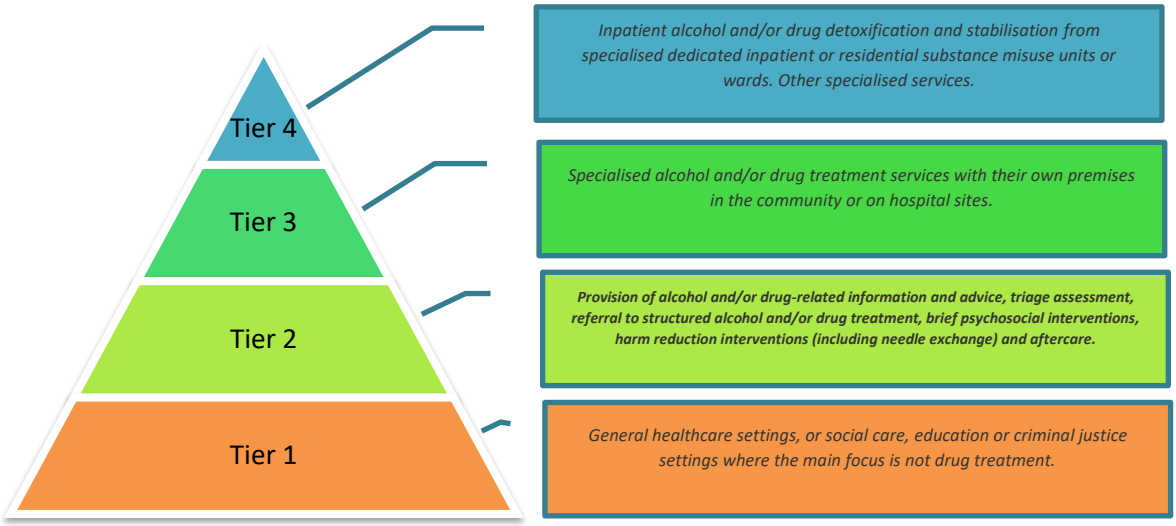


Figure 1 ADRS Tiers

7.1. NHSGGC Service Tiers

7.1.1. Tier 1

Information regarding ADRS services, and pathways into treatment including self-referral, are available from a variety of sources including GP practices and community pharmacies, and in a variety

7.1.2. Tier 2

Injecting Equipment Provision (IEP)

WAND (Wound Care, Assessment of injecting Risk, Naloxone and Dried Blood Spot Testing) Initiative (Glasgow City)

Naloxone Supply - Supply may be made from GP shared care, Police Custody, Acute Addiction Liaison team, Prisons, Scottish Ambulance Service and SFAD in addition to ADRS.

7.1.3. Tier 3

Community alcohol and drug teams are delivered from 16 sites

7.1.4. Tier 4

There are a number of tier 4 services delivered by GGC ADRS: Inpatients, Occupational Therapy, Psychology, Dietetics, Alcohol Related Brain Damage (ARBD) Team, Enhanced Drug Treatment Service (EDTS), Glasgow City Centre Outreach Team, Glasgow Crisis Outreach Service, Acute Addiction Liaison Teams.

Glasgow City hosts board wide ADRS services such as in-patient wards at Stobhill and Gartnavel, however most ADRS services are delivered and managed in each HSCP area. Heads of Service for each locality manage locality multi-disciplinary teams. Board wide systems exist to ensure governance and sharing of best practice and information. Clinical and Care Governance is via the

relevant HSCP and NHS GG&C governance leads and groups. Incidents and complaints are managed through HSCP processes utilising the NHS GG&C Significant Adverse Event Policy.

In addition to the local HSCP specific roles, there are a range of roles with a board wide responsibility e.g. the Associate Medical Director, lead nurse, lead psychologist, and lead pharmacist.

There is a heavy burden of drug harms in GGC. In 2020, there were 444 drug-related deaths in GGC, and the age-standardised rate of drug-related deaths was 30.8 per 100,000 population (95% confidence interval 29.4-32.3), higher than any other large NHS Board area and nearly 50% higher than the rate in Scotland as a whole. Since 2015, there has also been an outbreak of HIV amongst people who inject drugs in GGC, and the estimated prevalence of chronic active hepatitis C infection amongst this population is 19%. Alcohol prevalence data is not readily available, however previous research has demonstrated that the vast majority of dependent drinkers are not engaged in treatment. In recent years alcohol referrals tend to dominate presentations to the ADRS teams**.**

7.2. Alcohol and Drug Partnerships

The ADPs act as the strategic and planning group for alcohol and drugs in their locality. In the six localities, the ADP is hosted by the local authority and involves a range of relevant partners including ADRS.

The ADPs are tasked by the Scottish Government with tackling alcohol and drug issues through partnership working, membership includes health boards, local authorities, police and voluntary agencies. They are responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs. The ADPs work to the framework 'Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs (2019)'. ADPs also have action plans in relation to the national Drugs Deaths Task Force (DDTF) priorities. The ADPs deliver annual reports and other reports to government as requested. ADP action plans are approved by local IJBs.

8. Forensic Mental Health & Learning Disabilities

Forensic mental health services specialise in the assessment, treatment and risk management of people with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings. Some other people are managed by forensic mental health services because they are deemed to be at a high risk of harming others or, rarely, themselves under civil legislation.

The Directorate of Forensic Mental Health and Learning Disabilities provide services to the NHS Greater Glasgow Clyde area (NHSGGC). There are both national and regional services located within the medium secure service at Rowanbank Clinic, which forms a key component of the Scottish Forensic Estate.

Multi-disciplinary forensic teams include, Forensic Psychiatrists, Clinical Psychologists, Occupational Therapists, a Speech and Language therapist, a Dietician, a Pharmacist, and Nursing Staff.

Central to management of forensic patients is the Care Programme Approach and all our patients are subject to enhanced CPA as set out in national guidance for Forensic Services. Risk management is a key feature of the forensic service, and all patients case-managed by the service will have a risk assessment, formulation and risk management plan to inform the individualised care-plan.

8.1. Medium Security

The service provides medium secure care for male mental illness patients from the West of Scotland region (NHSGGC, NHS Lanarkshire, NHS Ayrshire & Arran, NHS Dumfries & Galloway and the "Argyll part of NHS Highland"). Rowanbank Clinic provides a female medium secure service for NHSGGC patients, occasionally taking female patients from across the regions on a case by case basis. It also hosts the National Medium Secure Intellectual Disability service for Scotland.

8.2. Low Security

Low secure in-patient services for NHSGGC are based at Leverndale Hospital serving male mental illness (MMI), male learning disability beds (LD), male pre-discharge beds (MMI & LD) and Low Secure Women Beds.

8.3. Forensic Community Services

There are 2 Forensic Community Mental Health Teams covering NHSGGC. Both teams have a caseload comprising mainly patients subject to compulsory measures. Within NHSGGC all restricted patients are managed within forensic services (with the exception of pre-trial remand patients who may also be managed in IPCUs, depending on the level of offending and presentation). The service does look after some informal patients, particularly complex cases with significant risk issues, but will aim to move patients back to general psychiatry community teams when appropriate.

8.4. Forensic Intellectual Disability Services

There are both medium and low secure Intellectual Disability beds as noted above. The medium secure beds are provided as a National service on a risk share basis through the National Services Division (NSD) of NHS National Services Scotland. Low secure male LD beds are provided for NHSGGC patients, although out of area referrals are accepted if capacity allows. There is no specialist provision for female LD patients. In terms of community forensic Intellectual Disability services, a small team covers the NHS Greater Glasgow & Clyde area for those patients who require ongoing forensic input (including restricted patients) in the community.

8.5. Forensic Liaison Services

8.5.1. Prison

The Forensic Directorate provides consultant forensic psychiatry support 3 prisons and although not managed by forensic services, each prison has a specialist mental health team which includes RMN input and psychology. Prisoners can be referred by the prison GP and may also self-refer. Referrals are assessed by a nurse and may then be seen by the visiting psychiatrist.

8.5.2. Sheriff Court Diversion Schemes

The Forensic Directorate provides 5 day per week cover to one court diversion scheme covering Glasgow Sheriff Court and Clyde Sheriff Courts (Greenock, Paisley and Dumbarton). A Forensic CPN is on call each morning to receive and assess referrals of individuals who are having their first appearance in court. If a psychiatric assessment is required then there is an on-call psychiatrist (specialist trainee), supervised by an on call forensic consultant. There is no additional funding from the court to provide this service.

8.5.3. Forensic Opinion Work

The Directorate frequently receives requests for forensic opinions and risk assessments and attempts to respond as quickly as possible. Requests may be refused because they do not seem appropriate at the outset. It would only be in exceptional circumstances that formalised risk assessment work would be undertaken, often in liaison with the STAR service.

8.5.4. Psychiatric Reports for Procurator Fiscal

Requests for psychiatric reports may be allocated to a trainee under the supervision of a Consultant Forensic Psychiatrist. Consultant Psychiatrists may also provide psychiatric reports for patients known to them, especially if this is integral to their ongoing care however, there is no agreement to provide court reports routinely.

8.6. STAR Service

The Specialist Treatments Addressing Risk (STAR) service accepts referrals from secondary and higher level services. Individuals can be referred to the service if they have a presentation consistent with a major mental disorder, present a risk of harm to others and there appears to be a functional link between the client's mental disorder the risk of harm. In addition to providing consultations, assessments and interventions regarding risk and mental disorder the STAR service also offers specialist assessments regarding and a prescribing service for anti-libidinal medication and a specialist assessment service for autistic patients.

8.7. Forensic Service Governance Structure - Nationally, Regionally and Locally

The core function of the forensic governance groups are to monitor and provide assurance. Groups monitor all aspects of the service and provide regular reporting under the headings of the six dimensions of healthcare quality (Institute of Medicine) proposed in the Healthcare Quality Strategy for NHS Scotland: Person Centred, Safe, Effective, Efficient, Equitable and Timely.

The other main functions of the Groups are to share good practice and to support each NHS Board area in delivering services to a consistent and high quality level.

8.8. Multi-Agency Public Protection Arrangements (MAPPA)

Multi-Agency Public Protection Arrangements (MAPPA) are the way in which legislation is implemented. The approach to implementing MAPPA, supported by National policy and guidance, has been to develop local Implementation Groups, comprising all relevant agencies. MAPPA are organised within the structures and boundaries of Community Justice Scotland and for NHSGGC this involves three Authorities covering nine local authorities, one police force and three NHS Boards. NHSGGC are represented on all steering groups. The Strategic Groups are supported by MAPPA Operational Groups. The MAPPA Strategic Groups report to the Chief Officer's Group which has been established in each local authority area and on which the Health Board's Chief Executive sits. These Chief Officers' Groups regularly receive reports on operational, strategic and performance issues related to MAPPA and other public protection matters such as Adult Support and Protection and Child Protection.

NHSGGC Nurse Director is NHSGGC board lead for MAPPA. This role is strategically and Operationally supported on a day to day basis by the General Manager and Service Manager from the Forensic Service who provide oversight, approval of protocols and procedures so as to ensure the NHS Board fulfils its duty as Responsible Authority in respect to Restricted Patients and its duty to co-operate role with other agencies where any individual comes within the MAPPA process.

In addition the NHSGGC Board has a designated MAPPA manager who is the single point of contact (SPOC) for all communications relating to MAPPA from and to MAPPA Co-ordinators within the Authorities regarding Registered Sex Offenders and MAPPA extension cases in or who are about to be placed in the community.

9. Mental Health Rehabilitation (Service)

The 2018 iteration of the mental health strategy provided a brief description on mental health rehabilitation. This section provides additional information:

In NHSGGC, rehabilitation services specialise in supporting people who typically have a long-term primary diagnosis of schizophrenia, other psychosis (e.g. delusional disorder), or bipolar disorder. However, on a case-by-case basis, it may be that an inpatient rehabilitation need may be justified on an individualised case conceptualisation for people who do not have the above presentations. Typical difficulties may include:

- Ongoing (e.g. positive and negative syndromes) psychotic features (sometimes referred to as "treatment resistant" from a medication perspective, leading to high dose anti-psychotic medications)
- Difficulties or a high likelihood of difficulties sustaining community residence (recent extended duration of hospital admission, high frequency admissions, recent loss of a supported living environment). Low prospect of successful and safe living in the community without specialist rehabilitation.
- Vulnerabilities due to cognitive impairment, difficulties engaging with services, risk of harm to self/others, self-neglect, difficulties with motivation & daily life skills, risk of exploitation, and/or complex physical health problems.
- Experience of severe 'negative' symptoms that impair motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking etc.) and placing and individual at risk of serious self-neglect.

Most require an extended admission to inpatient rehabilitation services and ongoing support from specialist community rehabilitation services over many years.

Although some users of rehabilitation services may be subject to Mental Health or Incapacity legislation it is imperative to gain consent and work towards mutual goals wherever possible. Consequently matching the goals of an individual with the service best placed to empower them to achieve this is the most important consideration.

Maintaining a positive and therapeutic environment and culture within inpatient rehabilitation units is very important.

The social and individual functioning and engagement of an individual is a key consideration. Significant deficits in functioning and engagement should not be a barrier to accessing rehabilitation care but may influence decisions about when an individual is most likely to benefit or which type of unit is most suitable.

The physical health and intellectual capacity of the individual again may influence their ability to engage in rehabilitation however intellectual disability or physical health should not by itself preclude the opportunity of rehabilitative care.

Diagnosis alone should not be a barrier to accessing rehabilitation services in those with a primary functional mental disorder.

10. Digital and eHealth

Mental health services have a dedicated structure responsible for delivering and implementing IT / eHealth systems across mental health services. This involves close working with corporate eHealth services to deliver on the digital agenda and to manage practice change required with clinical services.

Before the pandemic, mental health services were already evolving to make better use of data and digital tools. COVID-19 demanded that we move further and faster with our plans, by providing the ability for people to connect face-to-face without being in the same room, or to enable clinicians to monitor a patient's health in their own home. These demands created an increasing requirement to deliver more consultations remotely and to have a more agile work force who can meet the increased demand.

Data and digital technologies impact on every element of our lives and this applies to mental health and mental health services, including:

- Existing and emerging people and patient facing technologies, extending beyond virtual consultations (e.g.cCBT)
- The use of digital to support decision making and provide clinical informatics
- Systems development to support electronic patient records for better patient care and information sharing
- By necessity, the need for digital literacy for people to learn and develop alongside digital

A dedicated work stream, directly reporting to the programme board, has been established to ensure the focus that is warranted in order to support the progression of digital technologies within mental health services.