Dear Minister for Mental Health,

Mental Health in Scotland

In launching the Mental Health Strategy for Scotland covering the period 2012-2015 the then Minister for Public Health indicated “Improving mental health and treating mental illness are two of our major challenges”. That strategy set out a series of key commitments and set an ambition to “take a step into the future and think beyond how services are currently structured and delivered”.

The Health and Sport Committee determined to look at the previous mental health strategy to identify both positive and negative impacts. It was however disappointing to hear from various submissions¹ there was no regular programme of reporting nor rigorous evaluation of the commitments in the strategy on the extent to which they were delivered, how the themes were supported or what outcomes were achieved. In light of that and given your offer to delay publication of the new 10 year strategy to allow the Committee an opportunity to input their findings we are concentrating our thoughts on more strategic areas where we wish to see improvement and change.

Our short inquiry was split into two parts, we held two evidence sessions in relation to Child and Adolescent Mental Health (CAMHS) as well as a round table event which provided an overview of participant’s hopes for the new mental health strategy before hearing from yourself. We also received 31 written submissions on both topics.

**CAMHS**

Research indicates that 10% of children and young people (5-16 years) have a clinically diagnosable mental health problem, disproportionately affecting persons from lower income households. We sought to understand the barriers to accessing children’s mental health services and why significant variations in waiting times and accessing treatment continue to occur across Scotland.

¹ Including the Mental Welfare Commission, Alliance and SAMH
Referral pathways
We heard the number of rejected referrals was around 20%, or around 6000 children per annum.

While Dr Mitchell assured us this was similar to general psychiatry the Committee was also told that triage often takes place before a young person is referred to specialist CAMHS and there can be local referral criteria in place. Given this, it is difficult to understand why rejected referrals are at such a high level. While the Committee cannot speculate about the reasons for rejected referrals, the level of rejected referrals is of concern and, whatever the reason behind them, the Committee has some sympathy with the call for a review. Not only could this prevent young people waiting for the right support, it would enhance the efficiency and capacity of the system if the number could be reduced.

We wish to ensure referral pathways are clear and consistent across the country with transparent eligibility criteria established nationally. The provision of services should be clearly signposted along with the applicable criteria. We expect this issue to be directly addressed and closely monitored and reported within the new strategy.

Demand, Resources and Waiting Times
It was clear to us from a consideration of the available data that existing resources are inadequate to meet current demand within acceptable time-limits. In our short inquiry we have not endeavoured to fully understand the causes which will inevitably be a combination of factors, including staff numbers in certain areas, funding and appropriate use of third sector and other resources including teachers, link and outreach workers.

We share the Minister’s disappointment that the CAMHS target has not been met. The most recent data shows that only half of NHS boards have achieved the target. We are concerned at the huge variation in performance between NHS boards in delivery of the CAMHS targets.

While we accept the limitations of targets and their unintended consequences, we believe targets in this area are important in order to drive much needed improvements and overall we think it is likely the target has improved access to tiers 3 and 4.

We acknowledge that the work of Harry Burns in reviewing targets is ongoing but would urge the review group and the Scottish Government to retain a target/s in this area. However, any such target/s should better recognise quality and outcomes and be embedded across the tiers. In light of this, we make no recommendation on a reduction to 12 weeks as we think the target needs a fundamental rethink. However, if simply based on time to access a service, we cannot see the justification for a continuation of different waiting time targets between mental health and physical health conditions. And, while we note the Minister is equally unhappy with existing performance across the country, we expect the new strategy and the review of

targets to remove the waiting time discrepancy and set out a clear, funded and measurable timetable for the delays to be eradicated.

We are also generally unclear on what parity for mental health conditions would look like and would urge the Scottish Government to clarify this in the strategy.

**Tiers 1 and 2; early intervention and prevention**

Evidence suggested the need for a consolidated strategy across various branches of government. In particular we heard about inadequacies in early intervention and prevention services, perhaps as a consequence of existing targets, skewing resources. Equally, witnesses suggested a greater focus at tiers 1 and 2 would likely reduce later demand by reducing inappropriate referrals and preventing problems from escalating.

We heard about the multi-agency approach being taken in Glasgow who we were told are working towards using the GIRFEC model to ensure referrals go through joint support teams and are appropriately referred much more quickly. While there is further work to do there to fully involve GPs and teachers this seems a sensible approach and we look forward to the strategy encouraging this or similar approaches.

Equally, schools will have a vital role to perform and while we cover the need for a cross cutting approach later, in this particular area the role of schools will be fundamental and we expect this to be clearly set out alongside expectations to be met across the country. We hope, as was suggested by the Minister, those working in nurseries and schools will all have some training in mental health enabling them to recognise when children are showing signs of distress. We look forward to the figures relating to the number of schools and nurseries who have access to counselling as discussed when you gave evidence to us.

One of the strongest themes to emerge particularly from the written submissions was the importance of early intervention and the need to prevent mental health problems in the first place. We noted the 2003 Scottish Needs Assessment Programme (SNAP) report highlighted the disconnect between NHS Board strategic plans for CAMHS and health promotion work. From the evidence heard, we are not convinced there have been significant improvements in prevention and early intervention work over the last 13 years.

In relation to the above we note little was received or heard about the actions of joint integration boards who require to take the lead in this area and we expect the strategy to ensure their role is clear and set out clear expectations alongside ways in which performance can be monitored. In our forthcoming prevention inquiry we will be monitoring how this aspect is being developed and delivered.

Finally in this area, while we support the benefits setting targets can have we are equally concerned about the impact and potential deterioration of a child’s health while they are waiting for services at the various tiers. We heard of young people being sent to wait for a referral being provided with no more than an information

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3 Official Report 29 November 2016 columns 8-10
leaflet. One written submission highlighted a survey showing out of 71 respondents only 5 received support. From our perspective this also emphasises the importance of monitoring more than just waiting times.

Once a child is in the system we would like the strategy to make clear ongoing support should be available after decisions to move between the tiers are made. We expect to see the strategy setting out ways in which this can be monitored and reported.

**Tiers 3 and 4**
We did not focus on what is provided at tiers 3 and 4 but we did receive some evidence in this regard. As a consequence, we have some more general comments about the model of services on offer and their suitability for many children and young people living in troubled and chaotic home environments. We would like to see the strategy recognise this and for the delivery of services to be as flexible as possible.

For example, we wonder about treatment always being provided in a clinic setting during the “normal” working day coupled with a low tolerance for non-attendance. We look forward to seeing how the strategy seeks to provide the maximum flexibility including outreach and ensure a patient-centred approach.

We also heard about the high resource impact of assessing and diagnosing children with neurodevelopmental disorders and the knock on impact this has on the capacity of tiers 3 and 4 due to the need for specialist input. We urge the Scottish Government to review whether the required specialist skills are at the level necessary to provide timely access to tiers 3 and 4 for all children and young people.

**Age of eligibility and transition across services**
We heard a child’s progress through the services and transition through to adult services depends upon how services are provided. There is a need for a more flexible response to suit the needs of individuals and fit their symptoms as opposed to how the system fits them. This should apply to the services being provided and to the age at which children transition, with flexibility to meet their needs paramount, regardless of existing cut-off ages. We hope the new strategy will ensure the service fits the needs of children, and in this area at least we do not expect to see a prescriptive approach taken.

**Inappropriate admissions**
We heard about a lack of inpatient beds for adolescents and adolescents being sent for specialist in-patient treatment far from their families, including south of the border. While we heard that the number of inappropriate admissions of children and young people to adult hospital beds has significantly decreased over the last year, this follows an increase in the preceding 2 years. The decrease is to be welcomed but we note inappropriate admissions were an issue considered by the previous Health Committee in its CAMHS inquiry in 2009 and so from this perspective it is disappointing the issue has still not been resolved. While we have not been able to consider this area in significant detail we expect any unmet need to be met by appropriate facilities being commissioned. Intensive home treatment teams may

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provide a solution for more locally based treatment and we also expect provision to be considered beyond the central belt.

**Adult Mental Health Services**

Our look at adult mental health was quite brief but informed by the round table session we held on 22 November involving participants from key agencies and Boards, as well as the written submissions. The key theme emerging from that meeting was the desire of all participants for an ambitious new mental health strategy with a reach beyond mental health services. We share that desire.

**Inequality**

“We all have mental health, all the time; on some days it is better than others. For some people it is worse for a long period of time and they need to be supported.”

Yet we were struck by the level of inequality both in relation to who is affected by mental illness, as well as the morbidity and mortality experienced by those with long standing mental health problems. Addressing these inequalities should be both at the heart of the strategy and a priority area for action. The level of inequalities present across Scotland within mental health emphasises to us the need for the strategy to be transformative and far reaching. The strategy needs to affect change across all of the determinants of mental health. It needs to be cross-cutting and we look forward to understanding how these elements are all being addressed across government.

**Overriding principles**

While we are grateful for this opportunity to input our views we are conscious of the limited reach of our inquiry both in terms of subject and personnel considered. Necessarily therefore and without the benefit of user input our comments in relation to adult services are restricted. Nevertheless we trust these will be useful when finalising the strategy.

We agree the strategy should be bold, visionary and ambitious. It is essential it addresses the causes and prevention of mental health, as was stated to us the strategy should look “beyond good mental health services and begin to look at how we improve the mental health of Scotland’s population” and we expect to see this as the foundation of the strategy.

There have been undertakings to establish a parity of esteem between mental health services and other health provision and we expect the strategy to explicitly set out how this is to be achieved, including putting in place and retaining within the area the necessary funding to make that happen. Efficiencies made within mental health services should be retained within those services and we would support provisions to prevent such savings being diverted elsewhere until such time as parity is clearly established.

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5 Dr Andrew Fraser NHS Health Scotland Official Report 22 November 2016 col 18.
6 Dr Alastair Cook Royal College of Psychiatrists in Scotland Official Report 22 November 2016 column 4
We were struck by the evidence we heard on a rights based approach, which you also supported, and we anticipate the PANEL principles being firmly and fully embedded.

The only way transformative change in this area can be delivered is through a cross-cutting and joined-up approach covering education, welfare, employment, justice and other branches of government. We look forward to the strategy not only making this clear but including clear commitments and measurable milestones applying widely across government.

We would like to see a heavy emphasis and support for preventative approaches being included and evaluated within the strategy. Only through a multi-agency approach can resilience be built up and pressures on treatment be relieved.

**Targets, Monitoring and evaluating**
Throughout this letter we have highlighted the need for appropriate targets and for monitoring and evaluation of delivery and outcomes. We have not sought to be prescriptive as to how this is to be achieved and indeed as indicated earlier are mindful of the ongoing review of targets and indicators being conducted by Sir Harry Burns. We have forwarded to him a petition we received in relation to mental health targets.

That said it is essential appropriate arrangements are put in place through the strategy which will allow all involved in service delivery to benchmark their services and which make clear the measurement of appropriate outcomes.

**Prescribing**
We note that the 10 year trend for dispensing drugs used in the treatment of mental health problems shows a consistent increase in most drugs. The same report found prescribing rates higher in more deprived areas with a wide variation in dispensing between NHS Boards. While ISD suggest this reflects “different populations and methods of service delivery” we ask what further investigation has been carried out into the reasons for this.

We also would be interested to learn what work the Scottish Government is doing to expand social prescribing in response to the continuing increase in the use of antidepressants.

**Support for those nearing the end of life**
There are a number of issues associated with mental health and support toward the end of life and many people living with a terminal illness have mental health issues than can often go untreated and unsupported. There are also those with conditions such as schizophrenia and bi-polar who are coming to the end of their lives needing access to palliative care services. We support calls that *Die Well* should be added to the mental health strategy setting out how people at the end of life, or living with a terminal illness, are able to access support for mental health problems to support them to die well.

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7 ISD (Scotland) (2016) Medicines used in mental health
The Forthcoming Strategy
We were pleased to learn the Government had initiated widespread discussion on their engagement paper although we heard concerns around limited engagement on the terms of the emerging strategy. All, including the committee, are keen to ensure that a 10 year strategy is the best it can be. You indicated to us you wanted the strategy to be “visionary and ambitious” while ensuring it is practicable and deliverable.\(^8\)

One cautionary note expressed to us relates to the extent to which service users have been involved in the development of the strategic direction and we would welcome specific detail around the number of service users who have input and the extent to which their comments have fed through into the final strategy. Similarly we would anticipate you have had close collaboration with and input from the many people involved in delivering services and again would welcome this specific detail.

However, we were struck by the strong opinion of stakeholders that the engagement document does not give them hope that the final strategy will be transformative or ambitious enough. While we recognise that this is not based on sight of the final strategy, we share the stakeholders concerns and feel that 10 years is a long time requiring the strategy to be right at the outset and have widespread buy-in. A decade with the wrong strategy would be a missed opportunity to affect real change in Scotland’s mental health. We see merit in ensuring as wide agreement as possible to the terms of the final strategy and we would like to hear from you how you plan to achieve this. We trust the Government will also ensure a mechanism is in place to allow the strategy to be reviewed early on and throughout its lifetime, with the potential to update it whenever necessary.

We would be grateful if you could respond to the Committee by 21 January 2017.

Kind regards,

Neil Findlay
Convener to the Health and Sport Committee

\(^8\) OR 29 November 2016 column 4