HEALTH AND SPORT COMMITTEE

AGENDA

12th Meeting, 2016 (Session 5)

Tuesday 22 November 2016

The Committee will meet at 10.00 am in the James Clerk Maxwell Room (CR4).

1. **Subordinate Legislation:** The Committee will consider the following negative instrument—


2. **Mental Health:** The Committee will take evidence from—

   Lucy Mulvagh, Director of Policy and Communications, Health and Social Care Alliance Scotland (the ALLIANCE);

   Chris O'Sullivan, Head of Partnerships and Business Development, Mental Health Foundation;

   Colin McKay, Chief Executive, Mental Welfare Commission for Scotland;

   Dr Andrew Fraser, Director of Public Health Science, NHS Health Scotland;

   Dr Alistair Cook, Chair, Royal College of Psychiatrists in Scotland, Consultant Psychiatrist, NHS Lanarkshire;

   Carolyn Lochhead, Public Affairs Manager, Scottish Association for Mental Health;

   Wendy McAuslan, Development Coordinator, Voices of Experience;

   Bob Leslie, Chair, Mental Health Sub Group, Social Work Scotland.

3. **Public Petitions: PE1611:** The Committee will consider the following petition-PE1611 by Angela Hamilton on improving access to mental health services in Scotland.
4. **Mental Health (in private):** The Committee will consider the main themes arising from the oral evidence heard earlier in the meeting.

5. **Health and Social Care Integration budgets (in private):** The Committee will consider a draft letter to the Finance Committee.

6. **Work programme (in private):** The Committee will consider its work programme.

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The papers for this meeting are as follows—

**Agenda item 1**
Note by the clerk
HS/S5/16/12/1

**Agenda item 2**
Written Submissions
HS/S5/16/12/2
PRIVATE PAPER
HS/S5/16/12/3 (P)

**Agenda item 3**
Note by the clerk
HS/S5/16/12/4

**Agenda item 5**
PRIVATE PAPER
HS/S5/16/12/5 (P)

**Agenda item 6**
PRIVATE PAPER
HS/S5/16/12/6 (P)
Overview of instrument
1. There is one instrument for consideration at today’s meeting:


Background
2. The Order approves Rules made by the General Pharmaceutical Council (“the GPhC”) which amend the General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (which are set out in the Schedule to S.I. 2010/1615); the General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010 (which are set out in the Schedule to S.I. 2010/1616) and the General Pharmaceutical Council (Registration) Rules 2010 (which are set out in the Schedule to S.I. 2010/1617). The Rules which this Order approves, are contained in the Schedule to the Order, and these have been made by the GPhC under powers taken in the Pharmacy Order. The Policy note from the instrument is attached at Annexe A.

3. An electronic copy of the instrument is available at:

4. There has been no motion to annul this instrument.

5. The Committee needs to report by 28 November 2016.

Delegated Powers and Law Reform Committee consideration
6. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 1 November 2016. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.
POLICY NOTE

THE GENERAL PHARMACEUTICAL COUNCIL (AMENDMENT OF MISCELLANEOUS PROVISIONS) RULES ORDER OF COUNCIL 2016

2016 No. 1008

The above Instrument was made in exercise of powers conferred by articles 23(1), 27(1), 32(4), (5) and (6), 37(3), 52(1) and (2), 55A(1) and (3), 57(3), 61(1) and (3)(h) and 66(1) of, and paragraph 5(1)(a) of Schedule 1 to, the Pharmacy Order 2010. The Instrument is subject to negative procedure.

Background

1. The rules scheduled to and approved by this Instrument, amend the following three General Pharmaceutical Council (GPhC) Rules: the General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (which are set out in the Schedule to S.I. 2010/1615); the General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010 (which are set out in the Schedule to S.I. 2010/1616) and the General Pharmaceutical Council (Registration) Rules 2010 (which are set out in the Schedule to S.I. 2010/1617).


Policy Objective

3. The policy behind this Instrument is to make amendments to the Rules noted in paragraph one, using the powers inserted by the Knowledge of English Order and the Indemnity Order, and other powers contained in the Pharmacy Order to make other miscellaneous amendments, and in particular, to:

- Give power to the Registrar to direct pharmacists and pharmacy technicians, where appropriate, to undertake an examination or other assessment of knowledge of the English language.
- Require the provision of evidence of knowledge of English on registration.
- Detail the information to be provided by applicants or registrants and the action that may be taken if a registrant does not comply with the indemnity requirements.
- Detail the information to be provided by a person seeking registration or restoration, or at any time for registrants, to the
Registrar to determine whether there is compliance with the duty for all practising pharmacists (or as the case may be, pharmacy technicians) to have in place an indemnity arrangement in force and in relation to them.

4. Further details of the proposed changes are set out in the attached Department of Health Explanatory Memorandum, in paragraph 7, headed “policy background”.

Consultation

5. The GPhC carried out a public consultation between 24 September 2015 and 17 December 2015. The GPhC received 73 responses to its consultation. These responses came from pharmaceutical professionals and members of the public.

6. The GPhC’s analysis of its consultation shows that responses were broadly supportive of the proposed changes. The GPhC therefore decided to go ahead with the changes set out in its consultation. A copy of the consultation can be found online at http://www.pharmacyregulation.org/rules-and-guidance-consultation.

Guidance

7. Alongside the consultation on amendments to rules, the GPhC consulted on draft guidance about the evidence, information and documents that may be provided by an applicant or registrant for the purpose of satisfying the registrar that they have the necessary knowledge of English, and the process by which the registrar will determine whether he is satisfied that the person has this knowledge.

Impact Assessment and Financial Implications

8. A registrant that works for a charity or voluntary organisation could be required to provide evidence of their indemnity arrangements. If these arrangements included cover by their employer, the charity or voluntary sector organisation would need to give the registrant information on this cover, which the registrant would then provide to GPhC. GPhC does not request evidence of indemnity cover from registrants on a routine basis; therefore the GPhC consider the costs on the charitable or voluntary sector to be minimal.

9. In relation to the public sector, there will be a cost to the GPhC of implementing indemnity and language checks. There would also be some one-off costs associated with changing GPhC systems, producing guidance and communicating the changes to registrants. The DH’s impact assessment for the Indemnity Arrangements Order estimated the transition cost for all affected regulatory bodies as £716k, with annual recurring costs of £80k.

10. Impact Assessments were prepared by the Department of Health in relation to the Knowledge of English Order and the Indemnity Arrangements Order. These can be found on the legislation.gov.uk website at:
Monitoring and Review

11. The GPhC reviews its Rules from time to time and will continue to do so.

Scottish Government Health and Social Care Directorates
26 September 2016
Mental Health

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 1,500 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

The ALLIANCE’s vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

On 5 August 2016, the ALLIANCE convened a group of members and third sector partners to share views on the consultation. Our response is informed by this discussion, our work with members and partners over a number of years on mental health, including in the development of the Mental Health (Scotland) Act 2015, and our various projects, programmes and research.

Part One: Children and Adolescent Mental Health Services (CAMHS)

1. What are the key factors that result in long waits for CAMHS services?

Around Scotland there is a disparity between the ages of eligibility for CAMHS, with some areas (e.g. NHS Borders) allowing eligibility until age 18 and others (e.g. NHS Lanarkshire) capping access at age 16 (if referred before 16th birthday). This means that there are more cases relevant to the CAMHS waiting time target in some areas of the country than others and, consequently, a disparity between the figures.

At the same time, young people report that education staff do not appear confident enough to deal with mental health issues or make referrals to CAMHS for the children and young people they work with. This was reflected in focus group discussions undertaken as part of the Scottish Youth Parliament’s “Our Generation’s Epidemic” report, particularly in relation to talking to teachers about mental health.

“With mental health, teachers understand they don’t know enough, so they don’t feel they can support you, so they won’t talk about it.”

Participant, Our Generation’s Epidemic

2 http://www.alliance-scotland.org.uk/what-we-do/our-work/
3 http://www.syp.org.uk/our_generation_s_epidemic
Interventions such as the named person under the Children and Young People (Scotland) Act 2014 should allow for greater support and connections into these services. Further emphasis should also be placed on the existence of supportive tools and teaching resources for schools such as Positive Mental Attitudes\(^4\), a schools curriculum pack which was produced in 2007 as a response to teachers not feeling confident in relation to mental health issues.

ALLIANCE members also identified a range of staffing issues among mental health professionals that have had an impact on CAMHS waiting times across Scotland. This includes a lack of available psychiatrists to supply diagnosis and insufficient respect for the role of non-clinical mental health specialists in assisting with diagnosis (such as extensive expertise within third sector organisations).

In Scotland, as elsewhere, CAMHS services are generally delivered via a four-tiered model. Tier 1 includes primary, community and school-based health services; tier 2 combines primary and community care with more specialist CAMHS services; tier 3 consists of specialist multi-disciplinary CAMHS services; and tier 4 includes highly specialized acute, inpatient and intensive CAMHS units. In Scotland to date, there has been an unacceptable lack of focus on tiers 1 and 2, which are predominately aimed at early intervention and preventative approaches. As such, children and young people cannot access the support they need when first experiencing difficulties with their mental health. This has therefore led to further pressure on, and a greater demand for, services operating at tiers 3 and 4, i.e. once many children and young people’s mental health has worsened because they have been experiencing problems without adequate or any support. This system of practice is further encouraged and perpetuated by an approach that is driven by targets which focus on access to services at levels 3 and 4, rather than mainstreaming accountability measures through tiers 1 and 2 as well.

2. **What would you identify as the main reason(s) for the CAMHS waiting time target not being met?**

In addition to the points raised above, ALLIANCE members and partners note that the following issues have an impact on CAMHS waiting times:

- Community mental health teams retreating towards medical responses at a local level rather than diverting resources to support early intervention, prevention and other recovery oriented approaches

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Health and Social Care Alliance Scotland (the ALLIANCE)

- Lack of willingness to access mental health assessments from anyone other than a clinically trained mental health practitioner
- Unequal provision of and access to support across the country
- Poor retention rates and shortfall of staff working in CAMHS
- Different recording systems for CAMHS statistics, for example some areas are unable to work out the length of time between start and end of treatment.

Alongside this, we have received anecdotal evidence from our members of referrals from GPs to CAMHS having been rejected as “unsuitable” – even in circumstances where the young person had reached a crisis point. In September 2015 it was widely reported that over 16,000 referrals for young people to get specialist mental health care had been rejected in the previous three years\(^5\). In the quarter ending March 2016, 1,675 referrals for CAMHS were rejected across NHS Scotland (including 714 people in Greater Glasgow and Clyde, 164 in Tayside and 167 in Lothian)\(^6\). We are concerned that the number of rejections could, potentially, be influenced by the need to meet waiting times targets and we would urge the Committee to consider this as part of its inquiry.

We are concerned that CAMHS, a medical intervention designed to support children and young people with particularly severe mental health problems, is often prioritised over social responses which may be more appropriate. We believe that alongside those who need specialist Child and Adolescent Mental Health services, a wider focus on prevention and wellbeing is required, as well as faster access to community-based support for a much larger number of young people. Focusing on CAMHS means that resources are prioritised for a medical service, when longer term investment strategies in other forms of support may meet people’s needs and allow for services to better meet demand. Currently young people may wait up to 18 weeks to be assessed, only to be told their situation is not sufficiently serious to access CAMHS, with little, if anything, else on offer and months passed with no support.

Primary care and community based approaches, like the National Links Worker Programme\(^7\), can offer guided support to get the right type of help at the right time and help prevent the need for individuals to ever even access the medical system.

3. Are there any other issues in CAMHS that you would identify as being a priority for improvement?

\(^7\) [http://links.alliance-scotland.org.uk/](http://links.alliance-scotland.org.uk/)
ALLIANCE members and partners have expressed concern that as long as CAMHS targets are the key measurements for these services this will continue to drive investment, energy, resources and strategic decision making within Health Boards. Whilst the targets are useful for measuring access to services, prioritising them can lead to young people not receiving support at a much earlier stage and preventative action not being taken. This has the unintended consequence of resulting in people requiring to be in a more severe condition in order to get support.

Other priorities for improvement:

- Moving beyond a medical model of support to a broader approach which encompasses rights-based\(^8\) community and guided support to the right types of help to meet personal circumstances.
- Improved communication about the eligibility for CAMHS and progress of a referral to CAMHS.
- The current target is a measure of whether someone receives access to a service – not whether they get any benefit from doing so. Improved monitoring and evaluation of people’s personal outcomes is critical to determining the effectiveness of a service.
- Greater recognition of recovery approaches. SRI 2, developed by Scottish Recovery Network to provide services with a practical tool to review, develop and improve how they support recovery\(^9\) has rarely been used in CAMHS services. There have been 400 SRI 2 completions to date most of which are by NHS services but only 2 completions are by CAMHS services\(^10\).
- Improved links between the education system and CAMHS – with integration of mental health support into schools a priority. These services, in some areas, have been withdrawn due to a lack of local resources, despite evidence showing that raising awareness and removing stigma influences outcomes.

In order to fully hear from people who have experience of using CAMHS services, rather than operating them, we believe that the Committee should invite young people to give evidence or arrange visits to CAMHS at a local level to see how they operate and identify, with people rather than services, what needs to change.

4. Are there any particular factors/initiatives you can identify which have helped improve services either locally or in other parts of Scotland?

\(^8\) [http://www.mwscot.org.uk/media/240757/human_rights_in_mental_health_care_in_scotland.pdf](http://www.mwscot.org.uk/media/240757/human_rights_in_mental_health_care_in_scotland.pdf)

\(^9\) [http://www.sri2.net](http://www.sri2.net)

Referral and access to the partnership form process of counselling response in North Ayrshire has been highlighted as an area of good practice. Lead professionals are appointed in each case and three partnership forum groups meet on a regular basis, with input from head teachers, psychologists, CAMHS and senior social workers. Collectively they decide on support packages for each child, bringing together health, social care and education to plan and collaborate on appropriate support and services. Alongside this clear pathways have been developed with third sector providers, including Crisis, to provide support.

Strong communication and collaboration have been a feature of this approach and it has resulted in a greater focus on early intervention and preventative strategies; appropriately matched responses; a 100% reduction in dual referrals; and the creation of appropriate therapeutic pathways which enable young people early access and increase confidence in services.

**Part Two: Mental Health Strategy**

5. **Which parts of the previous mental health strategy have been the most successful?**

6. **Which parts of the previous mental health strategy have been the least successful?**

We have chosen to provide a combined respond to Questions 5 and 6.

In our view, people who use support and services and third sector organisations who work in mental health have led much of the limited success of the previous mental health strategy. Organisations including SAMH, Scottish Recovery Network (SRN), the Mental Health Foundation and Voices of eXperience (VOX) have been involved in authoring key reports with a series of far reaching recommendations which must be supported to influence the Government’s future strategic priorities.

ALLIANCE members and partners welcomed the development and growing strength of See Me as an area of real strength from the previous Mental Health Strategy. Members recognise the importance of a broad engagement campaign with the Scottish population to raise awareness, support and understanding of mental health problems. Addressing stigma and discrimination has long been a fundamental issue related to long term conditions in general, and as a public facing campaign See Me has added value.
We would like to see more done to ensure that the rights based messages promoted by initiatives like See Me and Rights for Life\textsuperscript{11} are fostered throughout mental health support and services – where these values are often presumed to exist – as well as across the wider general public.

The previous mental health strategy was very broad in approach - offering thirty six commitments – however, it is extremely unclear as to the achievements made with no overall evaluation, analysis or reporting having been made available. The previous strategy was, in our view, largely output based and did not focus on either achieving or evaluating the outcomes for people affected by mental health problems, those who access support and services, unpaid carers and the wider public.

ALLIANCE members believe that the Scottish Government has yet to demonstrate the impact of its work towards many of these commitments and it is, therefore, impossible to practically assess or report measures of success. We believe that analysis of the work compiled in the previous strategy must be undertaken and further consideration of the recommendations of reports be produced before any future strategy.

7. What would you identify as the key priorities for the next mental health strategy?

The ALLIANCE believes that a more transformational strategy is possible than has currently been implied by the Scottish Government’s consultation paper on its new 10 year vision for mental health\textsuperscript{12}. We add our support to the recent call from the Scottish Mental Health Partnership\textsuperscript{13} for a high level Commission of enquiry to lead and inform the transformation required. Such a Commission could focus its deliberations in a number of areas but this would, in our view, require significant reflection on the range of outputs from the previous strategy, including:

- Integrating human rights based approaches to health and social care in the mainstream of support and services
- Prevention, early intervention and recovery being core to the development of future strategy and guiding the mental health support and services of the future (including evidence-based approaches to supporting recovery)
- Clear measures to combat isolation, exclusion, stigma and discrimination

\textsuperscript{11} http://rightsforlife.net
\textsuperscript{12} http://www.gov.scot/Resource/0050/00503669.pdf
\textsuperscript{13} http://www.rcpsych.ac.uk/pdf/Why%20Mental%20Health%20Matters%20to%20Scotland.pdf
• Cross-sectoral, coordinated approaches that are focused on the whole person and incorporate employment, housing and education, as well as mental health care, treatment and support.

These are measures which should be strongly informed and influenced by people with lived experience of mental health problems and unpaid carers. Our members tell us that, to date, the development of the vision for the new mental health strategy has not strongly reflected previous discussions between people and the Scottish Government. The ALLIANCE has written to the Scottish Government calling for a coproduction approach to be taken to any new strategy.

The Scottish Government is also currently establishing a suite of specialist mental health key performance indicators (KPIs). We believe that these indicators need to link more closely with existing indicators to help drive change and transformation in line with the Scottish Government’s policy agenda and captured in the National Health and Wellbeing Outcomes. This should be a priority area for the new strategy.

We are concerned that the new draft vision does not adequately reflect the range of far reaching research and recommendations made in reports commissioned under the commitments of the previous Mental Health Strategy. The ALLIANCE believes that this is largely because the previous strategy was output driven, rather than outcome driven and any new strategy must be developed from an outcomes based approach, containing measurable indicators of success.

For example, in relation to Commitment 1 of the 2012-15 Strategy, the Mental Health Foundation and Voices of eXperience (VOX) have published A Review of Mental Health Services in Scotland\(^\text{14}\), providing a snapshot of experiences and views on future development and reflection on the successes and challenges of the mental health system in Scotland. Our concern is that the detailed information provided in this report has not subsequently influenced the development of the new 10 year vision.

We urge the Committee to ask the Scottish Government for a clearer indication of its commitment to recommendations outlined in the Mental Welfare Commission and the Scottish Human Rights Commission report on progress towards increasing and developing the focus on rights as a key component of mental health care in Scotland\(^\text{15}\) (Commitment 5 of the previous strategy). This report contained the following


\(^{15}\) http://www.mwcscot.org.uk/media/240757/human_rights_in_mental_health_care_in_scotland.pdf
recommendations for the Scottish Government to take forward in relation to human rights and mental health:

- The next mental health strategy should be explicitly build around a human rights based approach, utilising a human rights framework to shape its aims and mainstream human rights across its commitments.
- Measures to combat stigma and discrimination and improving the awareness of the rights of people with mental health problems.
- Development of policies, practices, procedures and priorities employing integrated human rights and equality impact assessments.
- A review and consolidation of existing training initiatives across the mental health workforce against the human rights framework.
- Promotion of the wider use of advance statements.
- National action to focus on strengthening existing forms of supported decision making.
Mental Health

1. The Commission is grateful for the opportunity to submit evidence to the Committee. We will be happy to provide further evidence in support of this submission.

2. The Commission is a statutory body which protects and promotes the human rights of people with mental health issues and related conditions. We visit people who use mental health services, monitor the use of mental health and incapacity legislation, promote best practice, and investigate where people experience deficiencies in care.

3. We strongly support the view that the mental health strategy, particularly for children and young people, needs to be much wider than specialist mental health care, with a strong focus on prevention of mental ill health and promotion of wellbeing. However, we have focused in this response on matters about which have direct experience. We have a particular concern with compulsory care, and our visits are predominantly to people in hospitals. In that respect, our work tends to be at the ‘sharp end’ of the mental health system.

Question 3: Are there other issues in CAMHS that you would identify as being a priority for improvement?

4. Some children and young people who require in-patient care find themselves admitted to adult mental health wards or occasionally general paediatric wards, rather than a specialist in-patient CAMHS service. We have been concerned to note a rise in such admissions in the last two years – see our monitoring report at [http://www.mwcscot.org.uk/media/240702/yp_monitoring_report_2014-15.pdf](http://www.mwcscot.org.uk/media/240702/yp_monitoring_report_2014-15.pdf)

5. We are pleased that our as-yet-unpublished report for 2015/16 shows a significant reduction in the number of such admissions. However, there are still issues of concern, particularly that young people who are admitted to hospital are not always receiving adequate support to maintain their education, and that access to activities can be extremely limited.

6. We are also concerned about the small number of people with complex needs (including learning disability or autistic spectrum disorders or a need for secure mental health care) who can find themselves sent to specialist services in England, hundreds of miles from families, and at huge cost to the Scottish NHS.

Question 6. Which parts of the previous mental health strategy have been the most successful?

Question 7. Which parts of the previous mental health strategy have been the least successful?

7. We find these questions difficult to answer, because there does not seem to have been any rigorous evaluation of the last strategy: on the extent to which
particular commitments were delivered, how that work has supported the seven themes in the strategy, and what outcomes have been achieved.

8. Our impression is that there has been good progress on challenging stigma, and embedding the recovery approach (at least the language of recovery, even if practice still falls short). There has been more modest progress on developing a rights based approach, but with the possibility of further development in the next strategy. Although HEAT targets have not been met, they have at least driven more activity in relation to psychological therapies.

9. Progress has been less evident on:
- reducing the health inequality experienced by people with mental health issues, and
- developing holistic community based supports which promote wellbeing, prevent deterioration in mental health, and respond effectively in a crisis.

10. A specific example is in relation to employability – Commitment 29 of the strategy. Our recent visits to people in the community with enduring mental health problems found that almost none had any meaningful connections to the labour market or hopes of a job.

Question 8. What would you identify as priorities for the next mental health strategy?

11. The type of strategy is almost as important as the detailed commitments. We welcome the Government’s commitment to a ten year vision for mental health, although our initial response to the consultation issued in July is that it is rather modest and short term in scope. More ambition is needed, and a process through which a truly transformative vision can be developed across the whole of Government.

12. Our submission to the Government before the election¹ set out our 6 priorities for the next strategy. These are:

1. A target to reduce the huge disparity in life expectancy affecting people with severe mental health issues.

13. The difference in life expectancy between people with severe mental ill-health and the general population is shocking – women with severe mental health problems die around 15 years earlier, and men 20 years, compared to the general population.

14. The increased rate of early death is not driven by increased suicides or injuries, but poor physical health.

2. A rights based approach

15. The Mental Welfare Commission and the Scottish Human Rights Commission reported in September 2015 on progress towards meeting the commitment in

¹ http://www.mwcscot.org.uk/media/307343/mental_health_strategy_statement_final.pdf
the 2012 strategy to develop and increase the focus on rights as a key component of mental health care in Scotland. A key recommendation of that report was that the next mental health strategy:

‘should be explicitly built around a rights-based approach. It should utilise the human rights framework to shape its aims and mainstream human rights across its commitments. In doing so, it should be informed by the lived experience of service users and should align with the aims of Scotland’s National Action Plan for Human Rights.’

16. In particular, we believe the time has come to begin a fundamental review of the legislative framework for non-consensual care and treatment (the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, and the Adults Support and Protection (Scotland) Act 2007) to ensure Scotland keeps pace with developments in human rights.

3. **Children and young people** [see response to question 3]

4. **Responding better to those who do not fit our current service approaches**

17. Several of our investigations have resulted from harm coming to people with diagnostic labels such as personality disorder, who have found themselves without adequate support. We also see services struggling to respond well to people whose needs fall into more than one diagnostic or service category, and particular conditions such as Asperger Syndrome. Too often, people are expected to fit what services can offer, rather than the other way round.

5. **A commitment to ending unequal provision of care**

18. We visits all hospital services for people with mental health problems, as well as care services and prisons. We report on many examples of high quality facilities and excellent practice. At the same time, we see ward environments that would never be tolerated in health settings for physical conditions, and people kept in hospital for much longer than they need to be, sometimes with little meaningful activity in their day.

6. **Workforce development**

19. Any public service strategy is only as good as the workforce which delivers the service. We need a revised set of skills and competencies to deliver a modern mental health service, focused on recovery and relationships.

20. Alongside this broader workforce agenda, there is a particular need to ensure that the Mental Health Officer (MHO) service is properly resourced and supported. The current position is not sustainable, in the face of the increase in the demand for MHO services, driven by a year on year rise in mental health detention and measures taken under adults with incapacity legislation.

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Mental Health

Background

NHS Health Scotland is a national Health Board working with public, private and third sector organisations to reduce health inequalities and improve health. Our 2012–17 corporate strategy A Fairer Healthier Scotland sets out our vision of a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. Our primary role is to work with others to produce, share and implement knowledge of what works to improve the health of the people in an equitable way, thereby reducing health inequalities.

Our work spans the wider social determinants of health, shown below. We can provide the Committee with further evidence in any area relating to equitable health improvement on request.

In this submission we are focussing specifically on obesity and mental health, in line with the Committee's work programme.

Figure 1: Social Determinants of Health

What are Health Inequalities?

The overall health of the Scottish population is continuing to improve, along with a decline in the death rate. However, the gaps between those with the best and worst health and wellbeing still persist and there are thousands of unnecessary premature deaths every year in Scotland.

As set out in our Inequality Briefing Health Inequalities: What are they? How do we reduce them? health inequalities are the unfair and avoidable differences in people’s
health across social groups and between different population groups. Health inequalities are unfair because they do not occur randomly or by chance, but are influenced by the wider social determinants detailed above. They are avoidable because they are rooted in political and social decisions and priorities that result in an unequal distribution of income, power and wealth across the population and between groups.

The stark reality of health inequality is illustrated by the Glasgow train line map below. Life expectancy in men goes down by two years for every station on the trainline travelling from Jordanhill (in the west end) to Bridgeton (in the east end). On average, a man born in Bridgeton can expect to live 14.3 years less than his counterpart in Jordanhill, and a woman 11.7 years less.

Figure 2: Health Inequalities in Glasgow

Health inequalities are described and measured by comparing the health outcomes of different groups. Health outcomes such as life expectancy (mortality), healthy life expectancy and rate of disease (morbidity) are compared using groupings such as social class, area deprivation, educational attainment, employment status, gender and ethnicity.

The simplest measure of health inequalities is to compare the health of those in the lowest socio-economic group with those in the highest group. The evidence shows that, in general, the lower a person’s position is in society, the worse their health will be.

However it is not only those in the lower socioeconomic deciles who experience health inequalities. Simple comparisons of the lowest and highest groups do not account for the social gradient in health across the whole population. As highlighted by the Scottish Government, health inequality affects almost everyone:
“All the way, from top to bottom of society, the lower you are, the worse your health. The gradient includes all of us below the topmost 1 per cent.”

**What Causes Health Inequalities?**

There is widespread agreement that the fundamental cause of health inequality is the unequal distribution of:

- **Income**: money received by individuals or groups over a specific time period.
- **Power**: This is a complex concept which includes the ability or capacity to do (or not to do) something and control, force or influence through a variety of means. Power can also arise from additional resources such as knowledge, prestige, beneficial connections and other necessary social resources that protect health, no matter what mechanisms are relevant at any time.\(^6,7\)
- **Wealth**: Accumulated material and capital assets which provides a reserve of financial resources and often provides an income stream (e.g. from interest, rents and share dividends).

These fundamental causes also influence the distribution of wider environmental influences on health, such as the availability of good quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities in an area and in society.

The wider environment in which people live and work then shapes their individual experiences of, for example, low income, poor housing, discrimination and access to health services. This all results in the unequal and unfair distribution of health, ill health (morbidity) and death (mortality). This is shown in the figure overleaf.
What works to reduce health inequalities?
Tackling health inequalities requires a blend of action to undo the fundamental causes, prevent the harmful wider environmental influences and mitigate (make less harmful) the negative impact on individuals. Action must be based on evidence of need, understanding of barriers to social opportunities and what is most likely to work.⁸

- **Action to undo the fundamental causes of health inequalities**
  Action is needed to address the fundamental causes of social inequality which determine inequalities in income, employment, education and daily living conditions. Resources and actions need to be reallocated from interventions that are not effective to those focused on reducing health and social inequalities with the prioritisation of social equity and justice. For example:
  - Introducing a minimum income for healthy living.
  - Ensuring the welfare system provides sufficient income for healthy living and reduces stigma for recipients through universal provision in proportion to need.
  - Developing more progressive individual and corporate taxation.
  - The creation of a vibrant democracy, greater and more equitable participation in elections and local public service decision-making.
  - Active labour market policies and holistic support to create good jobs and help people get and sustain work.

- **Action to prevent harmful environmental influences on health inequalities**
  Action is needed to ensure equity in the distribution of, for example, good work, high quality and accessible education and public services in line with proportionate universalism. The most effective means of reducing health inequalities in relation to health behaviours are those which involve taxation and regulation to tackle causes of poor health (e.g. alcohol duty or sales restrictions). These interventions are also amongst the most cost-effective because they require fewer resources to deliver them and they have wide reach. For example:
  - Ensuring local service availability and high quality green and open spaces, including space for play.
  - Drink-driving regulations; lower speed limits.
  - Raising the price of harmful commodities like tobacco and alcohol through taxation and further restrict unhealthy food and alcohol advertising.
- Protection from adverse work conditions (greater job flexibility, enhanced job control, support for those returning to work and to enhance job retention).
- Provision of high quality early childhood education and adult learning.

- **Action to mitigate the effects of health inequalities on individuals**
  Action is required to tackle the unfair differences in people’s experiences of environmental factors such as work, education and health. These differences are largely beyond an individual’s control but can limit their chances of living longer, healthier lives. Action should, therefore, be taken to ensure equal access to public services, targeting high risk individuals with intensive, tailored individual support with a focus on young children and the early years. For example:
  - Training to ensure that the public sector workforce is sensitive to all social and cultural groups, to build on the personal assets of service users.
  - Link services for vulnerable or high risk individuals (e.g. income maximisation welfare advice for low income families linked to healthcare).
  - Provide specialist outreach and targeted services for particularly high risk individuals (e.g. looked after children and homeless).
  - Ensure that services are provided in locations and ways which are likely to reduce inequalities in access (e.g. avoiding discrimination by language).
  - Maintain a culture of service that is collaborative and seeks to co-produce benefits, including health and wellbeing, through work with service users.

**The importance of a preventative approach**
Inequalities account for a significant element of the increasing demands on our public services because of a persisting cycle of deprivation: children and young people brought up in deprived circumstances are more likely to be deprived in later life, which affects the life chances of their children. The Christie Commission report suggested that around 40% of our spending is currently accounted for by interventions that could have been avoided by prioritising a preventative approach. The focus needs to shift (from meeting the cost of dealing with health or social problems after they have developed) to prevention and early intervention.

Understanding the likely impacts of interventions on health and health inequalities can help Scottish Government, Health Boards and local government make challenging decisions about where best to invest resources. Modelling work undertaken by ScotPHO shows that interventions focusing on individual behaviours (such as alcohol brief interventions, smoking cessation and anti-obesity interventions) have modest impacts on inequalities and overall health compared to interventions which redistribute income (such as increasing benefits, creating jobs and increasing the minimum wage).

**Policy Context**

At a UK level, the Black Report of 1980 and the Whitehead Report of 1987 both found that health inequality is caused by wider socio-economic factors and that action was required on redistribution, increased public expenditure and taxation. Similarly, in 1998 the Acheson Inquiry into Inequalities in Health found that the root cause of health inequality is poverty and income inequality.

The World Health Organization established the Commission on Social Determinants of Health in March 2005 to support global action to address the social factors leading
to ill health and health inequities. This resulted in the report Closing the gap in a generation: Health equity through action on the social determinants of health.6

In 2008, Professor Sir Michael Marmot was asked by the Westminster Government to chair an independent review into health inequalities in England. The report, Fair Society Healthy Lives13, the “Marmot Review”, concluded that reducing health inequalities would require action across early years, good work, standard of living, places and communities and ill-health prevention.

In Scotland, the Ministerial Task Force on Health Inequalities reported in June 2008. The report, Equally Well14, outlines the actions required by national and local government, NHSScotland and the third sector to tackle health inequalities and the underlying causes of health inequalities. It also links reducing health inequalities with sustainable economic growth.

Since the publication of Equally Well the Scottish Government has published the Equally Well Implementation Plan15 and the Equally Well Review16.

In 2012, the Ministerial Task Force was reconvened in order to review new evidence, look at lessons learned to date and highlight new areas for attention. NHS Health Scotland produced a Health Inequalities Policy Review17 to provide evidence to the task force about what works to reduce inequalities and to make recommendations for future strategy. The review concluded that in order to make a real impact on health inequalities, the following key issues would have to be addressed:

- The case for tackling health inequalities will have to be widely understood and be given the highest priority across government.
- A shift of emphasis toward suitable use of regulatory and fiscal measures – which do not rely on individual take up – and away from addressing individual lifestyle issues and the targeting of specific areas.
- Effective coordinated and focused action at both a national and local level.

Most recently, the Health and Sport Committee’s report on health inequalities18 published in January 2015 emphasised the need to tackle the structural causes of health inequalities and recognised that the responsibility to reduce health inequalities extends far beyond the health service.
Mental Health

Approximately 1 in 4 people experience a mental health problem (such as depression or anxiety) at some point in their life\(^{19}\). Mental health problems are one of the major contributors to disability in the UK\(^{20}\).

Good mental health is not only the absence of mental health problems. The World Health Organization defines good mental health as:

“a state of [mental] well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”\(^{21}\)

The cost of mental ill health

The most recent data suggest that the economic costs of mental health to Scotland are substantial. In 2009/10 this was approximately £10.8 billion, a 25% increase from 2004/5 (£8.6 billion)\(^{22}\). This is made up of estimates of:

- Almost £2 billion spent on health and social care for those with mental health problems. However, English data suggests that only around a quarter of people with mental ill health are in receipt of treatment.\(^{51}\)
- £3.2 billion of losses as a result of mental ill health in the workforce during 2009/10. This is the result of worklessness\(^{23}\), loss of unpaid work, sickness absence and premature mortality.
- £5.6 billion in human cost. This is a monetised estimate of the adverse effects of mental health problems at a population level, in terms of morbidity, quality of life and, premature mortality resulting from suicides due to mental health problems.

Mental health inequalities

Mental health problems are not equally distributed across the population. Those who are socially disadvantaged are at increased risk. For example adults living in the most deprived areas in Scotland are approximately twice as likely to have common mental health problems as those in the least deprived areas (22% versus 11%).\(^{24}\) In 2010/2011 there were twice as many GP consultations for anxiety in areas of deprivation than in more affluent areas in Scotland (62 versus 28 consultations per 1,000 patients).\(^{25}\) The prevalence and type of mental health problems also varies by gender and age.\(^{26,27}\)

What drives inequalities in mental health?

Current thinking suggests that the link between social status and mental health problems is the level, frequency and duration of stressful experiences and the extent to which these are buffered by social and individual resources and sources of support.\(^{28}\) These stressful experiences (including poverty, family conflict, poor parenting, childhood adversity, unemployment, chronic health problems and poor housing) occur across the life course and contribute to a greater risk of mental health problems if they are multiple in nature and if there are no protective factors to mitigate against the negative impact.\(^{ibid}\) The stress-vulnerability model suggests that stressful life circumstances and events trigger and exacerbate mental health problems amongst those who are vulnerable.
Where should we intervene?
Actions across the life course and in all policy areas have the potential to impact on mental health and mental health inequalities. Key areas where there is strong evidence of an association with mental health problems include:

- adversity and disadvantage in early years
- low and insecure income and problem debt
- unemployment and access to good work
- poor housing
- violence and physical abuse
- the physical environment

Childhood adversity
Half of all lifetime mental disorders start by the mid-teens and three-quarters by the mid-twenties. Mental health problems are influenced from an early age by the social environment. Adversity and multiple disadvantage in childhood, as well as abuse and neglect, poor parenting and parental mental health problems are some of the factors associated with an increased risk of mental health problems in both childhood and adulthood.

Action to reduce adversity and multiple disadvantage in childhood and promote emotionally and physically secure, safe and supportive relationships and environments will contribute to reduced levels of psychological distress in both childhood and adulthood.

Key actions to tackle childhood adversity:
- Addressing the inequalities and adversities in childhood through actions to reduce child poverty and actions to prevent child abuse and neglect including those outlined in Equally Safe
- Targeting high risk individuals with intensive tailored interventions focusing in particular on pregnant women and early years
- Actions to promote early childhood development
- Early identification and management of childhood mental health problems

Low income and debt
Low and insecure income and problem debt are associated with an increase in the risk of mental health problems. Data from the Psychiatric Morbidity Survey in 2007 found that men in the lowest income group (less than £10,575 per annum) were three times more likely to have a common mental health problem than those in the highest income households (>$40,384 per annum). Similarly, estimates suggest that adults in debt were three times more likely to have a common mental health problem than those not in debt. The relationship between problem debt and mental health problems is likely to be two way. Around a quarter of those with mental health problems report being in serious debt. Having a mental health problem can effect ability to manage financial commitments and trigger problem debt as well as affect ability to regain financial control, thus contributing to a cycle of deprivation.

Key actions to tackle low income and debt:
NHS Health Scotland

- Introduce a minimum income for healthy living and ensure the social security system provides sufficient income for health living.
- Tighten regulation and enforcement of the Office of Fair Trade guidelines about responsible lending and address premium rates for essential services for those on low income. \textit{ibid}
- Maximise income through provision of welfare benefits advice in or via health care settings or social services and money advice. \textit{ibid}

Unemployment/poor quality employment
Unemployment has consistently been associated with an increased risk in common mental health problems. \textsuperscript{35,36} This is of particular concern in relation to young people with few qualifications who find it difficult to enter the labour market and those with mental health problems who are often excluded from the workforce.

Supporting people to move into sustainable paid employment that lifts them out of poverty and protects their mental health is important. But poor quality employment which does not protect against poverty and offers limited control is associated with an increased risk to mental health\textsuperscript{37}. The Marmot Review\textsuperscript{13} argued that to reduce health inequalities:

"Jobs need to be sustainable and offer a minimum level of quality.... Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable action".

The NHS Health Scotland Inequality Briefing on Good Work for All\textsuperscript{38} highlights actions that can be taken to ensure good work for all including supporting good mental health and ensuring people with mental health problem have the opportunities to get and keep good work.

Violence and abuse
There is a strong link between experiencing violence and increased risk of mental health problems. In a large English survey half of those who had experienced extensive physical and sexual violence (many of whom experienced childhood sexual abuse) had a common mental health problem and were five times more likely than those with little experience of violence to have a common mental health problem and more likely to have attempted suicide or self-harmed.\textsuperscript{39} Similarly there is a strong relationship between experiencing domestic violence, for both men and women, and mental health problems.\textsuperscript{ibid,40} Women and girls are often at increased risk of violence and women living in poverty are disproportionately affected by violence and abuse. Whilst the reasons for this are unclear it may reflect increased economic pressure and reduced access to resources to leave abusive relationships. The impact of intimate partner violence and abuse can be far reaching, affecting the next generation and having a negative impact on a broad range of infant and child health and wellbeing outcomes.\textsuperscript{41}

Key actions to tackle violence and abuse include:
- Implement interventions that promote gender inequality, including fiscal policies to improve the economic status of women.
Interventions should aim to have a broad impact on violence, rather than focusing on individual behaviour, and challenge the norms which give rise to and sustain such abuse. Proven interventions include collaboration between agencies to provide a co-ordinated response with a focus on increased identification, e.g. routine enquiry, and provision of tailored advocacy, support and outreach to enhance protection and reduce re-victimisation. School-based programmes and early years’ interventions support longer-term prevention of abuse.

**Poor physical and social environments**

The environment we live, work and play in, including our homes, neighbourhoods and access to green space can influence mental health and contribute to inequalities in mental health.

Poor quality housing is one example of the physical environment that has a negative effect on mental health. Fuel poverty in particular is associated with poor mental health both in childhood and adulthood. Warmth and energy efficiency interventions have been found to result in improvements in mental health as well as other health outcomes. Whilst the mechanism linking aspects of poor housing to mental health is unclear it is possible that either poor quality housing acts as a direct source of stress or that poor quality housing is risk factor that is related to poverty and is therefore associated with other physical and social risk factors.

The availability of and access to green space is associated with low levels of mental distress. Current thinking suggests that green space might offer psychological restorative effects for those experiencing stress. However green space is unevenly distributed in urban areas, those living in areas of the greatest socioeconomic deprivation are less likely to live within walking distance of greenspace and are less likely to be satisfied with that greenspace. Improving access and quality of greenspace in proportion to need therefore has the potential to reduce health inequalities.

The NHS Health Scotland Inequality Briefing on Place and Communities highlights the role that good quality places can play in improving health and wellbeing and reducing health inequalities and actions that can contribute to reducing health (including mental health) inequalities.

**Social and health inequalities experienced by people with mental ill health**

Evidence shows that people experiencing mental health problems experience significant stigma and social exclusion, have higher rates of morbidity and mortality and are at increased risk of poor social outcomes such as unemployment, financial hardship and poverty, homelessness and loss of human rights. This is particularly stark for those experiencing long term mental health problems. These health and social inequalities cannot be accounted for by the illness alone and are not an inevitable outcome.

**Unequal access to healthcare services**
NHS Health Scotland

Estimates suggest that only 1 in 4 people with significant symptoms of mental health problems are receiving treatment (either medication or psychological interventions). Poor access to mental health services is associated with:

- lower social class
- geographic location
- ethnicity
- presence of sensory or other impairments
- presence of learning difficulties
- other demographic factors such as age and gender

Stigma and fear, lack of knowledge about mental health services, language/communication problems amongst the general population as well as the knowledge and behaviour of practitioners (including adequacy of assessment and communication style) and systemic and resource issues (such as provision and capacity in mental health services) also influence access to services.\textsuperscript{ibid}

Rates of physical ill health amongst those with long term mental health problems are much higher than the general population. Life expectancy for men with a diagnosis of schizophrenia is 20 years less than the general population and for women this difference is 15 years.\textsuperscript{51} Approximately a fifth of premature deaths are due to suicide and accidental death, however a large proportion are due to physical illness.\textsuperscript{52}

The current healthcare system is not designed to support an integrated approach to meeting the mental and physical health needs of the population. In addition the continued stigmatisation of mental health and diagnostic overshadowing (the process by which physical symptoms are misattributed to mental illness) means that those with mental health problems, particularly long term mental health problems, do not always receive the same quality of care for physical health problems. For example, despite higher rates of cardiovascular disease and related health issues amongst people with a diagnosis of schizophrenia, there is evidence of under-recognition and treatment of these conditions.\textsuperscript{ibid}

Key actions to improve equal access to health care and other public services:

- Provide training to ensure that the public sector workforce is sensitive to all social and cultural groups, to build on the personal assets of service users
- Develop a more integrated physical and mental health service and ensure equal access to health and other services
- Implement NICE Guidance on increasing access to primary care mental health services\textsuperscript{82}
- Implement NICE Guidance on promoting better access to health for those with long term mental health problems.\textsuperscript{83,53}

Unequal access to work

Many people with long term mental health problems actively want to and can engage with work, training or education and this is important for recovery. Lack of work has significant implications in terms of income, daily routines and choices as well as contributing to social isolation and exclusion.\textsuperscript{84}

Rates of employment are much lower amongst people with mental ill health. Whilst rates vary with diagnosis, a large English survey found the employment rate for those
with severe mental ill health was 40% compared with 64% for those with common mental health problems and 76% for those with no mental health problems.\textsuperscript{54}

Action to support people with mental health problems access and remain in work, training or education involves a commitment to workplace adjustment and specialised support. In many cases individuals are not given sufficient support or are discriminated against by employers.\textsuperscript{55} Individuals themselves are often fearful of losing benefits and employers lack the experience to put support in place.

Key actions to support people with mental health problems to access and remain in work, training and education:

- Make necessary adjustments to job, workplaces and educational institutions that help people with mental health problems get and keep work, training and education and implement of guidance such as offered by NICE.\textsuperscript{84,85}
- Implement NICE guidance on workplace policies and practices that can help improve the health and wellbeing of employees.\textsuperscript{56}

**Stigma and discrimination**

Whilst mental health problems and side effects of some medications can contribute to poor health and social outcomes; stigma, injustice and discrimination are significant barriers to achieving parity of access, health and citizenship. Good mental health for all means reducing stigma and discrimination and ensuring equal access for everyone to all public services including mental and physical health services and good work.

Key actions to address stigma and social exclusions include:\textsuperscript{69}

- Implement the Equality Act 2010 with respect to mental illness in all areas of life and supporting employers and public services to implement the Act
- Tackle stigma and discrimination and implement a human rights based approach to mental health including empowering service users to respond to stigma
- Develop evidence based programmes to reduce stigma and discrimination amongst target groups prioritised by mental health service users and including social contact with people with mental health problems

**Conclusion**

Given the social, economic and human cost of mental health and the current financial constraints on service provisions, there is a clear case for investment in prevention of mental ill health and promotion of mental wellbeing. Comprehensive, evidence based strategies at a population level to address the determinants of mental ill health are likely to prevent mental health problems and in the long term contribute to a reduction in mental ill health and inequalities in mental health. This is consistent with the recommendations of the Christie Commission report.\textsuperscript{9}

Achieving good mental health for all means that actions to improve mental health across the population must also reduce inequalities in mental health and not make them worse. This can be achieved through:

- addressing the fundamental cause of inequalities
- reducing the harmful environmental influences by improving life circumstances and ensuring equity in the distribution of, for example, good work, high quality and public services proportionate to need
NHS Health Scotland

- ensuring equal access to public services including mental health services.

Taking actions to improve life circumstance means addressing factors that increase the risk of mental health problems at each stage of life from pre-natal to later life as well as building opportunities and sources of support which we know can help buffer against difficult life circumstances.

Achieving good mental health for all is not the responsibility of one agency or policy area. Actions across health, social, economic and environmental policy areas are likely to have an impact on mental health and collaboration across all policy areas as well as integrating mental health into health and health inequality outcomes is necessary. In parallel, any potential unintended negative consequences of policies on mental health and inequalities in mental health should be considered and addressed.
Highlighted interventions were assessed for potential scaled impact and cost-effectiveness. Those not assessed either did not have sufficient quality data or were not relevant in the context of the United Kingdom (our pilot geography for this analysis).

### 1. Active Transport

<table>
<thead>
<tr>
<th>Area</th>
<th>Theme</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban redesign:</td>
<td>walking</td>
<td>Government authorities redesign urban planning to facilitate and encourage walking</td>
</tr>
<tr>
<td>Urban redesign:</td>
<td>cycling</td>
<td>Government authorities redesign urban planning to facilitate and encourage cycling</td>
</tr>
<tr>
<td>Disincentivise</td>
<td>driving</td>
<td>Government authorities redesign tariffs, pedestrianization, and parking laws, and improve the quality of public transport</td>
</tr>
</tbody>
</table>

### 2. Healthy meals

<table>
<thead>
<tr>
<th>Area</th>
<th>Theme</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free compulsory meals</td>
<td>for all</td>
<td>Government provides free compulsory school meals and improves quality</td>
</tr>
<tr>
<td>Subsidized compulsory meals</td>
<td>for all</td>
<td>Government subsidizes compulsory meals and improves health quality.</td>
</tr>
<tr>
<td>Free healthy meals in the</td>
<td>workplace</td>
<td>Employers provide free healthy meals</td>
</tr>
<tr>
<td>Supermarket targeted promotions</td>
<td></td>
<td>Grocery retailers promote healthy eating through campaigns and recipes</td>
</tr>
<tr>
<td>Lower-calorie options in the</td>
<td>workplace</td>
<td>Employers introduce healthy options in canteens but do not remove existing options</td>
</tr>
</tbody>
</table>

### 3. High calorie food and drink availability

<table>
<thead>
<tr>
<th>Area</th>
<th>Theme</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supermarket layout: space</td>
<td></td>
<td>Grocery retailers allocate greater share of space to healthier products and categories</td>
</tr>
<tr>
<td>Supermarket layout: prominence</td>
<td></td>
<td>Grocery retailers allocate greater prominence (aisle ends, checkout counters, store entry) to healthier products</td>
</tr>
<tr>
<td>Reduced access to high calorie</td>
<td>regulated</td>
<td>Government bans vending machines and snack shops in schools</td>
</tr>
<tr>
<td>Reduced access to high calorie</td>
<td>self-regulated</td>
<td>Schools voluntarily ban vending machines and snack shops in schools</td>
</tr>
<tr>
<td>Reduced access to high calorie</td>
<td>in the workplace</td>
<td>Employers remove vending machines and easy access to high calorie foods</td>
</tr>
<tr>
<td>School canteen layout</td>
<td></td>
<td>Schools place healthier canteen areas (e.g. vegetables, fruit and salad) more prominently</td>
</tr>
<tr>
<td>Workplace canteen layout</td>
<td></td>
<td>Employers place healthier canteen areas (e.g. vegetables, fruit and salad) more prominently</td>
</tr>
</tbody>
</table>

### 4. Labelling

<table>
<thead>
<tr>
<th>Area</th>
<th>Theme</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calorie/nutrition ‘plain’</td>
<td>labelled on package: regulated</td>
<td>Government mandates nutritional labelling on all packaged foods</td>
</tr>
<tr>
<td>Calorie/nutrition ‘plain’</td>
<td>labelled on package: self-regulated</td>
<td>Industry self-regulates nutritional labelling on all packaged foods</td>
</tr>
<tr>
<td>Calorie/nutrition ‘engaging’</td>
<td>labelled on</td>
<td>Government mandates front of pack ‘engaging’ format nutritional information</td>
</tr>
<tr>
<td>5. Media restrictions</td>
<td>Media restrictions on high calorie food advertising on all supports: regulated</td>
<td>Government restricts advertising of high calorie foods on all advertising supports</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Media restrictions on high calorie food advertising on TV: regulated</td>
<td>Government restricts advertising of high calorie foods on TV from 6 a.m. to 9 p.m.</td>
</tr>
<tr>
<td></td>
<td>Media restriction: self-regulated</td>
<td>Food and beverage industry voluntary restricts high-calorie food advertising (e.g., to children)</td>
</tr>
<tr>
<td>6. Parental education</td>
<td>Parental education: pre-schoolchildren</td>
<td>Government authorities provide educational program (e.g., 12-week course) to parents of pre-schoolchildren covering nutrition and parental feeding styles, and providing opportunities for physical activity</td>
</tr>
<tr>
<td></td>
<td>Parental education: schoolchildren</td>
<td>Government authorities provide educational program (e.g., 12-week course) to parents of schoolchildren covering nutrition and parental feeding styles, and providing opportunities for</td>
</tr>
<tr>
<td>7. Pharmaceuticals</td>
<td>Over-the-counter pharmaceuticals</td>
<td>Provision of non-prescription weight-loss drugs</td>
</tr>
<tr>
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<tr>
<td></td>
<td>Prescription pharmaceuticals</td>
<td>Medical prescription of weight-loss drugs</td>
</tr>
<tr>
<td>8. Portion control</td>
<td>Reduced portion size</td>
<td>Food producers reduce average portion sizes</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: restaurants</td>
<td>Restaurants reduce average portion size of meals and snacks</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: workplace</td>
<td>Employers reduce average portion size of foods in workplace canteens</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: reduce portions of high-calorie beverages</td>
<td>Beverage producers reduce average portion sizes of high-calorie beverages</td>
</tr>
<tr>
<td></td>
<td>Eliminate “supersize” items from menus and product ranges</td>
<td>Remove extra-large single-serve portions from packaged food ranges and restaurant menus</td>
</tr>
<tr>
<td>9. Price Promotions</td>
<td>Price promotion reconfiguration: regulated</td>
<td>Retailers and producers restrict promotional activity (e.g., two-for-one) of high-calorie food and Beverages</td>
</tr>
<tr>
<td></td>
<td>Price promotion reconfiguration: voluntary</td>
<td>Food producers/retailers voluntarily increase price of high-calorie food and beverages</td>
</tr>
<tr>
<td>10. Public Health campaign</td>
<td>Comprehensive public-health campaign</td>
<td>Government launches public-health campaign promoting healthy habits across various media (e.g., TV, radio, out-of-home advertising)</td>
</tr>
<tr>
<td>11. Reformulation</td>
<td>New “better for you” products</td>
<td>Introducing new product ranges with improved nutritional profile, and advertised as such</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: food</td>
<td>Food producers deliver small, incremental changes to formulation of food products (e.g., reduction in sugar) that consumers do not notice</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: beverages</td>
<td>Beverage producers deliver small, incremental reduction in the caloric content of beverages that consumers do not notice</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: restaurants</td>
<td>Fast-food retailers deliver small, incremental changes in the formulation of food products that consumers do not notice</td>
</tr>
<tr>
<td>12. School</td>
<td>School temporary diet</td>
<td>Schools provide short-term intensive</td>
</tr>
<tr>
<td>Curriculum</td>
<td>and exercise programs</td>
<td>nutritional education or exercise programs</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>--------------------------------------------</td>
</tr>
<tr>
<td>School curriculum</td>
<td>mandates physical</td>
<td>regulates the amount of physical activity in the curriculum</td>
</tr>
<tr>
<td>includes nutritional-</td>
<td>activity: regulated</td>
<td></td>
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<tr>
<td>health education:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regulated</td>
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</tbody>
</table>

### 13. Subsidies, taxes and prices

<table>
<thead>
<tr>
<th>Relative price increase: regulated</th>
<th>Government introduces a tax in order to drive price increases on certain types of food or nutrient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced agricultural subsidy</td>
<td>Government reduces subsidies on certain food commodities that drive prices (e.g., processed foods such as corn, sugar, and palm oil)</td>
</tr>
<tr>
<td>Relative price decrease on fresh produce and staple foods: increased agricultural subsidy</td>
<td>Government subsidizes fresh food such as fruit and vegetables</td>
</tr>
<tr>
<td>Relative price decrease on fresh produce and staple foods: personal subsidies</td>
<td>Government provides personal subsidies (e.g., food stamps for low-income individuals for sole use on certain healthy food types)</td>
</tr>
</tbody>
</table>

### 14. Surgery

| Bariatric surgery: gastric banding | Provision of gastric-banding surgery |
| Bariatric surgery: gastric bypass | Provision of gastric-bypass surgery |

### 15. Urban Environment

| School physical exercise facilities | Government authorities/schools invest in higher-quality physical exercise facilities |
| Improved community sports facilities and programs | Government authorities increase access to community sports facilities and programs |
| Supermarket availability | Retailers increase presence in areas with poor access to grocery stores |

### 16. Weight management programmes

<p>| Personal technology and wearables to support healthy eating and physical activity: cross-platform | Health systems/employers provide personal technology platforms and wearable technology to support goal setting, tracking, and measuring of key behaviour and health outcomes |
| Health-system individual counselling | Health system provides a short-term (e.g., 12-week) one-to-one counselling program on nutrition and how to change dietary and physical activity behaviour |</p>
<table>
<thead>
<tr>
<th>Health-system group counselling</th>
<th>Health system provides a short-term (e.g., 12-week) group counselling program on nutrition and how to change dietary and physical activity behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activities on prescription</td>
<td>Health system prescribes physical activities and provides free gym membership or other facilitative measures</td>
</tr>
<tr>
<td>Commercial weight-management programs</td>
<td>Commercial provision of weight-management programs (e.g., Weight Watchers) that include group counselling, goal setting, and community support</td>
</tr>
<tr>
<td>Short-term, intensive weight-management programs: adults</td>
<td>Health-care system or commercial market provides short-term (e.g., two- to six-week) residential “boot camp&quot; providing nutritional education and physical activity to adults</td>
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<tr>
<td>Short-term, intensive weight-management programs: children</td>
<td>Health-care system or commercial market provides short-term (e.g., two- to six-week) residential &quot;boot camp&quot; providing nutritional education and physical activity to children</td>
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<tr>
<td>Weight management around childbirth</td>
<td>Health-care system provides weight-management advice as part of pre- and postnatal care</td>
</tr>
<tr>
<td><strong>17. Workplace wellness</strong></td>
<td></td>
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<tr>
<td>Workplace team challenge incentive schemes</td>
<td>Employers provide team challenge activities to encourage physical activity and improved key health indicators</td>
</tr>
<tr>
<td>Workplace individual challenge incentive schemes</td>
<td>Employers provide individual challenge activities to encourage physical activity and improved key health indicators</td>
</tr>
<tr>
<td>Employer material (financial) incentive</td>
<td>Employers provide material incentives for improved key health indicators (e.g., discounts on insurance premiums, gym membership, prizes)</td>
</tr>
</tbody>
</table>
These data have been updated using the ScotPHO profiles published in June 2015 comparing the intermediate zones – Broomhill in Glasgow’s west end (close to Jordanhill Station) and Parkhead & Barrowfield in the east end (close to Bridgeton Station).


Jones PB. Adult mental health disorders and their age at onset. Br J Psychiatry 2013; 202, s5-s10. Doi 10.1192/bjp.bp.112.119164


Mental Health

The College is pleased to respond to this important consultation. We would like to preface our responses to specific questions 1-5 with a diagram representing the CAMH System, which is broader than NHS CAMHS.

![Figure 1: The CAMH System](image)

**1. What are the key factors that result in long waits for CAMHS services?**

On receiving a referral, most CAMH Services prioritise those in need of an emergency response (immediate) or urgent response (within a few days). Systems need to be well-enough resourced and flexible enough to respond in a timely matter and also deal with more routine (non-urgent) cases.

The structure of teams in addition to their size may not allow this flexibility and those deemed non-urgent may have to wait longer. Whilst workforce numbers have increased, they have not kept pace with referral numbers (see Q2).

There continue to be workforce challenges with psychiatrists in particular facing serious recruitment issues. In practice, this means that children and young people with the most complex presentations or the most serious mental illnesses may not get an ideal service. The enhancement of skills is critical to the delivery of evidence based treatment, and NES (NHS Education Scotland) has developed appropriate training, particularly for professionals with a psychology background. However, patients may have to wait some time for the right treatment after a period of assessment.

**2. What would you identify as the main reason(s) for the CAMHS waiting time target not being met?**
Increased awareness of mental health problems in children and young people has led (appropriately) to a hugely increased referral rate to CAMHS. The investment in the workforce, whilst considerable, has not matched demand. In addition, there appears to have been a real increase in the prevalence of mental health problems. For example, there has been a considerable rise in the numbers of young people presenting with self-harm and overdose.

The CAMHS System includes agencies other than Health who have appeared to be less well able to respond to the need for early intervention. Local authority cuts have impacted on the capacity of Social Work and Education to respond to children in need. Referral on to specialist services should be reserved for those with the most severe and enduring problems, but in the absence of multiagency CAMHS at Tier 1 and 2, a lot of children and young people are being referred to Tier 3 services.

Within NHS structures, the HEAT target has led to a reorganisation of workforce to meet demand and this is often at the expense of Primary Mental Health work and other work at Tier 2 level, for example, a Psychology led drop in clinic for young people which includes prevention and early intervention. Children and young people should have access to the right support at the right time as part of a stepped response.

Non-recurring funding can support better training and systems within the CAMHS system but does not address the need for sustained increased staffing within CAMHS.

3. Are there any other issues in CAMHS that you would identify as being a priority for improvement?

The needs of children with Neurodevelopmental disorders (e.g Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Tourette’s syndrome) should be met more consistently across the country. There is a need for post-diagnostic services within the wider CAMH System.

Children and young people with Learning Disability continue to receive a variable service across Scotland and have higher rates of psychiatric disorder than the general population.

The role of nurses in Community CAMHS has not been valued historically. The development of community psychiatric nurse services is essential to the care of unwell young people in the community (Community Tier 4).

Within systems where performance is only measured in relation to patient attendance, there is a need to re-establish models of work which facilitate specialist mental health practitioners having time to support partners in the multiagency system to deliver direct services - for example, consultation to Health Visitors - which supports work with infants and pre-school children.

4. Are there any particular factors/initiatives you can identify which have helped improve services either locally or in other parts of Scotland?
(a) in relation to outpatient services, some areas have successfully adopted a patient flow model (eg CAPA) which has resulted in more efficient practice

(b) The use of Early Care Planning Meetings in inpatient services has resulted in shorter stays and increased capacity

(c) Training community staff in specific therapeutic modalities and ensuring that these are delivered as reflected in appropriate implementation strategies. Examples include the use of Family Based Treatment for Eating Disorders, and Dialectic Behaviour Therapy Programmes for the treatment of emotional dysregulation often associated with chronic self-harming behaviour.

5. What support is provided to children and young people while they are waiting for a stage 3 referral?

The availability of Tier 1 and Tier 2 services varies across the country.

6. Which parts of the previous mental health strategy have been the most successful?

There has been some progress against most of the commitments in the 2012-15 strategy, but few areas where action has translated into noticeable impact, either in services or for the people that use them. The two areas where there has been demonstrable change would appear to be CAMHS and psychological therapies. There has been investment in both areas but, as mentioned in response to previous questions, increased capacity has uncovered the unmet need, fuelling an increase in demand that has resulted in targets not being met. There has been growth in the availability of telephone or online therapies and of social prescribing, but this is patchy across the country.

In regard to CAMHS, we have welcomed the improved access to Tier 4 services including specialist Inpatient services. Variable development of community intensive intervention teams as an alternative to admission have resulted in shorter inpatient stays and increased capacity in inpatient provision as a result.

7. Which parts of the previous mental health strategy have been the least successful?

The strategy did not seem to set a direction for mental health services in Scotland. It was made up of a series of discrete pieces of work that have progressed to a greater or lesser extent, mostly with little discernible impact across the mental health community. Much of the work seems to have reached a point where a report or a paper has been produced, but there is then no follow-up action which changes anything within the system. Services are struggling with significant issues created by ongoing requirements for efficiency savings and the impact of health and social care integration on budgets. New resources are being made available for mental health
services and these are very welcome, but there is a danger that core services increasingly struggle while new initiatives attract investment and attention. In most areas there is a sense that resources are removed from mental health and other community services to prop up significant overspends in the acute sector, created by the pressure on health and social care systems to deal with access and delayed discharge targets. The strategy has done little to address the real issues mental health services face in achieving parity of esteem for those people with severe and enduring mental illness within the health and social care system.

Improved access for hard to reach young people has still not been achieved, with CAMH services for Looked After and Accommodated young people needing further development. Young people in secure care and in prison remain ‘hard-to-reach’.

8. What would you identify as the key priorities for the next mental health strategy?

The next strategy needs to depart in tone and style from the previous two mental health strategies for Scotland. It needs to set ambitious aims and seek transformational change in the way we think about the mental health of the population of Scotland. We need a vision that sets a new direction for mental health in Scotland, not another list of laudable aims that are not too stretching to achieve. There needs to be much greater focus on mental health improvement for all. We need to develop thinking about what we mean by mentally healthy communities and how we can achieve them through a process that engages the public and those with lived experience of mental health problems. We need to consider how we plan our communities with a view to improving mental health. We need to think about what support employers can offer workforces in improving mental health.

Welfare services need to be designed in a way that respects the needs of those with mental health difficulties and focuses on enabling them to maximise their potential. We need to plan health and social care services in a way that encourages parity between physical and mental health and reduces the gap in life expectancy between those with mental health problems and the rest of the population. Where mental health problems arise, we need services that facilitate early intervention, focus on self-management where possible, and offer a diverse range of approaches in local communities, centred around the needs and wishes of the person involved.

Specifically for Children and Adolescents

(a) Health promotion and prevention in children and adolescents will be enhanced by the development of infant mental health services which offer a stepped and tiered response to early difficulties. This should include early intervention. Specialist CAMH services for children and families in the most adverse situations should also be developed.
Royal College of Psychiatrists in Scotland

(b) Working in partnership with Education to ensure that young people are aware of how to maintain good mental health and develop good strategies in the context of supporting structures to ensure that problems are identified and treated early. Education about relationships and parenting should be a key component of this.

(c) Development of Primary Mental Health Work in CAMHS. The Government’s previous aim was to have 25% of the workforce in primary mental health by 2015. This was seriously eroded by the waiting times initiative which sought to address the increased referrals. The need for a stepped and tiered service with the right input at the right time will be supported by the (re-)development of Primary Mental Health.

(d) Developing services for hard to reach and disenfranchised young people; for example, those in the Looked After system, those with Learning Disability or those with a need for a more specialised Forensic mental health service.

This submission was prepared by Dr Alastair Cook, Chair of the RCPsych in Scotland and Dr Anne McFadyen; Chair, Child and Adolescent Faculty, RCPsych in Scotland
Mental Health

In summary:

- The numbers of young people currently seen and supported by CAMHS in Scotland represent a small proportion of young people who need mental health support.

- Despite the investment in CAMHS workforce, there continues to be high pressure on accessing services; the majority of funding seems focused on acute rather than preventative services.

- SAMH wants to see a wholesale review of CAMHS, and its extension up to age 25

- Mental Health education in schools should be a priority, to develop life skills around resilience, to promote wellbeing and improve early intervention. Better teacher training in mental health is required.

- The previous Mental Health Strategy was more focused on outputs than outcomes, with poor reporting of progress and no published evaluation to date.

In preparing our submission, we have consulted children and young people who have experience of CAMHS, through a survey and focus group; and discussed these challenges with sector colleagues. We have drawn on our experience of being involved in the last Mental Health Strategy for Scotland 2012-15, and on the evidence which led to our Ask Once, Get Help Fast Manifesto. We hope that the Committee will speak to young people directly when exploring these important issues.

1. What are the key factors that result in long waits for CAMHS services?

Some recent studies¹ suggest higher levels of poor mental health than 1 in 10 young people experiencing poor mental health. Rates of poor mental health amongst children in areas of deprivation are significantly higher than these statistics suggest²; the interaction between poverty, austerity and poor mental health cannot be separated. The increased awareness of mental wellbeing and (relative) reduction in stigma may also have alerted young people to ask for help.

CAMHS waiting times are measured for tier 3 and tier 4 specialist CAMHS services, with Health Boards tasked to ensure referral to treatment within 18 weeks for 90% of children and young people. Only 8 of the 14 Health Boards are reported as achieving this target, which was due for delivery by December 2015.\(^3\)

Resources appear to be focused on specialist services rather than on prevention and early intervention. Many young people are unable to receive support at the early stages of their illness, leading to them joining waiting lists for more specialist treatment due to a dearth of appropriate support, or if their unsupported condition deteriorates.

There has been a 30% increase in the CAMHS workforce from 764.6 WTE (883 headcount) in 2009 to 993.5 WTE (1154 headcount) as at 31 March 2016.\(^4\) In that time period, however, there has been a significant increase in the waiting list for assessment, as well as the numbers of young people being admitted for CAMHS treatment (4,436 children started treatment in the quarter leading to March 2016; compared with 2,600 in the quarter leading to June 2012).\(^5\)

Of the 993 WTE CAMHS workforce, there are 80.6 WTE medical staff (i.e. psychiatrists), a drop of 4.3% in 2015; this figure has remained relatively static in recent years. The small proportion of medical staff overall may contribute to long waiting times for assessments; and SAMH heard of short assessments which may not capture the full picture of a young person’s mental health.

“I waited a year for my CAMHS assessment, and it lasted 20 minutes. It was the school nurse who told me a few weeks later that I wasn’t being referred, they never sent me a letter. I asked why not and apparently it was because I wasn’t suicidal. But they never asked if I was suicidal.” (Female, SAMH focus group)

With over 16,000 children rejected for treatment over a three year period,\(^6\) the needs of too many young people are not being met. Demand outstrips supply, and we believe it will continue to do so until there is a radical shift towards prevention and supporting people at the earliest opportunity in social as well as medical settings.

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\(^{5}\) [http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/index.asp](http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/index.asp)

While ISD Scotland reports the waiting times for treatment to begin, there is no subsequent measurement of the wait between first and second appointments for treatment; nor follow up if support is provided for young people who are deemed not to need CAMHS treatment, or whether they re-enter the system at a later date; and there is no record of the waiting time for support for tiers one and two.

Referral routes to CAMHS differ by health boards – there is no consistent ‘Ask Once, Get Help Fast’ approach. Nor is there equity of provision for all children in Scotland; some health boards still only provide CAMHS services to children aged 16, rather than 18, which will also affect numbers on waiting lists, and the outcomes for those young people attempting to access support.

Speaking to children and young people who have been assessed for CAMHS, many apparently struggled to be taken seriously about their mental health; this problem also perseveres for young people treated in adult settings due to lack of CAMHS capacity. Reductions in school nurses and counselling services could also mean there are ‘risk-averse’ referrals due to lack of capacity, training or awareness amongst existing tier 1 services. SAMH therefore recommends a wholesale review of CAMHS tier 1-4 provision.

2. What would you identify as the main reason(s) for the CAMHS waiting time target not being met?

SAMH acknowledges the additional funding and staffing for CAMHS in recent years, and that there has been progress for some young people in accessing treatment; however, we believe that the lack of investment in prevention and early intervention to this point has impacted the provision of CAMHS support in the round. The support needed by young people before they become acutely unwell is not adequately provided.

“I saw my GP twice, who was very understanding, and my school were excellent. However, I did feel a bit "stranded"- my problem was recognised but there was limited resources to address it. By the time of my assessment, I believe my problem has deteriorated.” (Survey respondent)

Clear training in mental health and guidance on referrals is required for everyone working with children and young people. A consistent approach to referral is required across Scotland, and the measurement of access needs to improve. We know that many people assessed by CAMHS do not receive treatment, yet wait for a long time without support before this assessment, and if they do not receive a diagnosis or referral to treatment, they have no support at all. More support should be provided in tiers one and two, with greater emphasis on primary care and community support, including within schools.
Recent reductions in educational psychologists\(^7\) is concerning and educational authorities must do more to ensure adequate staffing.

Social prescribing and community support for young people should be explored outwith the medical model of CAMHS; GPs, teachers (including named persons), school nurses and other tier 1 CAMHS professionals should be able to quickly direct young people to community supports. This requires knowledge of local support services and for those services to be resourced.

3. Are there any other issues in CAMHS that you would identify as being a priority for improvement?

SAMH believes the time is right for a wholesale review of CAMHS, and a longer term, recovery-focused approach which builds on the work to date, and drills down into how this is helping young people to recover. As 50% of mental illness in adult life starts before the age of 15\(^8\), we need to ensure children and young people get the help they need, when they need it. A rights-based approach should be adopted. As well as ensuring fast support for young people, the quality of the support they receive must improve – we hope the Health and Sport Committee will scrutinise the adequacy of staffing, the availability and range of community based services, and the interaction between health, social services, advocacy and education; and what happens to children and young people who are deemed not to need support from CAMHS, despite being referred for assessment. On a clinical basis, the Mental Welfare Commission’s young person monitoring report 2014/15\(^9\) highlighted a number of issues which require improvement – including not receiving information from all Boards on a quarterly basis about young person admissions to adult wards; the lack of educational links and age-appropriate activities for young people when in hospital; and the ongoing disparity of CAMHS provision to under-18s across Scotland.

Transition from children’s to adult services can often set back the recovery of young people; some of our focus group attendees reported not being referred to adult services after they had turned 18, yet they felt they still needed support. The Scottish Government’s Children and Young Person’s Act 2014 recognised that some young people require support beyond their 18th birthdays, and this principle should extend to mental health care and treatment for those vulnerable young people. SAMH recommends that access to CAMHS, for those young people who need this support, should be extended until the young person is 25, in order to cement their recovery.

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\(^7\) Scottish Parliament PQ S5W-00691
Stigma from health and social care workers remains an issue according to the young people we heard from. In our focus group, one young person spoke about attending A&E whilst in crisis, having been waiting for a CAMHS assessment; but he was told to go home and wait for his assessment because ‘you’re still here’ (i.e. he hadn’t attempted or completed suicide).

64% of our survey respondents felt they were not consulted about their care.

“I was given a really unsupportive occupational therapist who I felt didn’t really take me seriously and it was only until I started self harming more severely that they begun to take me seriously.” (Survey respondent)

“My GP was really dismissive. He told me I just need to learn to calm down. I have anxiety!” (Female, SAMH focus group).

“I was self harming and went to see my CPN. She said, those marks on your arm, those are cat scratches, aren't they?” (Male, SAMH focus group)

It should be said that other members of the focus group and survey praised their GPs as providing them with ‘top notch’ support.

“GP was the best help I received I think even more so than the CAMHS team. Very, very reassuring and sympathetic with me and made me feel like I was doing the right thing, unlike the CAMHS team who made me leave my sessions feeling like I didn’t want to go back because I felt pressured to take blood tests and make diaries that I didn’t want to do or share.” (Survey respondent)

In our focus group, young people told us about the pressures to open up to strangers about their mental health, often in a short space of time for their assessment; and how they disengaged from a process when they felt unheard, leaving their health unsupported. There must be more time to ensure that young people are supported and treated with dignity and respect; a holistic assessment that takes all their needs into account and co-produces their recovery journey; and if CAMHS as is currently set up is not appropriate for them, they must receive support elsewhere.

SAMH reiterates calls from other organisations, such as See Me, Barnardo’s Scotland and the Scottish Youth Parliament10, for better mental health education. There must be capacity building in schools for a whole school approach, to help teachers to promote wellbeing and respond appropriately to young people who may need support in this environment; and outwith schools,

10 http://www.syp.org.uk/our_generation_s_epidemic 2016
with other adults who support and interact with young people. SAMH highlights the respectme model – policy support, training and resources to build the capacity of parents and other adults working with children and young people.

The overwhelming majority of individuals responding to our survey felt they had received no mental health education in school aside from minimal information about coping with exam stress. Due to such a lack of provision, most said that any form of mental health education would be helpful – even if it was very general or basic. Respondents felt there was a lack of knowledge about mental health issues amongst teachers, including guidance teachers; and a lack of communication between schools and health bodies.

“I haven’t received any mental health education in school. I think it should be taught as much as physical health issues. It may be helpful for young people to be taught the signs/symptoms and how to help others and themselves. As well as giving them advice on where to go for help, such as CAMHS but also a teacher or school counsellor”. (Survey response)

“My guidance teacher didn’t know what CAMHS was” (Focus group attendee)

4. Are there any particular factors/initiatives you can identify which have helped improve services either locally or in other parts of Scotland?

Young people told us that third sector counselling in schools had been helpful, when it was offered; recent reductions in funding and cuts to services in many parts of Scotland have therefore left these young people unsupported; time will tell if this will translate into greater demand for specialist CAMHS support.

5. What support is provided to children and young people while they are waiting for a stage 3 referral?

We asked people responding to our survey what support they had received whilst waiting for an assessment. Fewer than 5 respondents (71 responded to this question) said that they received support, stating that their GPs and schools had provided support.

“We have received no support at all. No follow up communication, no updates, no suggested support or advice.” (Survey respondent)

Many comments in our survey stated that support once received was helpful but lack of continuity was a problem. Many also noted that there was a lack of range of support available and not having a say in the type of help provided; some young people spoke of being dismissed when they said that the support they were getting wasn’t appropriate to their needs.
Our survey responses also showed a great reliance on support from parents, who themselves might be struggling to help their child navigate a confusing and disjointed system.

“CAMHS idea of help is for my mum to hold me close when I’m knocking lumps out of her.” (Survey response)

6. Which parts of the previous mental health strategy have been the most successful?

General Points
SAMH welcomed the overarching seven themes for mental health and four Key Change Areas. SAMH has been an active participant in implementing the strategy, participating in several working groups, and co-leading the Employability (Commitment 29) group.

Commitment 4
One of the most successful aspects of the strategy was the refounding of See Me (Commitment 4). This followed a 2009 evaluation, which highlighted See Me’s ground-breaking work in tackling attitudes but recognised the need to refocus on behavioural change. The development and management of the newly constituted See Me are excellent examples of partnership working between Government, the third sector and people with lived experience.

Commitment 5
Another success was the partial fulfilment of Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care in Scotland. The report was published in September 2015. It identified good practice and made recommendations to embed a human rights approach in the next Mental Health Strategy. However, publishing a report does not in itself fulfil Commitment 5: we need to see a genuine shift in mental health care in Scotland. There have undoubtedly been other successes. We have limited our comments both for brevity and because, due to the lack of reports or scrutiny of the strategy, it is very hard to know which commitments have been fulfilled.

7. Which parts of the previous mental health strategy have been the least successful?

11 Scottish Government Evaluation of ‘see me’ - the National Scottish Campaign Against the Stigma and Discrimination Associated with Mental Ill-Health 2009
12 MWC and SHRC Human rights in mental health care in Scotland A report on progress towards meeting commitment 5 of the mental health strategy for Scotland 2015
Commitments 11 and 13
Commitments 11 and 13 related to the 18-week waiting times target for CAMHS and psychological therapies respectively. Both targets were due by December 2014. However, the most recent statistics showed just five of the fourteen Health Boards have achieved the psychological therapies target\textsuperscript{13} and eight met the CAMHS target\textsuperscript{14}.

Commitment 36
Commitment 36 required arrangements to coordinate, monitor and performance manage progress on the strategy. This did not happen. While six Implementation and Monitoring groups\textsuperscript{15} were established, there has been no regular programme of reporting and no consistent publication of the implementation and monitoring group meeting minutes. Indeed, a recent response to a PQ about progress on the strategy confirmed that there were no plans to publish a final report and stated that updates could be found on a Scottish Government webpage\textsuperscript{16}. But at the time of writing, there were no updates whatsoever for 14 of the 36 commitments\textsuperscript{17}. Indeed, as part of our role chairing the Commitment 29 group, SAMH and our colleagues delivered a report to the Scottish Government making recommendations on improving employability for people with mental health problems. This report has never been published.

8. What would you identify as the key priorities for the next mental health strategy?

It is essential that an outcomes approach is adopted in the forthcoming 10 year Scottish mental health strategy. We need:

- A clear overall vision to transform Scotland’s mental health
- Supplementary rolling 3 or 4 year delivery plans
- Targets for each commitment, reported on annually
- A Steering Group, chaired by the Minister and including the key delivery partners, meeting at least three times a year

\textsuperscript{13} ISD, \textit{Psychological Therapies Waiting Times in Scotland}, June 2016
\textsuperscript{14} ISD, \textit{CAMHS Waiting Times in Scotland}, June 2016
\textsuperscript{15} See Scottish Government \textit{Mental Health Strategy} (web page):
Mental Health Delivery Team (Commitments 1, 14, 24, 26, 27, and 28 - 36);
Psychological Therapies(Commitment 13);
Child and Adolescent Mental Health Services(Commitments 7-12);
Primary Care and Common Mental Health Problems(Commitments 6, 15-22);
Rights, recovery, Families and Carers, Peer to Peer and Employability (Commitments 2-5 and 29); Community, Inpatient and Crisis Services (Commitments 23 and 25)

Question S5W-01497: Monica Lennon, Central Scotland, Scottish Labour, Date Lodged: 14/07/2016

Specifically, commitments 6, 7, 8, 9, 12, 14, 24, 26, 30, 31, 32, 33, 35 and 36.

An Advisory Group, including people with lived experience, families and carers and the third sector, meeting at least biannually

Earlier this year SAMH launched our Ask Once Get Help Fast manifesto, informed by over 700 people. We propose the overall vision: “Everyone who needs mental health support will be routed to an appropriate recovery-focused source of help at the first time of asking, within a clear timescale”.

We propose four key areas of focus:

Access to Support
We want a new mental health support service within GP surgeries, providing community based supports that build on current care and treatment models. This is much-needed, since one in three GP consultations relate to mental health, rising to one in two in deprived areas. We want an independent inquiry into the failure of Health Boards to meet waiting time targets for psychological therapies. Health Boards should then be supported towards an interim 12 week target, giving mental health treatments parity with treatment for other illnesses. It is notable that in England, 61% of people are seen within 28 days.

Employment
Mental ill health accounts for the highest cohort of people who are unable to work due to sickness; yet it has the poorest outcomes through the DWP’s contracted Work Programme. SAMH recommends redesigning employability support to include Individual Placement and Support principles. IPS has eight times the success rate of placing and retaining individuals with mental health problems in work.

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13 SAMH Ask Once Get Help Fast 2016
14 RCGP Scotland Policy Paper on Mental Health 2012
16 Mind, We’ve Got Work To Do, 2014, p29
17 40% of SAMH IPS participants achieve employment within 6-12 months of joining
Supporting people in crisis
SAMH recommends a Scottish Crisis Care Agreement to strengthen joint working between NHS, social care, emergency services and police, creating clear pathways for people in crisis or distress. We must end the revolving door between A&Es, GPS, Police Scotland and other statutory services.

Children and Young People
We want a review of CAMHS, extending support to people up to the age of 25 and to a much wider cohort. In education, a whole school approach is required, with mental health education a stronger part of the curriculum, and training and support for all professionals working with children and young people with self-harming behaviours and eating disorders.
Petition PE1611 Mental Health services in Scotland

Petitioner Angela Hamilton

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to improve access to mental health services in Scotland by—

1. Reducing the mental health waiting time target from 18 weeks to 14 weeks for adult therapies, and to 12 weeks for child and adolescent mental health services, and committing to ensuring 90% of patients begin treatment within these times;

2. Providing funding to ensure primary care staff receive additional training on supporting patients with mental health conditions; and

3. Providing funding for third sector organisations that deliver community based services, such as support groups, which can be accessed by patients whilst waiting for referral appointments.

Webpage PE1611 – Mental Health Services in Scotland

Purpose

1. At its meeting on the 27 October the Public Petitions Committee agreed to refer petition PE1611 to the Health and Sport Committee. The purpose of this paper is to provide some background information on the petition and the actions that have been taken to date.

2. In considering this petition the Committee will then decide on any further actions they may wish to take.

3. For convenience the original petition and SPICE paper for PE1611 are at Annexe 1 and 2. The petitioner’s submission to the Petitions Committee is attached at Annexe 3

Background on the petition

5. The petition was lodged on 27 July 2016 and first considered by the Petitions Committee on 27 October when, in view of the Committee’s short inquiry on mental health it agreed to refer the petition to the Health and Sport Committee to be considered as part of that work.
6. Members in the briefing prepared for the CAMHS evidence session on 8 November were referred to the petition and provided with links to the material the petitioner submitted. The subject matter the petition raises forms an integral part of the mental health inquiry.

Action

7. Members are invited to consider the petition, and the background material included, as part of the mental health inquiry and to indicate any further specific action they wish to take at this time in relation to the petition.

Clerk to the Committee
November 2016
Annex 1

PE01611: MENTAL HEALTH SERVICES IN SCOTLAND

<table>
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<tr>
<th>Petitioner</th>
<th>Angela Hamilton</th>
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<tr>
<td>Date lodged</td>
<td>27 July 2016</td>
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**Petition summary**

Calling on the Scottish Parliament to urge the Scottish Government to improve access to mental health services in Scotland by—

1. Reducing the mental health waiting time target from 18 weeks to 14 weeks for adult therapies, and to 12 weeks for child and adolescent mental health services, and committing to ensuring 90% of patients begin treatment within these times;

2. Providing funding to ensure primary care staff receive additional training on supporting patients with mental health conditions; and

3. Providing funding for third sector organisations that deliver community based services, such as support groups, which can be accessed by patients whilst waiting for referral appointments.

**Previous action**

I met with Jamie Hepburn on 7 March 2016 at his surgery in Cumbernauld where I handed him a copy of my proposal, which forms the foundation of this petition. I also gave him the results from the survey I put in place. At the end of the meeting, he stated he would have someone from his office forward me further information on upcoming changes to accessing mental health services, but sadly I never received this and this has given me a further reason to petition the Parliament.

During February 2016, I conducted an online survey which I then shared over my social media pages. 35 people responded to the survey, which covered areas such as:

- Whether respondents have spoken to their GP about a referral. If not, why not? If so, what happened next?
- Whether referral was denied and, if so, why?
- The length of time waited for an appointment post-referral.
- If counselling/therapy was received, and if it was felt to be adequate.
- Whether respondents were informed of any local support groups, and whether they feel there should be more such groups.
- What more respondents feel could be done to reduce waiting times/take strain off the NHS.

These results are based on low response rates, but I believe that they still have value. Results:

- ½ of those who approached their GP for a referral were referred.
- Worryingly, several of those who were refused referral were not
given a reason.

- Half of those who were referred had to wait 6 months or longer for an appointment. This is not acceptable: those who have been referred are obviously deemed serious enough cases for referral, and 6 months is a long time for mental health issues to impact on somebody's life with no treatment.
- Half of respondents say that they were not given the appropriate number of sessions. This number should be determined on a case-by-case basis.
- 60% were not told of any support groups nearby. This is despite the fact that the majority believe that being informed of local support groups while waiting for therapy would help.

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<th><strong>Background information</strong></th>
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<td>In the quarter ending September 2015, only four health boards met the Scottish Government’s LDP Standard performance target for psychological therapy treatment. Ten fell short of the mark. The health boards were asked to ensure that at least 90% of patients who needed psychological therapies started their treatment within an 18-week period. In the same quarter, 13,030 people started their treatment, which meant only 81.1% were seen across the whole of Scotland. This means many were left waiting for access to the support they so badly needed.</td>
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It is my understanding that in November 2015, the Government announced that it will make available a further £100 million of funding, which will help to improve mental health services over a five-year period. The suggested improvement programme will see the Government work with health boards to help support them to reach the 90% within 18 weeks target it initially set. With a significant rise in demand for both adult and child and adolescent therapies, 27% for CAMHS and 26.5% for psychological therapies, is it right to expect those in such a vulnerable state to wait so long? The 18 week maximum is still too long to wait for much needed help. I believe this should be reduced from 18 weeks to 14 weeks for adult therapies, and to 12 weeks for CAMHS. This may seem a drastic reduction but the people who approach their doctor for referral are, for the most part, in desperate need of help and expecting them to wait 18 weeks is unreasonable.

I also understand that there has been an increase in workforce levels but is the workforce capable of dealing with the rise in patients? I believe there are other programmes that can be introduced which will help take some of the burden off the NHS while still giving help to those who need it.

On 12 January 2016, First Minister Nicola Sturgeon said “Delivering the very best mental health services is a priority for this government”, with money being spent over a four year period, provided to NHS boards,
to:

• Improve capacity to see more people more quickly.
• Work with Healthcare Improvement Scotland to redesign local services to be more efficient, effective and sustainable.
• Improve workforce supply and train existing staff to deliver services for children and young people, as well as psychological therapies for all ages.

I fully agree with the first point: improve capacity to see more people more quickly. As I previously mentioned, I firmly believe the times should be reduced to 14 weeks for adult services and to 12 weeks for CAMHS. Expecting vulnerable people to wait longer is unacceptable.

Moving on to the second point, the introduction of more support groups in communities will go a long way to take some of the strain off the NHS but I do not believe that peer groups are the way forward. Giving more funding to existing centres and services, rather than slashing funding, is a way forward.

On 7 April 2016, I spent the day at FDAMH in Falkirk. I met with service users and the staff who provide the services to the community. During my visit, I met with the women’s group and took part in arm knitting. I understand this may not sound relevant to you but it gives these women somewhere to go, they can learn new skills and, most importantly, they have a support network that helps aid recovery. I also met with the staff who deliver the services and it was evident that the work they do is so vital to so many who cannot wait for counselling on the NHS. They also offer services for young people who don’t fall under CAMHS criteria or are between the age groups for CAMHS and the NHS adult services. They offer a variety of services such as befriending, third age befriending, counselling, social prescribing, family and carer counselling, health and wellbeing groups, and the one that should be rolled out across Scotland: the immediate help service. Every single one of these services provide a lifeline for the community.

GAMH had their funding slashed by 40% last year, which changed the service to a short term service of up to 6 months support. Many people need more than 6 months. What happens once they are discharged from the service? They offer 1-on-1 sessions, group activities, young carer’s project, carer’s project, later life project, and cover the whole of Glasgow. Six months access is not enough.

Penumbra offer services across Scotland and they offer mental health support to almost 1000 people every week. This is a large number. They receive funding from councils but with budgets being slashed across the country, that funding will be reduced too. They offer services such as Projects for young people, projects which work with people who self-harm, and Supported accommodation and supported living
services to name a few.

Taking on more staff and training existing staff to deal with people off all ages is a very important move. Does this include primary care staff? GPs are the main point of contact for referral and help in the first instance. However, they, at times, are failing to provide appropriate care.

Not only did I visit FDAMH and contact other services across the country during February 2016, I conducted an online survey, open to those across Scotland, asking them to share their experiences with their doctors, the information given to them about support available, how they feel things could be improved, and, most importantly, the time they waited to receive therapy.

Overall, I found:

- 80% of those who asked for referral received one.
- Out of the 20% who were refused referral, some were not given a reason.
- Half of those who were referred had to wait 6 months or longer.
- Half of the respondents say they were not given the appropriate number of sessions.
- 60% were not told of any support groups nearby, this is despite the fact that the majority believe that being informed of local support groups while waiting for therapy would help.

These findings have highlighted some issues within the health service. Why are only 80% receiving the referral they have asked for? Why not more? This is not acceptable: those who have been referred are obviously deemed serious enough cases for referral, and 6 months is a long time for mental health issues to impact on somebody’s life with no treatment. The people who have been refused a referral and given no reason are fully entitled to be told why.

With regards to the number of sessions a patient receives, what is this based on? I understand that not everyone will need extensive treatment but if the patient feels they are not ready to be discharged from therapy, shouldn’t they be offered further appointments?

A large number of patients have not been advised of available support groups even though they feel they could help whilst waiting for their appointment to come through. There should be more service centres, either attached to the NHS or through a third party organisation (mental health charity). As someone who has looked into starting a support group myself, I found very little information on how to start a group or how to apply for funding for a new group. Having people who have the same conditions to talk to can really help the patient to realise they are not alone and they have somewhere to go where they feel safe and will
not be judged.

One of the biggest issues found was the lack of support given by primary care staff and this is something I have experienced first-hand.

GPs need to be given additional training on how to handle and deal with patients with mental health conditions, be it anxiety or paranoid schizophrenia. Doctors see people living with these conditions every day and they should be treated with the same respect and urgency as those with conditions such as diabetes or asthma.

You may not be able to see mental health conditions and all the symptoms and emotional heartache they cause, but they are very real. Yes, there is a stigma surrounding mental health conditions that needs to be addressed but doctors do not seem to help this matter when they do not listen or refuse to refer patients. This needs to change before more people take their lives. Structural stigma needs to be stopped, and fast.

In conclusion, many changes need to be made to the system and how the people of Scotland can access the services they so badly need. Lowering the maximum waiting times, creating and funding more community based services for patients to attend whilst waiting for referral appointments, training primary care staff to a better standard, and reducing the stigma surrounding these conditions will help make Scotland’s mental health better.

<table>
<thead>
<tr>
<th>Comments to stimulate online discussion</th>
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<tr>
<td>One in four of us will experience mental health issues. That could be your husband, wife, daughter, son or even you. It could be anyone you know and love. Like me, you will only want the best support and treatment. What you won’t want is the long waiting time and lack of services available in your area.</td>
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<tr>
<td>In 2014, I had to wait 11 months to get the help I needed. That is far too long and I really hope the Scottish Government will take notice, take responsibility and implement much needed change.</td>
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<tr>
<td>We need better access to psychological services, shorter waiting times and an increase in community based services.</td>
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<tr>
<td>Please take two minutes to sign this petition</td>
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<tr>
<td>Thank you</td>
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<tr>
<td>Angela</td>
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Briefing for the Public Petitions Committee

Petition Number: PE01611

Main Petitioner: Angela Hamilton

Subject: Mental Health Services in Scotland

Calls on the Parliament to urge the Scottish Government to improve access to mental health services in Scotland by –

1. Reducing the mental health waiting time target from 18 to 14 weeks for adult therapies, and to 12 weeks for child and adolescent mental health services, and committing to ensuring 90% of patients begin treatment within these times;
2. Providing funding to ensure primary care staff receive additional training on supporting patients with mental health conditions;
3. Providing funding for third sector organisations that deliver community based services, such as support groups, which can be accessed by patients whilst waiting for referral appointments.

Background

Early intervention for people with mental health difficulties is considered important because people who receive treatment quickly are more likely to make a full recovery. Timely intervention may also minimise the impact of mental health problems on young people’s development and education.¹

Psychological Therapies Waiting Time Targets

A waiting time target measuring access to adult psychological therapies has been in place since April 2011. Psychological therapies are interventions that help people better understand their feelings, thoughts and behaviour. A wide range of therapies are available, including different forms of counselling, Cognitive Behaviour Therapy (CBT) and Psychotherapy. The type, intensity and duration of therapy offered is dependent on the needs of the individual. More information about types of psychological therapies is available from NHS Education for Scotland.

The waiting time target specifies that people should wait no more than 18 weeks between being referred for treatment and beginning therapy, and that this standard should be met for at least 90% of patients.

More information about this target, and quarterly reports, are available at ISD Scotland. The most recent information published shows that for the quarter

¹ Mental health promotion and mental illness prevention: The economic case, Department of Health, (2011).
ending June 2016, 12,779 people started treatment for psychological therapies and 81.2% of these were seen within 18 weeks. The trend of patients seen within 18 weeks has remained relatively stable over the last five quarters. The median waiting time for treatment was 8 weeks. There is significant variation between the performance of different health boards: in the last quarter only five health boards met this target.

*Child and Adolescent Mental Health Services (CAMHS) Waiting Time Targets*

A waiting time target to deliver faster treatment from CAMHS was established in April 2010. It specified that that by March 2013 people referred to CAMHS should wait no more than 26 weeks between referral and treatment, and that this standard should be met for at least 90% of patients. This target was reduced to 18 weeks from December 2014. CAMHS comprises a wide range of treatments and therapies, including treatment by psychiatrists; psychologists; psychotherapists; speech and language therapists. IDS Scotland reports on this waiting time target quarterly.

The most recent information published shows that, for the quarter ending June 2016, 4,642 children and young people started treatment and 77.6% were seen within 18 weeks. Whilst this is a decrease compared with the previous quarter (84.4%) there is a slight increase compared to the same period quarter ending June 2015 (76.7%). The median time waiting for treatment was 10 weeks. There is wide variation between the performance of different health boards. In the last quarter, 7 health boards met this target. NHS Borders (85.6%), NHS Fife (87.7%), NHS Forth Valley (28.0%), NHS Grampian (41.0%), NHS Lanarkshire (88.9%), NHS Lothian (57.4%) and NHS Shetland (22.7%) did not meet the standard.

*Mental health training for primary care staff*

A target was established to increase from 16% (2008) to 50% (by the end of 2010) the number of frontline staff in mental health and substance misuse services, primary care and A&E who are educated in using suicide assessment tools and/or suicide prevention training programmes. This target was met, with 52% of frontline staff in these services trained in suicide assessment/prevention.2

*Funding for third sector organisations*

The third sector, which includes charities, voluntary and other not-for-profit organisations, plays an important role in the provision of services, support and information for people with mental health conditions. Current arrangements between NHS services and third sector organisations vary considerably between different NHS boards and local authorities.

**Scottish Government Action**

*Mental Health Funding*

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In January 2016, the Scottish Government announced an additional £150 million in mental health funding to be invested over five years. The Scottish Government indicated that £15 million will be allocated to a Mental Health Innovation Fund, improving access to services and support in primary care and frontline settings. £24.7 million will be provided to NHS Boards to improve capacity to see more people more quickly. £4.8 million will be allocated to a Mental Health Access Support Programme, delivered by Healthcare Improvement Scotland. £24.6 million will go to workforce development.

Minister for Mental Health

In May 2016, Maureen Watt MSP was appointed as Minister for Mental Health. Responsibility for mental health was previously included in the role of the Minister for Sport, Health Improvement and Mental Health.

Forthcoming Mental Health Strategies

The Scottish Government is in the process of developing a new national mental health strategy, due to be published in late 2016. Consultation on the strategy was open between 29 July and 16 September 2016. The Scottish Government’s proposed priorities for the new strategy include:

- A focus on prevention and early intervention for infants, children and young people
- Introducing new models of supporting mental health in primary care
- Improving access to mental health services and making them more efficient, effective and safe – which is also part of early intervention.

In June 2016, the Scottish Government committed to developing a 10 year Child and Adolescent Wellbeing strategy, addressing both physical and mental health. A Suicide Prevention Strategy is due to be published in 2017.

Distress Brief Intervention Pilot Scheme

In July 2016, the Scottish Government announced a Distress Brief Intervention (DBI) pilot scheme. The DBI is “a short intervention for people in distress who do not need emergency medical treatment in settings like A&E departments or GP surgeries. Specially trained staff will help them to manage difficult emotions and problem situations early on, and prepare a ‘distress plan’ to prevent future crisis”. The pilot scheme will receive £4.2 million of the £150 million additional investment in mental health services.

Review of NHS Targets

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3 Mental Health Funding, Scottish Government (2016)
4 Mental Health in Scotland – a 10 year vision, Scottish Government (2016)
6 Early Intervention in Mental Health, Scottish Government (2016)
In June 2016, the Scottish Government announced that current NHS targets will be reviewed. A consultation will be led by an expert group over the summer of 2016, and proposals for future plans published during 2016-2017.

Scottish Parliament Action

The Health and Sport Committee will lead a short inquiry on mental health services in November 2016, focusing on CAMHS waiting time targets and the implementation of the previous mental health strategy. The Health and Sport Committee will also lead a short inquiry on NHS Targets, inviting the expert group on the review of targets to give oral evidence.

Access to mental health services has been raised in a number of Scottish Parliament debates, notably Taking Scotland Forward: Health on 7 June 2016.

Motion S5M-01356 focuses on CAMHS waiting times:

Motion S5M-01356, Dean Lockhart, Mid Scotland and Fife, Scottish Conservative and Unionist Party, Date Lodged: 09/09/2016

Worrying NHS Forth Valley CAMHS Waiting Times

That the Parliament notes with concern that, according to the recently published IDS report, Child and Adolescent Mental Health Services Waiting Times in NHSScotland, the percentage of young people starting their mental health treatment between April and June 2016 who were seen within 18 weeks in NHS Forth Valley remains worryingly low; regrets that the health board is one of the poorest performing on this measure, with only 26.5% of young people being seen within the Scottish Government’s target of 18 weeks; understands that young people in the region face the longest average median wait for mental health treatment in Scotland, at 24 weeks, and believes that it is unacceptable that the youngest and most vulnerable people in the NHS Forth Valley area must wait approximately six months for treatment.

Several Parliamentary Questions have addressed access to mental health services, including:

Question S5W-00429, Murdo Fraser, Mid Scotland and Fife, Scottish Conservative and Unionist Party, Date Lodged: 02/06/2016: To ask the Scottish Government what work the Minister for Mental Health will carry out regarding child and adolescent mental health waiting times.

Answered by Maureen Watt (16/06/2016): As part of the £54.1 million package of support announced by the First Minister in January 2016, £4.8 million will be awarded to Healthcare Improvement Scotland to establish a mental health access improvement support team. This

team will provide support to boards to improve access to psychological therapies for all ages, including for children and adolescents.

The improvement programme will be delivered by Healthcare Improvement Scotland, with support from NHS education for Scotland to enhance the supply and training of workforce (£24.6 million Scottish Government funding).

The Scottish Government has invested £16.3 million over a six year period to increase the number of psychologists working in specialist Child and Adolescent Mental Health Services (CAMHS) with a further £3.5 million committed in 2016.

Roseannah Murphy/ Lizzy Burgess
SPiCe
21 September 2016

SPiCe research specialists are not able to discuss the content of petition briefings with petitioners or other members of the public. However if you have any comments on any petition briefing you can email us at spice@parliament.scot

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i Completed whilst on work placement from the University of Strathclyde as part of an AHRC funded PhD internship.
PE1611/A: Petitioner submission

Opening Statement

A service user arrived at the immediate help service at a mental health association extremely anxious to the point he had to leave. The person who was helping him advised him it was fine and he could come back when he felt ready. He did so two weeks later. Having left home at the age of 16 after living with an abusive father, the service user was staying with a friend. Sanctioned by the job centre, having very little food and not registered with a GP as he had recently moved. His previous GP had told him he had been referred to psychiatry but an appointment never came and he could no longer chase this up, the mental health association stepped in and the service user started attending their young person’s counselling service. They also helped him register with a new GP and arranged a food parcel from the foodbank. Since then the service user has been in contact with Citizens Advice and was also referred on to an advocacy service to ensure he had support at his next benefit appointment. The service user also met with Y-People at the mental health association once a month for housing advice. The above is an example of the work a community based service carries out and just how valuable a centre like it can benefit so many in different ways. So why are so many Scottish communities left with limited or no services? The government claim they are investing an additional £150 million over the next 5 years into improving mental health services in Scotland but where is this money going?

Mental Health Strategy

Having read “Mental Health in Scotland – a 10 Year Vision” I have concerns that this additional funding is not being used in a sufficient way. I will explain my reasoning on a point by point basis in the order in which they appear on the report.

- **Focus on prevention and early intervention for infants, children and young people.**

The Scottish Government states that over the next year that a range of evidence based programmes targeted to promote good mental health and support key vulnerable populations, which will then be delivered by 2018/19 will be developed. Which group does the Scottish Government class as the most vulnerable? Mental health issues can and do affect many regardless of class and other social aspects. The Scottish Government are also hoping to see improvements between CAMHS and other children’s services. Yes, this would be a very beneficial outcome and one that would help many, however, having spoken to parents who have attempted to gain access to CAMHS via their GP, health visitor or social worker, getting a child help the help they need proves to be very difficult. I recently carried out a survey, shared via social media, asking people their experiences of gaining access to psychological services and what they would like to see implemented and one response stood out which I believe the Scottish Government should take note of. “The funding for CAMHS was stopped so I was having to travel 130 miles each way every two weeks for my son to see someone. Then they referred my son to a mental health worker who is so busy it took months to get an
appointment. My son won’t speak to her as he needs to build up a bond and can’t speak about problems as they arise, as the time between appointments is far too long.”

Why stop funding for such an important service? Children need specialised care; they should not be expected to see someone who “fits them in” whenever possible. It should be continuous care with the same support worker. The government should be giving part of this extra funding to CAMHS to ensure every child who needs the service will be seen. Waiting times for young people are also something that need fixing as soon as possible. With only 73% of children out of the 90% target set by the Scottish government starting treatment within 18 weeks’ is a sad statistic. Children should not be expected to wait up to 18 weeks, with some waiting longer. CAMHS waiting times need to be reviewed as a matter of urgency.

With that said, community based services would also benefit young people who are perhaps not in need of intense therapies and are of an age where they are not classed as adolescent but are still too young to receive therapy suited for adults. Care could be adapted to suit the individual. I spent the day at FDAMH back in April and was surprised to find that many young people attended the centre. They had been turned away by CAMHS and their GP’s had no real idea how to help them.

- **Introduce new models of supporting mental health in primary care.**

By 2019-20, the Scottish Government hope to have delivered a programme of work on improving access to mental health services and address waiting times. Is this not something that, again, should be addressed now rather than 3 years down the line? In fact, this should not even be an issue at all. What happens between now and then when the targets are not met and people are being failed by the healthcare system? With regards to rolling out online cognitive behavioural therapy nationwide, I agree it will help some people but surely talking therapies such as counselling will also be needed so the person can talk about their problems and get to the root cause? Both would work to compliment the other. Expecting someone to go online every single week without some sort of guidance and support when they are in a depressed state or highly anxious is not reasonable. Used alongside face to face counselling where their online activity could be followed up then yes it would be very beneficial but only where appropriate and would need to be reviewed on a case by case basis.

- **Realise the human rights of people with mental health problems.**

As someone who lost a job that I loved in 2006 after being told that I was not fit enough to carry out my duties and was no longer suited to the company after returning to work with the support of my GP and CPN, I fully agree that more needs to be done by employers to support staff with mental health conditions. That said, this is something that employers should have been doing for many years. More training for key employees for example should be introduced, mental health first aid training should be mandatory in all work places and educational sessions for all staff should be introduced to help reduce stigma and to ensure those with the conditions feel fully supported and welcome.

**Community Based Services and The Benefits**

14
Over the last few months, I have spoken to many people face to face and on social media to ask what they would like to see in their communities and what improvements they would like to see with regards to accessing psychological services. Many did not know of any local services other than their GP or large charities such as SAMH or See Me Scotland but they do believe that more community based services would a massive benefit to them and so many others.

As I previously mentioned, I visited Falkirk’s mental health association after being invited along by the general manager. She had heard about my petition and wanted me to see what happened daily at their centre. I was amazed at what I heard when I arrived. They offer immediate help where people can be sent by their GP or walk in off the street and ask for help if they are in crisis. They wait a matter of minutes before being seen by a trained and qualified member of staff. They also offer: counselling, befriending, third age befriending, mental health and wellbeing drop in, social prescribing, arts and activities and a welfare benefits officer.

In the period 1st April 2015 – 31st March 2016, over 2,200 people were seen at the centre. With 25 staff and 103 volunteers this is an incredible achievement. I was also amazed to find out the centre needs £600,000 to operate. This is the equivalent of 4 salaried psychiatrists working in the NHS. Surely money from the additional funding should be going into maintaining and starting services like this across Scotland. The first two years of operation would cost £500,000. During my research, I also found that the Glasgow mental health association had a 40% budget cut meaning they had to reduce the services they offered and that the users only had access for 6 months. How is this acceptable?

Cumbernauld in North Lanarkshire has no local service other than Elament which is an online self-help website. With a population of 51,610 and with mental health affecting 1 in 4, going with that statistic, 12,903 people from that community have nowhere to go where they can access decent services that will help their recovery. With a town of that size, the government should be looking to give those people a service of their own. How many other towns do not have a local service? What will it take for the Scottish Government to take notice and do something about this? £600,000 a year is nothing to run an incredibly vital lifeline for a community. Not only that but with so many people visiting a centre like FDAMH, where GP's send their patients to, they also refer people to NHS based services such as Psychiatry. Community based services and the NHS work in unison, supporting each other.

Would it be possible to operate a pilot scheme based on the FDAMH model in Cumbernauld? Let it run for a year, get GP’s involved as that will also help unload the burden they carry and will give them somewhere to send their patients too rather than sitting them on a waiting list in the hope someone will help them soon. I firmly believe this would be a successful service in a town where it is needed badly.

The NHS and Mental Health
Very recently, a local woman contacted me asking me to share her story with you. She presented at a hospital in a depressed and anxious state asking to
be admitted for help due to suicidal thoughts. Whilst on the ward, she did not see anyone for the first 3 days, left in a room alone. Once there a little longer, she noticed a shortage of staff and one staff member admitted they were 8 staff members short. She had to help look after the older ladies on her ward, helping them to change, making sure they had a cup of tea and inviting them to her room for movie nights as they had no other stimulation from the staff at all. After complaining she was moved to another hospital which had more staff, but during the weeks she had been in hospital, she received only 2 counselling sessions. She was given a weekend pass so she could be at home with her family. When she returned on the Monday, she waited hours for the doctor who was due to see her only for him to not turn up at all. She was then given a pass for one night and returned the next day. A nurse on the ward believed she still needed help and should not be discharged. The doctor believed she should be and guaranteed that a CPN would visit her at home within a week, 2 weeks later she was still waiting and called to find out what had happened to be told her CPN was on holiday and there was no-one to cover.

I understand from various reports by the government that money is given to the NHS to increase staff numbers which in turn improves the quality of patient care. If that is the case, why then is a mental health ward short of 8 staff members leaving patients there for support and care looking after others?

GP’s are dealing with numerous people presenting with mental health conditions daily yet they can only do so much. They refer them to psychological services and they may, given it is the beneficial thing to do, prescribe antidepressants or beta-blockers. Money should go into placing mental health workers into GP surgeries to give extra support to both the patient and the GP.

Accident and emergency department staff are dealing with many patients who have arrived at the department in crisis as they feel they have nowhere else to turn and believe they will receive the help they so badly need. A&E staff can only do so much and again they need to call on someone from the mental health team to come and give an evaluation which most the time sees the patient being told to make an appointment with the GP. It then becomes a vicious circle.

This is where, yet again, community based services would be of massive benefit. Those people would have somewhere to go, they would feel supported and valued.

**Closing Statement**

I firmly believe more can be done to improve mental health services across Scotland. Creating new and supporting established community based services is one of many ways to improve access to psychological services. GP’s and Accident and Emergency staff need more support and guidance when dealing with patients presenting with mental health conditions. Employers need to be more understanding and supportive, given the correct training to carry that forward to support not only staff with conditions but to improve staff wellbeing meaning less sick days and more importantly encouraging those with mental health conditions back into the work place without fear of discrimination. Children and adolescents being treated in the
correct way and given quicker access to psychological services with improvements to accessing CAMHS. I ask the Scottish Government to make these changes and to revise the way the funding is distributed.