Mental Health

Health and Social Care Alliance Scotland (the ALLIANCE)

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 2015¹, and our various projects, programmes and research².

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.”

¹ http://www.legislation.gov.uk/asp/2015/9/contents/enacted
² http://www.alliance-scotland.org.uk/what-we-do/our-work/
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:

[^3]: http://www.syp.org.uk/our_generation_s_epidemic
- 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
- 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. 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). 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, 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.

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

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.

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\(^8\) [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)

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

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

\(^{14}\text{https://www.mentalhealth.org.uk/sites/default/files/Commitment%20One%20Report%2C%20January%202016.pdf}\)

\(^{15}\text{http://www.mwcscot.org.uk/media/240757/human_rights_in_mental_health_care_in_scotland.pdf}\)
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.