PE1716/C
SAMH submission of 7 May 2019

About SAMH

Around since 1923, SAMH currently operates over 60 services in communities across Scotland providing mental health social care support, primary care, addictions and employment services, among others. These services together with our national programme work in See Me, respectme, suicide prevention, sport and physical activity, inform our public affairs work to influence positive social change.

Introduction

We would like to thank the Committee for inviting SAMH to respond to this petition, which asks the Scottish Government to undertake a full review of mental health services. We would also like to extend our condolences to Karen McKeown and Gillian Murray and thank them for sharing their experience and that of their loved ones who died by suicide, Luke Henderson and David Ramsay.

Every day, around two people in Scotland die by suicide. That is why in 2012 we launched our Two Too Many campaign, which focussed on suicide and the devastating impact it has. We continue to campaign on suicide prevention today and, as an organisation, SAMH has significant experience in delivering existing suicide prevention training including ASIST and safeTALK. Since 2014, SAMH staff have undertaken at least 500 ASIST interventions, both with members of the public and people using our services. We also provide useful resources both for people experiencing suicidal thoughts and for families, friends and carers. These resources can be found at www.samh.org.uk/about-mental-health/samh-publications.

SAMH welcomed Scotland's Suicide Prevention Action Plan, which was published by the Scottish Government in August last year. We believe that it is important to be ambitious in our aims for suicide prevention, which is why we campaigned for a new target in the reduction of suicides, to build on the 17% reduction between 2002 and 2016. As such, we commend the Scottish Government for committing to a national target to further reduce suicides by 20% by 2022. We are also pleased to be part of the new National Leadership Group. These actions show ambition and commitment to making suicide prevention a national priority, which is essential.

NHS Signposting

We cannot say with certainty whether this is the situation across Scotland, though our experience as a social care provider is that many of our services do receive referrals from the NHS. We suggest the situation is likely to vary between NHS Boards. Most people who receive support from a SAMH service will have had contact with the NHS, whether through primary or specialist care. The referral routes for our services differ, ranging from drop-in and self-referral, to referral through a Community Mental Health Team or a local authority Care Manager.

While it is the case that people are referred to the third sector for support, we know from our own research that General Practitioners (GPs) would like to receive more information about local services, including information on social prescribing opportunities.[1] The Royal College of GPs in Scotland supports social prescribing, which is defined by NHS Health Scotland as 'a range of approaches to linking people to non-medical sources of support'.[2]

The SIGN guidelines on non-pharmaceutical treatment for depression recommend CBT, talking therapies, structural exercise and other treatments.[3] In a survey, SAMH found that 29% of GPs did not know about the SIGN guidelines and 17.8% were not sure if they knew about it.[4] It is clear that practitioners, particularly those in primary care, require more information on non-pharmaceutical support and treatment options, which are often accessed via the third sector.

One way in which to achieve this is through 'Link Worker' programmes. SAMH has experience delivering Link Worker programmes across Scotland, which seek to link people to support within the community. Currently SAMH has 20 full time equivalent Link Practitioners within 30 GP practices across Aberdeen. This service draws on SAMH's expertise; providing a customised approach to each GP Practice with each link worker having an area of focus, such as education or older people's services.

Risk Assessments

NICE guidance clearly states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm.[5] It is unclear if this guidance is being followed in Scotland. Where suicide risk assessment has taken place, research has shown that there is little consistency in the length, content or use of risk tools and that most tools consist of checklists that seek to predict future behaviour. [6]

While some clinicians report that assessment tools can be a helpful adjunct to management, there are concerns around lack of training in risk assessment processes and risk management, as well as practical issues around user friendliness and accessibility of information.[7] Indeed, one study found that the quality of risk assessment and management was considered by clinicians to be unsatisfactory in 36% of cases.[8] Furthermore, the National Confidential Inquiry into Suicide and

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[1] SAMH, Know Where to Go: a SAMH survey of General Practitioners in Scotland, March 2014
[2] NHS Health Scotland, Social prescribing for mental health: guidance paper, April 2016
[3] SIGN, Non-pharmaceutical management of depression in adults, January 2010
[4] SAMH, Know Where to Go: a SAMH survey of General Practitioners in Scotland, March 2014
[5] NICE, Self-harm in over 8s: long-term management, November 2011
[6] National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), The assessment of clinical risk in mental health services, Manchester: University of Manchester, 2018
[7] NCISH, The assessment of clinical risk in mental health services, Manchester: University of Manchester, 2018
[8] Rahman MS, Gupta S, While D, Windfuhr K, Shaw J, Kapur N, Appleby L., Quality of risk assessment prior to suicide and homicide: A pilot study, Manchester: University of Manchester, 2013

Safety in Mental Health (NCISH) found evidence of a 'low risk paradox', whereby the majority of people who took their life by suicide were judged as low risk at the final service contact.[9]

It is clear from the evidence that it can be extremely difficult to robustly predict someone's risk of suicide. Therefore, SAMH suggests giving more emphasis to the views of the person themselves and their families when they make contact with a service. People who ask for help should receive it.

Crisis Support

We want to see crisis support expanded. SAMH welcomed the inclusion of a Scottish Crisis Care Agreement in the Scottish Government's Suicide Prevention Action Plan,[10] which we had called for as part of our 2016 Scottish Parliamentary election manifesto. This will bring together statutory and non-statutory bodies, including the emergency service and third sector mental health providers, to agree a common set of standards and referral pathways for crisis support and local action plans.

In addition to a national Crisis Care Agreement, SAMH would like to see the national roll out of Community Triage. Community triage provides police officers with direct access to mental health professionals to support decision making and reduce inappropriate detentions of people in psychiatric distress or crisis. It has been successfully piloted in NHS Greater Glasgow and Clyde and the Lothians.[11]

It also important to consider self-harm which, while distinct from suicide as a coping strategy, is a clear risk factor for suicide. Most people who self-harm will not attempt suicide, but people who have self-harmed are 100 times more likely to take their own life within a year.[12] We welcome the ongoing piloting and development of the Distress Brief Intervention programme (DBI). We believe the DBI approach, once scaled up nationally, will create clear pathways for timely support for people in crisis and distress, including associated with self-harm.

Further responses to self-harm need to be developed. SAMH would like to see mandatory training in responding to self-harm for all frontline NHS staff; information and training for parents and key professional groups about self-harm; and access to the full range of psychological therapies listed as effective for management of self-harm in the Scottish Government's Psychological Therapy Matrix.

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[9] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Making Mental Health Care Safer: Annual Report and 20-year review, Manchester: University of Manchester, 2016

[10] Scottish Government, Every Life Matters, August 2018

[11] Police Scotland & NHS Greater Glasgow and Clyde, Community Triage – NHS Greater Glasgow and Clyde Crisis Out of Hours CPN (Community Psychiatric Nurse) Service Pilot Evaluation Report, 2015

[12] Scottish Government Responding to Self-Harm in Scotland Final report 2011 [citing Self-Harm Scope Final version 3, NICE 2002]

Fatal Accident Inquiries

SAMH welcomes the commitment in the Suicide Prevention Action Plan to review every death by suicide, [13] as well as the commitments to develop an appropriate assessment for reviewing the deaths of patients who were treated under the Mental Health Act and those in hospital on a voluntary basis.[14] SAMH was part of the group that reviewed the arrangements for investigating the deaths of patients being treated for a mental disorder and, as such, we look forward to the implementation of the recommendations and assisting where we can.

We also welcome the decision to immediately reintroduce Healthcare Improvement Scotland's suicide notification requirement and scrutiny of NHS boards' suicide reviews.[15] This is crucial in the promotion of shared learning and the reduction of suicides across Scotland.

While we believe that all deaths by suicide should be subject to a review, SAMH does not believe that a Fatal Accident Inquiry (FAI) is proportionate in all cases where someone has died by suicide and had contact with a mental health service within the last three months. As a judicial process, FAIs can be complex and time consuming, and could therefore add to the distress of many bereaved relatives. However, we do need to ensure that all suicides are reviewed and that these reviews are robust, gathering evidence from all relevant agencies, as well as families, friends and carers.

[13] Scottish Government, Every Life Matters, August 2018

[14] Scottish Government, Review of the arrangements for investigating the deaths of patients being treated for mental disorder, December 2018

[15] Scottish Government, Review of the arrangements for investigating the deaths of patients being treated for mental disorder, December 2018