PE1716/G
Minister for Mental Health submissions of 9 May 2019

I am writing in response to the matters raised in relation to public petition PE01716. This follows a recent evidence gathering session with Ms Karen McKeown, and with written evidence from Ms Gillian Murray, on Thursday 4 April 2019. I would like to reiterate my deepest sympathies for Ms McKeown and Ms Murray and their families following their sad loss.

You have asked me to respond on a number of the matters raised during the evidence session, and I provide this below.

Policies within the NHS about signposting patients to third sector organisations.

- Working to improve mental health care in Scotland is not just the preserve of the NHS or the health portfolio, it requires a collaborative and cross-sector approach. The Scottish Government recognises and welcomes the contribution that third sector organisations can bring, to support the people of Scotland and complement the ongoing work within our public sector. Many third sector organisations across Scotland provide vital support in collaboration with our frontline public services.

  It is a matter for local NHS Boards to decide how they engage with third sector organisations to ensure that they meet the needs of people in need of support. Individual NHS Boards will have agreements locally with the organisations that they are working with and these will differ from board to board, depending on local requirements. The legislative framework for Integrated Joint Boards sets out the planning arrangements for the development and delivery of services to support mental health in each locality. This must include engagement with people with lived experience, carers and other local stakeholders, including the NHS.

The use of risk assessments, which the petitioners state are inadequate and not fit for purpose as they are missing key aspects.

- Risk is inherent in every clinical decision and evidence shows that no risk assessment tool or process can ever be 100% accurate. Decisions around risk are a part of clinical practice and should always be made by the clinician in collaboration with the patient. In very specialist situations, risk does require lengthy and detailed assessment by trained specialists. Evidence shows that no one particular risk assessment tool is more effective than another, and so the Scottish Government does not mandate which assessment tools should be used in the assessment of patients who present to A&E. The Mental Welfare Commission for Scotland and the Royal College of Psychiatrists are clear that this is ultimately a clinical decision that lies with healthcare professionals, who should be undertaking an ongoing dynamic assessment of the patient. The Royal College of Psychiatrists publishes best practice information on risk that guides clinicians in their practice.

Crisis support services out of hours as there are concerns about gaps and consistency in the service.

- Scottish Government funds ‘Breathing Space’, a free, confidential telephone service for anyone in Scotland experiencing low mood, depression or anxiety. This service is delivered in partnership with the third sector and NHS 24. Breathing Space is an

alternative and easily accessible 'first stop' service, which provides assistance at an early stage in order to stop problems escalating, as well as direction for those who do not know where to seek help.

- NHS 24's 111 service provides a Scotland-wide phone triage service for people or carers seeking urgent health advice out of hours. Our 2018/19 Programme for Government committed to enhancing the handling of mental health calls to the 111 service with more specially-trained staff providing specialist mental health advice, and improved routing of mental health calls. Work is already underway, with the building of a mental health 'hub' model within the 111 service to route people to the appropriate person with the right skills.

- If an individual presents in crisis to A&E they will be seen and assessed, and be signposted to the method of treatment that is most appropriate for them. Work is currently underway to understand any variation across the country.

For Fatal Accident Inquiries to take place to identify failures within mental health services which have led to death by suicide.

- The Suicide Prevention Action Plan was published in 2018, and Action 10 of this plan confirms that the Scottish Government will work with the National Suicide Prevention Leadership Group (NSPLG) and partners to develop appropriate reviews into all deaths by suicide. A sub-group of key stakeholders has already been established to consider how this action should be implemented in full.

- Work has already taken place to support this action. Section 37 of the Mental Health (Scotland) Act 2015 requires that Scottish Ministers carry out a review of the arrangements for investigating deaths of people being treated for mental disorder. The report of the review was published and laid before the Scottish Parliament in December 2018. The report contains a total of 10 actions which will improve the way in which these deaths are reviewed, ensuring that families and carers are involved in a meaningful way, and that learning from such reviews is disseminated and used to inform relevant improvement work.

- One of the main actions arising from the review is that the Mental Welfare Commission for Scotland will develop a system for investigating all deaths (including suicide) of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended). The new system will include appropriate elements of public scrutiny and will involve staff, families and carers. It will also have clear timescales for investigation, reporting and publication.

- A further action in the December 2018 report is that the Scottish Government will begin an options appraisal in conjunction with partner organisations, to determine an appropriate process of review for the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder. This will link with the work of the NSPLG on suicide reviews.

Review of Mental Health Legislation

- I have recently announced an independent review of the Mental Health Act which will link closely to existing work considering the Adults with Incapacity legislation. The primary

focus of this review is to provide support and protect the rights of people who require care and treatment when they are unwell due to mental ill health, and to remove barriers for those caring for their health and welfare. This represents the most significant review of mental health legislation in recent years.

I also wanted to take the opportunity to respond to other matters raised during the evidence session:

A new Strategic Delivery Board has been established as a strategic forum for reviewing progress towards delivering the Mental Health Strategy. This Board includes representatives of those delivering services, as well as key voices from the third sector and representative bodies and representation of those with lived experience of mental ill health. The Board will be a driver to enable improvements in mental health services across Scotland, ensuring the actions to meet our collective vision are met and inform how that vision is delivered in future. The terms of reference for this board will be published by the end of June 2019 and I will share them with the committee when they are finalised.

The committee will be aware that here is currently an ongoing Independent Inquiry into Mental Health services in Tayside. This is to inquire into the accessibility, safety, quality and standards of care provided by all Mental Health services in Tayside. The Scottish Government is keen to hear the findings of this Inquiry and will ensure that the lessons learned are shared widely across Scotland and help to shape other services to deliver the best quality of care to all who need it. The report by the Health and Social Care Alliance, which was commissioned by this Inquiry, is a good example of taking an inclusive approach with people who have lived experience of using services. This evidence will shape part of the final recommendations from the Inquiry.

There are well documented links between problematic drug and alcohol use and poor mental health. We have stated our commitment to deliver the recommendations of the Lead Psychologists Addiction in Substance Misuse Services in Scotland (LPASS) Report published on 4 June 2018. The report provides national best practice guidance for the Delivery of Psychological Interventions in substance misuse services for both practitioners and IJBs. The Scottish Government will support ADPs and IJBs to use the evidence and learning from the LPASS report to evaluate current psychological interventions and support.

Let me finally assure the Committee that mental health is a priority for this government. You will already be aware of the extensive work being undertaken by the Scottish Government to help improve the lives of people experiencing poor mental health. We are investing significantly into services across Scotland to develop the provision of mental health support, and will continue to do so. This is in the form of an additional £150 million over five years (2017-22) to deliver our mental health improvement and delivery agenda.

I am determined that all mental health services across Scotland should be available to those who need them, when they need them, and be delivered to the highest standards.