for Scotland's mental health

Introduction

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

Thank you for the opportunity to submit evidence to this inquiry. Our response focuses specifically on mental health services within the NHS. To inform our response we surveyed 319 people who have used NHS mental health services in the last year. Respondents had used a range of different NHS mental health services and we received at least one response from all but two territorial health boards. Throughout this response we have included direct testimony from respondents.

Summary

- **Eighty-three per cent were confident they would be treated in a safe environment**
- **Sixty per cent were confident they would receive a high quality of care**
- **Almost half had received care of an unacceptable quality**
- **Seventy-six per cent said staff were courteous and sensitive**
- **Over half felt valued as an individual**
- **Almost two-fifths were not as involved in agreeing their care as they wanted to be**
- **Almost forty per cent had been treated disrespectfully**
- **Sixty per cent felt they were not offered the most appropriate care at the right time during the last year**
- **Almost eighty per cent had never been asked what NHS mental health services they would like in their area**
- **Almost eighty per cent did not know about systems in place to detect and deal with unacceptable care**

Are services safe, effective, and evidence-based?

Eighty-three per cent of respondents were confident they would be treated in a safe environment. This is encouraging, but leaves 17% who were not. We support the valuable work being done in the mental health workstream of the Scottish Patient Safety Programme (SPSP). We would like to see a continued and indeed expanded focus on safety, to address the fears of those who do not currently feel safe in NHS mental health service environments.

> ***"I once lost a significant amount of blood and had spent hours in A&E- I also hadn't eaten in days. On return to the ward I passed out on the floor and the nursing assistant told me to 'get up off the ground' by myself. I couldn't move without the dizziness overwhelming me and the nursing assistant refused to help. I ended up on***

the floor for half an hour, crying, before she took my blood pressure and realised there was actually a physical reason I couldn't move."

- Treatment and support options for mental health

Medication can be vital in facilitating a person's recovery from mental health problems. We would like to stress that we are entirely supportive of the use of medication to support recovery, where it is in line with both clinical guidance and the person's own wishes. However, medication is not always prescribed in accordance with guidance. Official guidance suggests people with mild to moderate depression should initially be offered therapy, self-help or physical activity.[1],[2] In 2012 SAMH surveyed over 400 GPs and found almost half were not aware of, or not sure if they were aware of, these guidelines.[3] In our survey, 60% of respondents did not feel that they were offered the most appropriate support at the right time. Some commented on the lack of treatment options.

"GP was helpful in prescribing medication. However that's all which was discussed"

"While dealing with my GP and enquiring about alternative forms of treatment other than medication for depression, I was offered a phone number to contact and that was it. No further assistance was offered, no available treatment options discussed."
"I requested mental health support from my GP for 17 years and got nowhere, was simply offered antidepressants."

One issue raised was a lack of after-care. Some people talked of feeling 'left to deal with' their mental health problems after an initial consultation. SAMH wants to see a system of prescription reviews at least every 2-4 weeks for the first three months after a prescription, followed by a review at six months after remission and then at least annually, to ensure people are always receiving the most appropriate care and support.

"Just the fact I had never been offered specialist mental health support. I had been to my GP about serious depression (suicidal tendencies) and felt like once I was put on antidepressants that was me left to deal with it. I am in a much better place now but would benefit now from counselling or some form of therapy, but this is never offered out."

"Shown the revolving door on many occasions. Appropriate follow on care was not put in place, nor was medication properly reviewed. It was only after being referred to the peri natal mental health service during my pregnancy I feel I have been properly cared for. The team there helped me access a wonderful psychiatrist and had my medication reviewed and changed as well as arranging psychotherapy that I should probably have been sent to years ago"

[1] NICE, Depression in Adults: the treatment and management of depression in adults, 2009
[2] SIGN, guidance on non-pharmaceutical management of depression, 2010
[3] SAMH, A SAMH Survey of General Practitioners in Scotland, March 2014

Official guidance says people should be actively involved in prescribing decisions.[4] But almost two-fifths of respondents weren't as involved in agreeing their care as they wanted to be. Respondents told us about they were often not consulted about changes to their medication and also when did try to intervene in the decisions about what kind of medication they were dismissed.

> ***"After several months on citalopram the Dr chose to change my prescription to fluoxetine despite me telling her I was unable to swallow tablets, resulting in me being off medication for several weeks until I could make another appointment to go back to the GP and change to sertraline"***
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> ***"Because I am only 18 I feel like a lot of times my experiences were underrated by professionals. For example, I asked for a certain type of medication for anxiety that would affect me psychologically rather than my physical symptoms as I knew this would be best, but the doctor disagreed and put me on the one for physical symptoms which has not helped half as much"***
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> ***"When I expressed that I felt I needed more input from mental health services during a particularly difficult time I felt I wasn't taken seriously by the psychiatrist I saw. I had to really insist on a referral and even then I left not sure if she was going to do what I requested."***

- Waiting times

The length of time someone has to wait to start treatment for their mental health can have a direct impact on the treatment's effectiveness. The latest statistics show only ten health boards met the 18 week CAMHS target and only three met the target for psychological therapies.[5],[6] This compares with provision in England, where 61% of people requiring psychological therapies are seen within 28 days.[7]

SAMH has been calling for an Ask Once Get Help Fast approach to mental health and we were pleased to see the Scottish Government commit to making this happen in the new Mental Health Strategy. However, there is much to be done to make this approach a reality. We believe the 18 week targets for CAMHS and psychological therapies are too long and should be brought into line with the 12 week treatment time guarantee for physical illness.

Psychological therapies are sometimes time-limited. We believe the length of treatment should be based on evidence of effectiveness and not resource rationing. Our previous research has found that that those who felt they had received the right amount of therapy were far more likely to think that therapy had been effective in helping them.[8]

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[4] General Medical Council, Good Practice in Prescribing and Managing Medicines and Devices, 2013
[5] ISD, Child and Adolescent Mental Health Services Waiting Times in NHSScotland, June 2017
[6] ISD, Psychological Therapies Waiting Times in NHS Scotland, June 2017
[7] HSCIC, Psychological Therapies: Annual Report England, 2013/14
[8] SAMH, Talking it Out: Psychological Therapies in Scotland, 2016

As part of the overall review of targets in the NHS system, we would like to see a new system of condition specific standards in mental health, each of which would be based on the following framework:

- A clinically informed maximum waiting time .
- For access to NICE or SIGN concordant care.
- With routine measurement of outcomes.

Our survey respondents gave examples of worrying cases. For example, one respondent said that despite an attempt to end their life they faced a wait of four months to get an appointment with their Community Mental Health team. Another told us they had to wait eighteen months to see a professional and during this time their mental health worsened.

> ***"There is no facility to receive out of hours care unless you pay privately. I was told in numerous occasions that I would have to do this."***

Are patient and service users' perspectives taken into account in the planning and delivery of services?
Almost eighty per cent of respondents had not been asked which NHS mental health services they would like to see in their local area.

"There is no treatment for my diagnosis available in my area. I have been diagnosed with borderline personality disorder."

Do services treat people with dignity and respect?
Over half of respondents felt valued as an individual, when using NHS mental health services. However, almost forty per cent had been treated disrespectfully while using an NHS mental health service.

"Me as an intelligent person ceases to exist in the eyes of NHS Mental Health professionals and I am treated as a bunch of troublesome symptoms. And when I try to raise valid concerns about my treatment, they are not taken on board as valid, and the response is very much 'oh you're only saying that because you have X diagnosis, and you're wrong whereas I as the professional am right.' The power disparity between patient and professional is too great and very unhelpful."

This highlights the stigma and discrimination that many respondents have faced. Mental health problems can affect anyone and should be treated in parity with physical illness. We need sustained action to ensure people's rights are upheld.

Are staff and the public confident about the safety and quality of NHS services?
Sixty per cent of respondents were confident they would receive a high quality of care. It's notable that this is lower than the percentage who were confident they would be treated in a safe environment. Almost half of respondents had received care of an unacceptable quality. This suggests a need for a strong focus on quality and perhaps on learning lessons from the Scottish Patient Safety Programme which can be applied to quality improvement.

Do quality of care, effectiveness and efficiency drive decision making in the NHS?
We heard from our survey respondents that decisions were sometimes made which did not appear driven by the principle of high quality care.

"No access given to a psychiatrist unless I said I was suicidal."

"I was told CPNs [Community Psychiatric Nurses] are very short staffed and only for suicide victims."

"Saw a GP about mental health issue recently (she was fantastic), proactive, listened to me and was supportive. My referral to mental health services was rejected as the authority is only taking severe and acute referrals. My GP was told to treat me in primary care but their mental health care is over capacity so they can't take referrals. The lists should be opening again in a few weeks, but it's quite a lonely, frustrating and anxious position to be in after making the huge step of talking about mental health issues for the first time."

Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?
Almost eighty per cent did not know about systems in place to detect and deal with unacceptable care. We would like to see a sustained focus on making people aware of their rights within NHS mental health services, particularly the right to advocacy held by everyone with a mental health problem in Scotland.

'I was in psychosis and hadn't eaten in 5 days because I thought that food was poisoning me. CPN refused to admit me to the ward and told my mum "I've seen her, she'll be alright if she doesn't eat for a few days". I'm about 3 stone overweight which is what I assume this was in reference to. A few months later I attempted to report this at which time the CPN denied it and told me it didn't happen and I was confused because of my psychosis, and my mum heard it wrong because she was emotional. I wasn't, and she didn't.'

We heard from a number of people who felt unable to complain for fear that they would not be believed and their experiences dismissed. We need safeguards to make sure that when people with mental health problems experience an unacceptable quality of care they feel able to talk about their experiences in an inclusive environment where they will be taken seriously. The systems for reporting and dealing with an unacceptable quality of care must be designed for people with mental as well as physical health problems. This requires an understanding of the nature of the situation someone with mental health problems may face when seeking to complain.

Conclusion
This is a necessarily brief summary of the issues raised. We would be pleased to expand further on these issues if the Committee would find this helpful.

Carolyn Lochhead, Public Affairs Manager
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Appendix One: Breakdown of Survey Results

NHS Board	N	%
Ayrshire & Arran	15	4.7
Borders	8	2.51
Dumfries & Galloway	14	4.39
Fife	23	7.21
Forth Valley	15	4.70
Grampian	44	13.79
Greater Glasgow and Clyde	59	18.50
Highland	18	5.64
Lanarkshire	38	11.91
Lothian	63	19.75
Orkney	1	0.31
Shetland	1	0.31
Tayside	17	5.33

Mental health service used	N	%
Community Mental Health Team	164	57.34
Psychological therapies	99	34.62
Community Psychiatric Nurse	89	31.12
Outpatient care	81	28.32
Inpatient care	41	14.34
Child and Adolescent Mental health services	36	12.59
Don't' know	15	5.24
Prefer not to say	3	1.05
Western Isles	3	0.94

Gender	N	%
Female	233	73.27
Male	77	24.21
Non-binary	3	0.94
Prefer not to say	3	0.94
Prefer to self-describe	2	0.63

Age	N	%
16-24	76	23.97
25-34	98	30.91
35-44	67	21.14
45-54	48	15.14
55-64	20	6.31
65+	8	2.52