PE1716/F
Health and Social Care Alliance Scotland (the ALLIANCE) submission of 8 May 2019

Thank you for your email dated 5 April 2019 requesting our views on petition PE1716 which proposes a full review of mental health service provision across the NHS in Scotland. The ALLIANCE believes that any activity to review mental health services should reference work going on by the Scottish Government and partners to take an equalities and human rights based approach, as is central to the Mental Health Strategy[1].

We would like the Committee to note that our response is largely drawn from workshops held across Tayside to inform an independent inquiry into mental health services in the area[2] and workshops held across Scotland by the ALLIANCE, Samaritans Scotland and NHS Health Scotland to inform Scotland's action plan on suicide prevention[3].

Policy within the NHS about signposting patients and/or families to third sector organisations

Joined up working across sectors is necessary for ensuring strong approaches to supporting communities with their mental health, preventing suicide and supporting recovery. In the course of our work in Tayside, participants favourably compared the recovery approach engrained within third sector services, with the crisis, symptom management approach of clinical, statutory support.

It is concerning not only to note the petitioners experience of statutory sector organisations failing to work closely with their local third sector organisations to make connections and find appropriate solutions, but also that professionals believe they cannot advocate third sector service provision.

> "I was told that they do not endorse charities—that they cannot advocate them."
> **Karen McKeown, Public Petitions Committee, 4 April 2019**

Closer connection between the third and statutory sector was a desired outcome of the health and social care integration process. The Scottish Government's

[1] https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/8/
[2] https://www.alliance-scotland.org.uk/wp-content/uploads/2018/12/Tayside-Report-03.12.18-v2.pdf
[3] https://www.alliance-scotland.org.uk/wp-content/uploads/2018/02/Suicide-Prevention-Report-2018.pdf

commitment to increase healthy life expectancy and deliver care in a homely setting[4], can only be met through developing a culture which encourages an ethos of co-ownership of public services and a shift to a more reciprocal, community facing model of care. This shift will only happen if the power of people in communities – volunteers and non-clinical staff, is harnessed through open approaches and social innovation.

Clear, unequivocal messages need to be directed to staff throughout health and social care services that this is the case.

Working in new ways means tapping into the knowledge and creativity of others outside the health and social care services. If primary healthcare professionals are not able to provide immediate support then there must be well-resourced community assets to provide support and safe spaces, and professionals must know where they can signpost vulnerable people to. Special attention should be paid to rural and remote communities, where support for those in distress can be patchy or difficult to reach.

The ALLIANCE's ALISS programme[5] provides a mechanism for ensuring that local assets such as peer support groups, walks, cafes, activities and events are more visible in local communities. We work with health and social care professionals to ensure the index is integrated into their everyday operations.

We would like the Committee to consider encouraging further health care settings to utilise the connections ALISS can encourage with local third sector organisations.

Risk assessments

During our work in Tayside, participants told us that risk assessments are not robust enough and participants cited the number of lives lost after an assessment was made that they are not a risk to themselves as evidence of their effectiveness.

Mental health assessments need to be set in a wider context than a healthcare professional asking set questions at a single moment in time. We believe that the role of unpaid carers should be a valued part of the assessment process – many unpaid carers can add context to behaviour, letting a professional know if such behaviour is out of the ordinary or part of a downward trajectory.

---

[4] https://www.gov.scot/publications/national-clinical-strategy-scotland/pages/4/
[5] https://www.aliss.org/

Advance Statements are a way of ensuring that a person is able to legally consent to the involvement of an unpaid carer or family member and more should be done to ensure people are informed about Advance Statements by clinicians and supported to develop one by someone who has been through the process or a local independent advocacy group.

Crisis support services outside office hours

When someone calls crisis support it is often the last resort for them and the need is immediate. Being denied this support or having to wait for support has been described to us as such a negative experience that in the future people refuse to or are unwilling to ask for help.

Participants in our work in Tayside noted that, at present, people must travel long distances, often on public transport to a potentially unfamiliar setting for support out of hours. Workshop participants in Angus spoke of the difficulty in navigating an urban and unfamiliar environment while in a state of high anxiety.

We believe that crisis intervention centres, staffed predominantly by volunteers and those who have experience with mental ill health, could capture and support people to access current on the ground third sector resources out of hours. Alternative models of mental health support such as Step-Up Step-Down services which offer intermediary support between care in their own homes or the community and in a hospital setting, should be part of future service redesign.

Fatal accident inquiry

We agree that, alongside better support during a crisis, a much greater understanding of the reasons why someone completed suicide is required in order to create better preventative support. This should be built into any inquiry following a suicide and a process of continuous improvement must be built into health and social care services that learns from this.

Alongside this, the support and information that is available to people who have been directly affected by suicide, through the loss of a person close to them, must also be improved. Participants in our work with NHS Health Scotland and Samaritans Scotland highlighted that the period of time following a suicide attempt represents a critical time for compassionate, high quality care, and the new action plan must consider how the care received by people at this vital juncture can be improved to ensure that an effective ‘safety net’ is in place to support them.

Evidence indicates that people who have been bereaved by suicide are themselves at a higher risk of suicide. We heard that the type of grief experienced by those bereaved by suicide is intense and the emotions experienced in the aftermath can differ considerably from those following other types of death. People spoke of the profound impact of losing someone close to them through suicide and the heightened social stigma experienced following a bereavement of this type, which can lead to isolation.