Mental Health Strategy for Scotland 2011-2015

Consultation Response

This Scottish Government strategy went out to consultation In September, with responses due by January 31 2012.

I have been asked to prepare a response on behalf of the Government's Emergency Access Delivery Team (EADT) in my capacity as clinical lead for mental health on the group.

Central concern:
There is much to commend in the strategy, as I anticipate will be apparent in the more general response from the Royal College of Psychiatrists. From the relatively narrow and circumscribed perspective of the EADT however, the strategy represents a major *missed opportunity.*

The EADT is a successor to the Unscheduled Care Collaborative Programme, which was established in 2005 to deliver the 4-hr target for A&E waiting times. EADT was set up in 2008 to continue to oversee the 4hr target, (now standard) and to deliver on the HEAT T10 target to reduce A&E attendances. While the 4 hr target was and still is a challenge for A&E and all those services (including mental health) whose patients pass through it, T10 is substantially greater challenge for the health service in general, as well as for other agencies.

Both these groups recognised, from the outset, the importance of engaging with clinicians and managers working in mental health services, as the necessary starting point in addressing service responses to people with mental health problems who attend A&E.

It is now clear that across Scotland there is good engagement between clinicians and managers working in mental health and their counterparts in A&E, via such shared work as regular breach analysis. This is confirmed by audits of 4-hr breaches in people presenting to A&E with mental health problems over the last two winters, which show that for Scotland as a whole, the proportion of 4 hr breaches arising from such presentations is low (figures)

This engagement contributes towards (but cannot deliver in isolation) the shared T10 aim of reducing the numbers of people with mental health problems attending A&E, by providing a range of services more appropriate to their needs elsewhere in the community.

Neither the success to date against the 4-hr standard, nor the T10 challenge still ahead, is referred to the consultation document. A&E is referred to *twice* in its 53 pages and on both occasions in connection with the training of A&E staff in suicide prevention awareness training. There is no other reference to A&E, the 4-hr standard, the good work to date in delivering it, or on meeting the T10 challenges on which this work must build (though there *is* much reference to other HEAT targets).

While there are three references to the general hospital setting, they all relate to the identification and management of people with dementia: the heavy burden of other forms of psychiatric morbidity in general hospital settings merits no mention.

This gives the appearance of different arms of Government working towards disparate goals with insufficient awareness of their respective roles and key concern:. and it points up a dilemma. If the work undertaken to date by mental health clinicians and managers matters – then it should be reflected in the overarching mental health strategy. If it doesn't, we shouldn't be doing it.

Additional points

The document states (p4) a wish to consult on:

- **The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;**
- **Whether there are any gaps in the key challenges identified;**
- **In addition to existing work, what further actions should be prioritised to help us to meet these challenges.**

And, on p5, it identifies four priority areas:

- improving access to psychological therapies;
- implementing the National Dementia Strategy;
- examining the balance between community and inpatient provision and the role of crisis services; and
- preventing suicide.

Several specific points arise:

1. Psychological therapies should not be reserved exclusively for those with mental disorders. There is a well-developed evidence base for the value of these treatments (notably CBT) in such common, distressing and disabling physical disorders as irritable bowel syndrome, non-cardiac chest pain, poorly controlled diabetes, and functional neurological disorder – many of which lead to A&E attendance, and avoidable repeated admissions to medical wards.

If it is discriminatory to deny access to physical treatments for medical problems on the basis of a coexisting mental disorder (and it is) then it is also discriminatory to deny or restrict access to psychological treatments of proven value for people who present in general settings with physical symptoms.

2. The balance between community and in-patient psychiatric provision cannot be fully considered without deciding where A& E and acute hospital wards fit. Are they part of the community or not? If so, then how do community mental health services cover them? If not, then how are the mental health needs of people within those services to be met? Any comprehensive mental health strategy needs to provide explicit answers to these questions, but this document does not offer them.

3. If crisis services are the sole or primary providers of mental health assessment for people presenting to A&E with mental health problems, they are required to operate to incompatible time standards. The general standard applying to crisis services across the community as a whole for time to response from referral is

set at 4 hours. If crisis services apply those standards in A&E then most or all of the patients referred to them will breach the 4-hr standard. No other speciality has such latitude.

The solution is to formally endorse the time standards for mental heath assessment in A&E jointly adopted by the Royal College of Psychiatrists and the British Association of Emergency Medicine (ref)

4. The emphasis on further development of child and adolescent mental health serves is welcome, but it is essential that any such development ensures round-the clock provision of age-appropriate mental health services for children and adolescents who present to A&E after self harm (including overdose). Current provision across Scotland in this area is very patchy and in some parts of the country absent for much of the time.

5. The emphasis on preventing suicide is again welcome. Given that overdose and other self–harm significantly very increases the risk of eventual death by suicide, the potential for intervention at the time of mental health assessment in A&E is obvious. Such assessment must be rapidly available, age-appropriate, and relevantly skilled. But even if self-harm services meet all these requirements, and are fully compliant with SIGN/NICE guidance, they will not succeed in their goals (reducing rates of repeat self harm, A&E attendance and eventual suicide) without rapid access to follow–on services elsewhere in the mental health service range, in primary care, and in the wider community. This is especially true of access to alcohol detoxification services (both inpatient and community-based).

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