

# **PE1871/O: Full review of mental health services**

## **Petitioner submission, 28 April 2024**

As stated by the Minister's last submission, an entry route to mental health services in crisis out with office hours is the policy. In October 2023 the HMICS published the thematic review of policing mental health in Scotland. The aim of the report was to review the policies and producer that are in place for police to effectively deal with mental health related calls and if they can meet the need of the demand for the services. There were 14 recommendations put in place.

The first recommendation is that "the Scottish Government should commission a strategic review of the whole system relating to mental health, involving a range of scrutiny bodies". This is a key piece of evidence that supports carrying out a review of the mental health services. During the review, it was found that police officers had little training to deal with a mental health crisis and the services had seen a high volume of calls for mental health related issues. In recommendation 5, it states "Police Scotland should provide clear guidance and effective training for officers and staff". The recommendation could be applied to other areas that are at risk of dealing with mental health crisis such as teachers, all A&E staff including general nurses, the fire brigade and the ambulance service. A review would help find the gaps within these services and identify meaningful solutions to building a better mental health service.

I submitted freedom of information requests to all 14-health board in Scotland and to NHS24. I have outlined a few findings.

The first one is the inconsistency of how mental health data is gathered between different health boards. With each response from each health board, they all provided information differently where some health boards were unable to provide information whilst others were not able to provide a response to the same questions. The evidence would suggest there are no clear guidelines on how information is collected and stored. To enable a full evaluation of the impact of mental health services, it would be important to evaluate data such as waiting times, referrals and waiting list numbers. The FOIs have only answered some questions however, the evidence suggests there is more work to be carried out in this area which would support a full review of the mental health services.

Scotland has a population of 5.453 million with 14 health boards. There is a total of 895 adult acute mental health beds throughout the full of Scotland. These beds are used for a wide range of issues from mental health crises, detox beds, medication reviews, or assessment beds. For the number of mental health beds to the population, there is 1 acute mental health bed for every 6,092 people in Scotland. The results show that a total number of patients who attend A&E due to mental health related issues who were admitted to hospital was 13,056 whilst only 1,434 patients were admitted to a mental health bed in 2023. The rest who were admitted were sent to general or medical beds. This shows there is a demand for more mental

health beds in comparison to the number of beds available. The evidence supports that there is a bed shortage which could be contributing to a lack of mental health services. A full conclusion cannot be drawn at this time without a full review being carried out to determine to what extent the bed shortages contribute to poor or inadequate mental health services.

The finding shows there is a high demand for mental health service in Scotland with services receiving 243,979 referrals in 2023 to adult services from 11 out of 14 health boards. Only 193,525 referrals were accepted which suggests 50,454 referrals were rejected. Therefore, 50,454 referrals which a GP has assessed individuals as needing the mental health team's input were turned away from getting support. The current waiting list over 11 health boards is 37,912, which on average means it can take 108 weeks for people to get the help they need. Within that time how many of the people waiting to be seen will take their own life? A suicide review takes place in Scotland when a person dies by suicide and has been open to the mental health service or been an inpatient to the services. Not all cases have a suicide review however, in Scotland there has been 99 suicide reviews in 2023 in 11 health boards. Therefore, the results show that there is a high demand for services and a high proportion of suicide deaths have received a suicide review. This could give more evidence that there is a breakdown within services which is resulting in a lack of support which may be impact suicide statistics.

The NHS would be nothing without the wonderful staff who support the public on a daily basis. The staff provide services from giving care to keeping our hospital clean and safe. During covid we had seen just how much we need the front-line staff that keep our NHS running. A service we pride ourselves for having which provide a universal health care. Within the full of Scotland, the NHS employees 154,544 however, it was reported there was a total of 378,980 sick days were taken due to mental health related issues over a 12 month period across 10 Health Boards. Our front-line staff are having high burn out rates which could be contributing to long waiting times. This places a bigger strain on the mental health service resulting in high caseloads for workers. An element that must be considered is how much public service money is being spent on bank or agency staff to ensure that wards have safe staff levels. Therefore, it is important to determine what is causing high sickness rates due to mental health. Do staff feel support to carry out their jobs or is there anything that the employer could do to help? All these questions are unable to be answered at this point which only a full review would be able to answer. I urge the committee to call for evidence from staff anonymously. This will ensure staff are able to express their true concerns without fear of backlash. It would give a more open view of the mental health services from the front-line perspective.

The evidence suggests that there is something not working. We can no longer put a plaster over it, and we need to take dramatic and brave action if we want to see a fit for purpose mental health service. Luke's death and others like him cannot be in vain and through their legacy we can save future generations. If action is not taken, there is a fear that wait times will continue to get longer, the NHS will continue to lose good staff and mental health services will continue to be inadequate.