Mental Health
Mental Welfare Commission for Scotland

1. The Commission is grateful for the opportunity to submit evidence to the Committee. We will be happy to provide further evidence in support of this submission.

2. The Commission is a statutory body which protects and promotes the human rights of people with mental health issues and related conditions. We visit people who use mental health services, monitor the use of mental health and incapacity legislation, promote best practice, and investigate where people experience deficiencies in care.

3. We strongly support the view that the mental health strategy, particularly for children and young people, needs to be much wider than specialist mental health care, with a strong focus on prevention of mental ill health and promotion of wellbeing. However, we have focused in this response on matters about which have direct experience. We have a particular concern with compulsory care, and our visits are predominantly to people in hospitals. In that respect, our work tends to be at the ‘sharp end’ of the mental health system.

Question 3: Are there other issues in CAMHS that you would identify as being a priority for improvement?

4. Some children and young people who require in-patient care find themselves admitted to adult mental health wards or occasionally general paediatric wards, rather than a specialist in-patient CAMHS service. We have been concerned to note a rise in such admissions in the last two years – see our monitoring report at http://www.mwcscot.org.uk/media/240702/yp_monitoring_report_2014-15.pdf

5. We are pleased that our as-yet-unpublished report for 2015/16 shows a significant reduction in the number of such admissions. However, there are still issues of concern, particularly that young people who are admitted to hospital are not always receiving adequate support to maintain their education, and that access to activities can be extremely limited.

6. We are also concerned about the small number of people with complex needs (including learning disability or autistic spectrum disorders or a need for secure mental health care) who can find themselves sent to specialist services in England, hundreds of miles from families, and at huge cost to the Scottish NHS.

Question 6. Which parts of the previous mental health strategy have been the most successful?

Question 7. Which parts of the previous mental health strategy have been the least successful?
7. We find these questions difficult to answer, because there does not seem to have been any rigorous evaluation of the last strategy: on the extent to which particular commitments were delivered, how that work has supported the seven themes in the strategy, and what outcomes have been achieved.

8. Our impression is that there has been good progress on challenging stigma, and embedding the recovery approach (at least the language of recovery, even if practice still falls short). There has been more modest progress on developing a rights based approach, but with the possibility of further development in the next strategy. Although HEAT targets have not been met, they have at least driven more activity in relation to psychological therapies.

9. Progress has been less evident on:
   - reducing the health inequality experienced by people with mental health issues, and
   - developing holistic community based supports which promote wellbeing, prevent deterioration in mental health, and respond effectively in a crisis.

10. A specific example is in relation to employability – Commitment 29 of the strategy. Our recent visits to people in the community with enduring mental health problems found that almost none had any meaningful connections to the labour market or hopes of a job.

**Question 8. What would you identify as priorities for the next mental health strategy?**

11. The type of strategy is almost as important as the detailed commitments. We welcome the Government’s commitment to a ten year vision for mental health, although our initial response to the consultation issued in July is that it is rather modest and short term in scope. More ambition is needed, and a process through which a truly transformative vision can be developed across the whole of Government.

12. Our submission to the Government before the election\(^1\) set out our 6 priorities for the next strategy. These are:

1. **A target to reduce the huge disparity in life expectancy affecting people with severe mental health issues.**

13. The difference in life expectancy between people with severe mental ill-health and the general population is shocking – women with severe mental health problems die around 15 years earlier, and men 20 years, compared to the general population.

14. The increased rate of early death is not driven by increased suicides or injuries, but poor physical health.

2. **A rights based approach**

\(^1\) [http://www.mwscot.org.uk/media/307343/mental_health_strategy_statement_final.pdf](http://www.mwscot.org.uk/media/307343/mental_health_strategy_statement_final.pdf)
15. The Mental Welfare Commission and the Scottish Human Rights Commission reported in September 2015 on progress towards meeting the commitment in the 2012 strategy to develop and increase the focus on rights as a key component of mental health care in Scotland. A key recommendation of that report was that the next mental health strategy:

‘should be explicitly built around a rights-based approach. It should utilise the human rights framework to shape its aims and mainstream human rights across its commitments. In doing so, it should be informed by the lived experience of service users and should align with the aims of Scotland’s National Action Plan for Human Rights.’

16. In particular, we believe the time has come to begin a fundamental review of the legislative framework for non-consensual care and treatment (the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, and the Adults Support and Protection (Scotland) Act 2007) to ensure Scotland keeps pace with developments in human rights.

3. **Children and young people** [see response to question 3]

4. **Responding better to those who do not fit our current service approaches**

17. Several of our investigations have resulted from harm coming to people with diagnostic labels such as personality disorder, who have found themselves without adequate support. We also see services struggling to respond well to people whose needs fall into more than one diagnostic or service category, and particular conditions such as Asperger Syndrome. Too often, people are expected to fit what services can offer, rather than the other way round.

5. **A commitment to ending unequal provision of care**

18. We visits all hospital services for people with mental health problems, as well as care services and prisons. We report on many examples of high quality facilities and excellent practice. At the same time, we see ward environments that would never be tolerated in health settings for physical conditions, and people kept in hospital for much longer than they need to be, sometimes with little meaningful activity in their day.

6. **Workforce development**

19. Any public service strategy is only as good as the workforce which delivers the service. We need a revised set of skills and competencies to deliver a modern mental health service, focused on recovery and relationships.

20. Alongside this broader workforce agenda, there is a particular need to ensure that the Mental Health Officer (MHO) service is properly resourced and supported. The current position is not sustainable, in the face of the increase

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in the demand for MHO services, driven by a year on year rise in mental health detention and measures taken under adults with incapacity legislation.