The next Mental Health Strategy

Mental Welfare Commission proposed priorities

The Commission believes there is an opportunity in the Scottish Government's next mental health strategy to improve the mental wellbeing of the country as a whole, and to transform how people with severe and complex mental health needs are supported.

This change cannot be delivered by mental health services alone, and nor can it be completed in three years. We need a clear focus and priorities, combined with a cross-government approach, and a long term vision. The way the last two dementia strategies have supported a long-term and rights-based programme of change may offer a helpful model.

The Commission visits people in mental health hospitals and using care services, investigates where things go wrong, monitors the use of mental health and incapacity law, and provides advice and guidance. Based on this work, and our connections with people who have treatment for mental ill health, carers and professionals, we believe the following six areas need to be priorities in the next mental health strategy.

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

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

Many factors contribute to this, including lifestyle issues such as smoking, inadequate diet and lack of exercise, the effects of long-term use of psychiatric medication, 'diagnostic overshadowing' (where physical problems are under-treated or wrongly attributed to mental health issues), poorer access to physical health care and higher rates of suicide, accidental and violent death.

This is a major challenge, but it is not impossible. A co-ordinated public health approach is needed, including improved access to primary healthcare, closer monitoring of physical health needs as part of mental health care, and addressing relevant risk factors, including better support for healthy lifestyles in psychiatric services. It requires achievable and measurable objectives to be set for year on year

[1] Thornicroft G (2011) Physical health disparities and mental illness: the scandal of premature mortality, British Journal of Psychiatry, 199:441-442

improvement – learning from other countries that have made this a public health priority.

2. A rights based approach

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, following consultation with a wide range of mental health organisations and networks, 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.'

This can be done using the well-established PANEL principles of Participation, Accountability, Non-discrimination and equality, Empowerment and Legality.

The rights based framework should encompass the whole strategy, but particular issues which should be addressed are

- Ensuring compliance with the requirements of the UN Convention on the Rights of Persons with Disabilities, particularly the need to develop models of supported decision making.
- Ensuring that services are held accountable for delivering the rights which already exist in legislation (for example the duties on local authorities in sections 25-27 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to provide a range of supports to people in the community).
- Building on the new duties on local authorities and health boards in the Mental Health (Scotland) Act 2015 to ensure advocacy is there when people need it.
- Reviewing the legislative framework for non-consensual care and treatment (the 2003 Act, the Adults with Incapacity Act and the Adult Support and Protection Act) to ensure Scotland remains at the forefront of human rights based law and practice.

3. Children and young people

Despite a commendable focus on the needs of children and young people with mental health issues in recent years, more needs to be done.

The Commission monitors the admission of children and young people to non-specialist mental health facilities, and numbers have risen over the last two years.

Services have also had difficulties in meeting the Government's HEAT targets for access to psychological therapies. We are particularly concerned about the small number of young people with complex needs (including learning disability or autistic spectrum disorders) who can find themselves sent to specialist services in England, hundreds of miles from their families (and at huge cost to the Scottish NHS).

Alongside those who need specialist Child and Adolescent Mental Health services, we need a wider focus on prevention and wellbeing, and faster access to community-based support for a much larger number of young people. Currently young people may wait up to 18 weeks to be assessed, only to be told their situation is not sufficiently serious to access CAMHS, with little else on offer and months passed with no intervention.

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

Our report on the death of Ms MN highlighted serious problems for people with autistic spectrum disorder, who can be inappropriately placed in learning disability or mental illness services. We recommended that the Scottish Government audit the availability of specialist services for this group.

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.

The last strategy identified the need to respond better to people who present in distress. However, we still find that significant numbers of people both in hospital and in the community do not have access to appropriate psychological therapies, including response to trauma. Services such as CBT can be very helpful for some, but we need a holistic, flexible and person centred approach, rather than focusing solely on one form of intervention.

Ultimately, as our Ms MN report said, no-one is beyond help. But 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

We are the only independent body which visits all hospital services for people with mental health problems, as well as care services and prisons. We see and 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.

We also believe that the level of timely access to psychological therapies and crisis response would not be accepted for other physical conditions, and should not be accepted for people with mental health problems. There should be a firm commitment to a high quality service, measured by user satisfaction.

Importantly, although many hospitals do need improvement, the greatest need is to develop support and resources in the community – to prevent problems from getting worse, and to support people to live connected, fulfilling lives.

6. Workforce development

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. This should be developed in partnership with training providers, higher educational institutions and professional bodies, and include ongoing professional development.

As part of this, there is an opportunity to rethink the role of the Community Mental Health Team.

The Commission reported recently on people living in the community under suspension of detention or community based compulsory treatment orders. Too often, the focus of support appeared to be maintenance, with insufficient attention given to recovery and purpose. We already have good tools to support recovery based approaches – we need to ensure that the workforce has the skills and support to deliver these.

That also means thinking more broadly about what makes up the workforce for good mental health services. It needs to be broadly defined to include mainstream services (such as district nurses, GPs, family support), as well as peer support and the third sector.

Our Mr JL investigation highlighted the particular challenges around rural and remote areas, and the need to ensure local services have access to specialist support and advice.

Alongside this broader agenda, there is a particular need to ensure that the Mental Health Officer (MHO) service is properly resourced and supported. Monitoring by the Scottish Social Services Council indicates that the numbers of trained MHOs is static or declining, while the statutory work they undertake rises year on year. This is unsustainable, and is already having a negative effect on the safeguards in mental

health and incapacity law. The Scottish Government needs to work with local authorities to ensure that this vital role is able to continue to operate effectively.

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