Scottish Human Rights Commission

Consultation Response – Mental Health Strategy 10 Year Vision

October 2016

**Questions:**

# Are these [8] priorities the most important priorities?

## HUMAN RIGHTS BASED APPROACH

We believe there is much more required to embed a rights-based approach across the strategy, which would indicate a rethinking of the priorities.

Under Commitment 5 of the Mental Health Strategy 2012-2015, the Scottish Human Rights Commission and the Mental Welfare Commission published a report ‘*Human rights in mental health care in Scotland’*[[1]](#footnote-1). The report made a series of recommendations, the first of which related explicitly to overall considerations for the next mental health strategy:

*“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.”*

The Minister with responsibility for mental health at the time, Jamie Hepburn, made a commitment to implement this recommendation at the launch of the report.

As noted in the report,

*“The components of the rights to health (Availability, Accessibility, Acceptability and Quality), the rights set out in the Convention on the Rights of Persons with disabilities and the PANEL principles all provide frameworks which can be utilised to shape what the strategy aims to achieve.”*

Using the PANEL principles would allow for a rights-based framework to shape the strategy and for the priorities already identified to be placed within this framework. Moreover, it allows for any gaps in actions that would fully address the principles to be identified.

The strategy states that is it using the PANEL approach, in particular, Non-discrimination and equality. However, it is difficult to see how the principles have been used to shape the proposed priorities. While aspects of some of the principles do arise at certain points, there is no coherent framework for how the principles apply. In order for the PANEL approach to be meaningful, each of the principles must be fully addressed. A selective approach to the principles (i.e. focusing on Non-discrimination and equality) would not achieve a rights based approach.

As highlighted later, we consider that much more action is required to bring Participation to life, in developing the vision for mental health. Importantly, it is crucial to identify the rights that are being impacted by the actions and to use those rights to inform the action taken. This forms the rights basis of a rights based approach, without which, the Legality element is missing. We do not consider that the strategy in its current form embeds a rights based approach.

It is useful to refer to the genesis of the Commitment 5 recommendation, in the report:

*“Many commitments within the Mental Health Strategy 2012-2015 have strong connections to human rights, such as the provision of peer support, carer involvement, stigma and employability. This linkage is not always explicit, however, and it would therefore be beneficial if the next mental health strategy mainstreamed human rights across all strands of work”*

This issue is again evident in the proposed priorities. Each of the 8 priorities has a basis in human rights standards, however, this is not identified and human rights considerations are not mainstreamed throughout them. Rather, the realisation of human rights is confined to a separate priority which, in fact, covers only specific legislative reviews. For example, Priority 5, improving access to mental health services and making them more efficient, effective and safe, should be directly underpinned by the right to health. The right to health requires that facilities, goods and services must be:

* **Available** in sufficient quantity.
* **Accessible**to everyone without discrimination, especially the most vulnerable or marginalised people. This includes being physically accessible and affordable and includes the accessibility of health information;
* **Acceptable**, respecting issues of confidentiality and being sensitive to cultures, communities and gender;
* Scientifically and medically **appropriate and of good quality[[2]](#footnote-2)**.

Using this framework would help ensure that the actions are sufficiently comprehensive to address the gaps in services and, accordingly, the gaps in human rights realisation. The right to health would, for example, help shape the planned programme of work on improving access to mental health services to increase capacity and address waiting times issues in CAMHS and psychological therapies.

We therefore recommend that, if the strategy is to embed a rights based approach, the whole strategy, should be aimed at “realising the human rights of people with mental health problems”.

## 10 YEAR VISION

We believe that one of the key priorities for the strategy should be to develop a 10 year vision informed by a broad participatory process. We note that the 10 year strategy is supposed to present an opportunity to build an ambitious vision for mental health in Scotland. We believe this should be the first priority. The process used to build this vision should itself take a rights based approach and should, in particular, ensure that it is fully informed by the participation of people with lived experience.

There are already a range of resources available to build on to inform the vision. The Rights for Life programme offers a clear outline of the rights which people with lived experience themselves have identified as requiring action[[3]](#footnote-3) and seems therefore to be a strong starting point for the shaping of a rights based vision. There is also the Special Briefing Paper Of the Scottish Mental Health Partnership[[4]](#footnote-4), the Mental Welfare Commission’s proposed priorities (<http://www.mwcscot.org.uk/media/307343/mental_health_strategy_statement_final.pdf>) and SAMH’s Ask Once, Get Help Fast (<https://www.samh.org.uk/media/462301/samh_ask_once_get_help_fast_manifesto_for_the_2016_scottish_parliament_election.pdf>)

The Scottish Mental Health Partnership[[5]](#footnote-5) and the Rights for Life Change Agenda have called for a root and branch review of the support offered to people with mental health issues, carried out by an independent Commission of enquiry. We would support an approach like this, guided by a rights framework such as the WHO QualityRights Tool Kit (<http://www.who.int/mental_health/publications/QualityRights_toolkit/en/>). The WHO QualityRights tool kit provides countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities. The Tool kit is based on the United Nations Convention on the Rights of Persons with Disabilities. It provides practical guidance on:

* the human rights and quality standards that should be respected, protected and fulfilled in both inpatient and outpatient mental health and social care facilities;
* preparing for and conducting a comprehensive assessment of facilities; and
* reporting findings and making appropriate recommendations on the basis of the assessment.

The WHO Quality Rights Tool kit covers 5 rights themes, which it breaks down into practical, specific standards.

## SUGGESTED PANEL OUTLINE

An outline of how the PANEL principles could robustly be employed in the strategy might look as follows:

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| **P**articipation | Everyone has the right to participate in decisions which affect them.Participation must be active, free, and meaningful and give attention to issues of accessibility, including access to information in a form and a language which can be understood. |

* A move to new models of support which are genuinely participative and person-centred
* The development of a 10 year vision developed alongside and fully informed by people with lived experience
* Concerted efforts to reorient services towards a supported decision-making model
* Action to support and reinforce existing supported decision-making mechanisms e.g. advocacy, Advance Statements

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| **A**ccountability | Accountability requires effective monitoring of human rightsstandards. For accountability to be effective there must beappropriate laws, policies, administrative procedures andmechanisms of redress in order to secure human rights. |

* Aligning the indicators to be developed with human rights standards
* Taking steps to address “exploration of service users’ understanding, views and experiences of accountability procedures e.g. whether people know where to seek redress and have support to do so (whether advocacy or legal support); the accessibility of legal and complaints mechanisms; and meaningful redress.” (per Commitment 5 report)
* Linking the planned review of how deaths of patients in hospital for mental health care and treatment are investigated to a strategic approach to accountability which commits to systems which allow for learning from things that go wrong in mental health care

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| **N**on-discrimination and equality | A human rights based approach means that all forms ofdiscrimination must be prohibited, prevented and eliminated.It also requires the prioritisation of those in the mostvulnerable situations who face the biggest barriers to realising their rights. |

* Consideration of whether all marginalised groups have been taken into account, both in terms of intersectional discrimination (e.g. LGBT, older people etc.) and the groups of people with mental health issues who do not ‘fit’ in current services (e.g. borderline personality disorder, ASD young people not deemed ill enough to qualify for CAMHS). The International Covenant on Economic, Social and Cultural Rights also requires action in relation to people marginalised by living in poverty, a group disproportionately impacted by poor mental health).
* Priority 7 to ensure parity between mental health and physical health should be guided by Article 25 CRPD providing the right to health for people with disabilities on the same basis as others, which specifies the areas that must be addressed to provide both the same range, quality and standard of health care as is available to the general population, and services specifically required because of disability

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| **E**mpowerment | People should understand their rights, and be fullysupported to participate in the development of policy andpractices which affect their lives. People should be able toclaim their rights where necessary. |

* Actions to promote self-management abilities (Priorities 4, 6) concern aspects of empowerment
* People’s awareness and understanding of their rights in mental health care and treatment. This should also encompass the workforce, who should be empowered to understand the rights of those they work with as well as their own rights
* Efforts to increase the focus on recovery and on a wider public health agenda which promotes good mental health and protects against mental ill health, as a means of empowering both services users and the wider populace

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| **L**egality | The full range of legally protected human rights must be respected, protected and fulfilled. A human rights based approach requires the recognition of rights as legally enforceable entitlements, and is linked in to national and international human rights law. |

* Mainstreaming human rights throughout the priorities of the strategy. Identifying the human rights on which they impact, looking to those standards to guide the areas which must be addressed and the outcomes sought
* Realisation of human rights standards, in particular, the UN Convention on the Rights of Persons with Disabilities. The Scottish Government’s CRPD Delivery Plan 2016-2020 coincides with the new Mental Health Strategy and the review of the UK’s compliance with the Convention is anticipated to take place in 2017
* A root and branch review guided by the CRPD framework (utilising WHO Quality Rights Toolkit)
* The various reviews of mental health and incapacity legislation carried out as a co-ordinated and comprehensive review of the legal framework for non-consensual care and treatment, based on the principle of supported decision-making
* Implementing each of the Commitment 5 recommendations to improve the focus on rights in mental health care
* Action to make more meaningful and effective rights which have already been set out in legislation, for example the rights to effective support in the community contained in sections 25-27 of the Mental Health (Care and Treatment) (Scotland) Act 2003

# Are there any other actions that you think we need to take to improve mental health in Scotland?

The three Results identified in Priority 8 are significant in the realisation of rights, however, they do not address the full range of rights which is impacted by the strategy. It is also difficult to see how the legislative reviews set out in the actions will lead to the results identified. For example, how will the reviews contribute to people with mental health problems successfully leading lives where expectations around privacy, employment, and other issues can be expected and supported as standard?

Action should be taken to follow-up on recommendations made within the previous strategy, in particular, the Commitment 5 report. Priority 8, while aimed at addressing rights, does not cover action on the recommendations of the report, which are repeated here for ease of reference:

1. 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.
2. The next mental health strategy should include measures to address stigma, discrimination and lack of reasonable accommodation, and improve awareness of the rights of people with mental health issues in mainstream health and social care services. Efforts to combat stigma and discrimination should recognise, maintain and build on existing work to view these as a matter of realising the human rights of those affected by stigma and discrimination.
3. Integrated human rights and equality impact assessments should be routinely deployed in the development of mental health policies, practices, procedures and priorities: doing so offers a mechanism for identifying, addressing and embedding equality and human rights considerations.
4. We recommend a review and subsequent consolidation of existing training initiatives across the mental health workforce against the human rights framework, and with reference to the Convention on the Rights of Persons with Disabilities. This should be used to provide national leadership and direction to all sectors of the health and social care workforce as to how to further embed human rights in workforce development.
5. The Code of Practice accompanying the Mental Health (Care and Treatment) (Scotland) Act 2003 should be revised to involve explicit connections to human rights principles and to the human rights framework. Doing so will help to embed rights based practice.
6. The Scottish Government should issue a Chief Executive letter to Health Boards setting out clearly the expectations on Boards to promote the wider use of advance statements, and should consider what national guidance and support should be made available to support this. This should reflect the new duties in section 26 of the Mental Health (Scotland) Act 2015, drawing on the experience of existing projects seeking to build such support and the work of the MWC-led group on advance statements.
7. The Scottish Government should coordinate interagency discussion and action at a national level to explore issues of capacity and supported decision-making. Efforts should be focused on strengthening existing forms of supported decision-making and identifying how further models can be developed which reflect the Scottish legal and service context, and respond to the implications of the UN Convention on the Rights of Persons with Disabilities.
8. There should be further exploration of ways for service users to be provided with consistent, reliable and accessible information on rights, prior to and during crisis points, with opportunities for them to be reiterated at key points during care and treatment. The manner in which this should be provided should be informed by the lived experience of service users.
9. We recommend the development of an online portal bringing together and making accessible rights-based materials, evidence and best practice. The content of this portal should be quality-controlled and curated to ensure that it remains focussed on content which is explicitly rights-based.

We accept that action on some of these recommendations may fall outwith the strategy. However, we would like to see explicit engagement with recommendations arising from that strategy and information on whether recommendations are being followed up and, if so, how. We are aware that other reports were compiled in the course of that strategy (such as the Commitment One report) and we believe action must follow from that work in order to actually result in progress.

# What do you want mental health services in Scotland to look like in 10 years’ time?

We refer to our comments above regarding the need for a root and branch review, carried out by an independent Commission of enquiry. We consider it crucial that people with lived experience are the ones to shape what mental health services look like in 10 years’ time.

Any changes to mental health services should, however, seek to progressively realise human rights obligations, in particular the UN Convention on the Rights of Persons with Disabilities (UNCRPD). One significant challenge which must be addressed is a move away from substitute decision-making (such as compulsory treatment) to supported decision-making. The UN Committee on the Rights of Persons with Disabilities has published a General Comment which states that legal capacity cannot be denied on the basis of disability (as this would constitute discrimination) and that decision-making must be supported not substituted. This requires that efforts be focused towards “developing effective mechanisms to combat both formal and informal substitute decision-making”. While the more absolute aspects of this remain controversial, it is clear that it will be necessary to shift as much as possible towards systems built around support for people with mental health issues in exercising choice and autonomy.

As noted above, a recommendation of the Commitment 5 report was that the Scottish Government should explore the implications of supported decision-making for mental health services. In particular, “*efforts should be focused on strengthening existing forms of supported decision-making and identifying how further models can be developed which reflect the Scottish legal and service context, and respond to the implications of the UNCRPD.”* The 10 year vision should embrace a clear and focused reorientation in that direction, in order to meet international human rights standards.

Again, the WHO Quality Rights Tool kit provides a set of practical standards to guide such work, for example:

**Standard 3.3. Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.**

*Criteria*

3.3.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.

3.3.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.

3.3.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.

3.3.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.

3.3.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.

3.3.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.

3.3.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.

1. <http://www.scottishhumanrights.com/application/resources/documents/Commitment%205%20report.pdf> [↑](#footnote-ref-1)
2. UN Committee on Economic, Social and Cultural Rights (CESCR). General Comment No.14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4. Available at: <http://www.refworld.org/docid/4538838d0.html> [↑](#footnote-ref-2)
3. <https://rightsforlife.org/the-declaration-2/declaration-text/> [↑](#footnote-ref-3)
4. http://scottishrecovery.net/wp-content/uploads/2016/02/Why\_Mental\_Health\_Matters\_to\_Scotland\_Future\_FINAL.pdf [↑](#footnote-ref-4)
5. <http://www.rcpsych.ac.uk/workinpsychiatry/divisions/rcpsychinscotland/partnership.aspx> [↑](#footnote-ref-5)