PE1716/D
Mental Welfare Commission for Scotland submission of 7 May 2019

1. The Mental Welfare Commission is grateful for the opportunity to comment on the issues raised in the above petition, and the consideration of it by the Committee on 4th April 2019. The issues raised by the Committee are in italics below.

Policy within the NHS about signposting patients and/or families to third sector organisations; during evidence the petitioner stated that the NHS "does not endorse charities; it's not something they advocate" (see video at 10:07)

2. Clearly, we cannot comment on the particular circumstances raised by the petitioner, but in our view it is entirely reasonable that the NHS should make people aware of support services which may be of assistance, and signpost to any appropriate referral routes, if these are not services to which the NHS can refer people directly. We are not sure if there is some question about whether this amounts to 'endorsing' particular charities, but generally we feel that advice about sources of support should be a routine part of the work of the NHS.

Risk assessments: the petition states that assessment tools are inadequate and not fit for purpose; are assessment tools "missing key aspects"? The petitioner feels that the more serious questions are getting missed, and there needs to be a more holistic, robust and patient centred approach; she does not believe that a thorough risk assessment can be conducted in 10 -15 minutes (see 10:08 to 10:12)

3. The Commission does not generally issue guidelines about issues of clinical practice, since this is more properly the role of bodies such as Healthcare Improvement Scotland (particularly SIGN – the Scottish Inter-collegiate Guidelines Network), at the UK level the National Institute for Health and Social Care Excellence (NICE) and professional bodies such as the Royal College of Psychiatrists. We are not able to comment in detail on current risk assessment tools.

4. That said, we broadly agree with Ms McKeown's suggestion of the value of ensuring there are consistent assessment tools, a shared understanding of how to operate them, and appropriate information sharing across the system.

5. We note that, over the last decade, there has been significant progress in relation to risk assessment of offenders through the development of the Risk Management Authority, and it may be that similar approaches could be considered for people at risk of suicide.

6. However, there is general acceptance amongst experts that risk assessment tools cannot in the current state of knowledge accurately predict who will or

will not commit suicide, so improving risk assessment is unlikely, on its own, to make a transformational difference to the level of suicide or self-harm amongst people in touch with mental health services. We believe there also needs to be a wider range of more flexible service responses, rather than simply focusing on the decision on whether to admit or not to admit to the current range of in-patient services.

Crisis support services outside office hours: the petitioner's suggestion that a central hub for mental health patients would be much more effective for patients; A&E can add to a patient's distress; there are also concerns about consistency and gaps in the service (10:12 to 10:16)

7. We are not able to give a definitive view as to how best crisis services should be configured. However, we support the call for the development of new and different services to respond better to people experiencing a mental health crisis. We agree that A&E wards are often not a good environment for people in crisis, and we welcome the recognition by the Scottish Government that we need both to improve the response in A&E and consider other options.

8. In 2018 we published a themed visit report on support for people with a diagnosis of borderline personality disorder, and the response at A&E services was an area of concern – see pages 48-51 at https://www.mwcscot.org.uk/media/431592/nov2018bpd_report_final.pdf

9. It is also our view that current in-patient services focused on acute mental illness are often not the best or safest options for people with complex personality or addiction issues, and we welcome the Government's commitment in the Mental Health strategy to develop a more system wide response to people in distress, which may need to include development of new types of short term support which don't currently exist or are undeveloped.

10. Actions 11, 13, 14 and 15 of the current mental health strategy are all relevant to this, as is the work of the Health and Justice Collaboration Improvement Board which has been established by the Scottish Government. We understand that the Board is developing a comprehensive strategy to respond to distress, and we look forward to seeing the details.

Fatal accident inquiry (10:16 to 10:18:30): the witness indicated very strongly that she felt a fatal accident inquiry would help to identify where any failure within the mental health services process had occurred;

11. In response to previous petitions the Commission has said we do not support FAIs in all cases of death (or more narrowly suicide) involving a person in contact with mental health services. It is true that these are mandatory in relation to prison deaths, but there has been very substantial criticism of

delays of several years in holding FAIs, and questions of their value, given that they rarely appear to make recommendations which result in service change.

12. That said, we strongly agree with the petitioners that the current system is inadequate. We believe there should be an appropriate review of any suicide of a person who has been in recent contact with mental health services, and generally support the recommendations of the review by Professor Craig White, which was published in December 2018 – see https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/4/

13. In particular, reviews need to be more consistent, more rigorous, more independent, and involve families better. The Commission is committed to developing a review process for deaths of people who are subject to compulsory measures under the Mental Health (Care and Treatment) Act at the time of death, and supporting the development of a more consistent review process for all people who complete suicide. We also agree with the petitioners that there needs to be a robust system to ensure lessons from suicides are disseminated widely and clearly influence practice.

Other comments

14. We welcome the planned review of the Mental Health (Care and Treatment) Act. Legislation cannot on its own prevent suicide, but this review is an opportunity to consider how far legislation can reflect and promote human rights, including the right to life in Article 2 of the European Convention on Human Rights, and the more general Right to Health. Currently the focus of legislation is on protecting against unwanted treatment or detention, reflecting the importance of personal liberty, and arguably it is less effective as a tool to ensure people get the support they need. The 2003 Act does contain legal rights to request assessments by or on behalf of people in need of mental health services (sections 227 and 228) but there are not widely understood or used.

15. However, new legislation will take several years and cannot solve all issues of services and culture, so service improvement in the meantime is vital.

16. We are sympathetic to the point made by Ms Lennon that people with co-morbid mental health issues and substance abuse problems can struggle to get appropriate help because the two services operate differently, and perhaps because of stigma around addiction. We hope to investigate this in more depth next year by undertaking a themed visit to people with co-morbid mental health and substance issues.