Consultation response – The Scott Review of Mental Health Law in Scotland

Date: 29/05/2020

Background

- The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training to retirement, and in setting and raising standards of psychiatry in Scotland and the United Kingdom. We have 1,361 members in Scotland, with faculties representing a full range of psychiatry specialisms.
- The College aims to improve the health and wellbeing outcomes of people with mental illness, intellectual disabilities, and other neurodevelopmental disorders. We also seek to improve the mental health of individuals, their families, and communities. To achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their supporters. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

Summary of response

"*The College welcomes and fully supports efforts to review the legislation around mental health law. We share the Scott Review's aim of improving the legislative framework for those with mental health conditions or incapacity, and believe the best means of achieving this would be through fusion legislation. We support an approach which builds on the already strong principles-based legislation in Scotland, with revisions directed towards further compliance with international human rights obligations while ensuring the legislation remains practical and incorporates a needs-based approach*."

- The College recognises and fully supports the focus of the Review on ensuring mental health legislation embraces a human rights focus. We encourage that all rights be considered. This includes recognising that, in most cases, the use of legal powers is in order to safeguard and guarantee rights such as the right to health and prevent degrading treatment.
- Human rights and the need to safeguard them is at the core of the professional duty of psychiatrists as frontline professionals and medical experts. This extends to training, professional guidelines and standards of practice.
- We would assert that the human rights of other groups, such as carers/supporters or victims of offences committed by individuals with mental health conditions, be recognised as part of the Review's conclusions. A whole population approach would be worthwhile and ensure the legislation truly provides equal protection and balance in considering people's rights.
- The current legislative framework works well in covering those groups it was specifically designed for. In practice, however, there are those whose needs span the different acts or do not fit clearly into any of the existing legislation, such as people with delirium. They can end up in a 'no man's land' without adequate support, oversight, or representation and where clinicians are forced to piece together different strands of each act in order to attempt to deliver care which best meets their needs.
- There are also those who feel they need to continue to be under an MHO or to remain subject to detention to ensure they receive adequate social care support. It would therefore be appropriate to make sure they can access the most appropriate care and treatment without needing to rely on such orders.
- Developing cohesive legislation which provides maximum coverage could be delivered as part of fusion legislation. We believe that the best approach would be to consider how to take the UNCRPD, ECHR and other relevant human rights conventions (including the ICESCR) and apply them through fusion legislation. Such an amalgamation could: establish clarity on what legislation applies in each situation; provide full coverage for all; provide equal protections across mental health conditions and incapacity, and; set common principles, tests and tribunal procedures.
- Fusion legislation would also acknowledge the wide scope of people who fall under mental health legislation, including those with longer term and complex conditions who may require the use of multiple pieces of legislation currently. It is possible for mental health, incapacity, and support and protection legislation, along with common law to currently be utilised in a single clinical scenario.
- We also believe the Review must be able to draw on a diverse range of voices and experiences when developing its recommendations. This includes those with a wide variety of professional and clinical backgrounds and direct experience of the use of existing law in clinical practice. We argue that having such clinical expertise on the Review group would make sure its work and recommendations capture the complexities of implementation on the frontline.

- The range of rights this Review seeks to protect include the right to health, which presumes a right to treatments which are effective in maintaining/restoring health, alongside the right to liberty and security. These can come into conflict, however. It is essential that the Review carefully balances these, which will require consideration of complex and difficult decisions.
- We would also call on the Review to not just look forward but also consider the workings of the current acts. This includes the safeguarding measures that have since been introduced, such as named persons and advance statements, which our members have reported have been poorly utilised.
- Our members have highlighted there are situations patients face where limiting liberty ensures the right to life, particularly among those with suicidal thoughts or those in an acute confusional state. The process for managing this can best be achieved through legislation alongside built-in safeguards and scrutiny methods.
- The College recognise that such fusion legislation would need to be fully stress-tested, and we intend to submit case scenarios to facilitate this. These will cover the range of complex issues experienced by patients and their carers and situations our members see daily and can help ensure the legislation holds up when called upon. It is essential that whatever proposals are pursued by the Review, their real-life consequences are considered and reflected upon as fully as possible.
- It is essential that such stress-testing also ensures that needs-based and rights-based approaches operate in harmony in the practical application of the legislation.
- It is also acknowledged that the implementation of fusion legislation would face difficulties incorporating proposals around forensic mental health.
- We would call for the role of tribunals to be clarified and the use of a significant harms test when applying measures. We also urge the Review to work alongside the ongoing review in forensic mental health services. If the original reason for an offender getting a mental health disposal changes – such as a change in diagnosis from an intellectual disability or mental illness diagnosis to personality disorder – there should be a referral back to the sentencing court to reconsider the appropriateness of the disposal.
- While, for the reasons set out above, the College recommends a move towards fusion legislation is prioritised. However, there are also changes to the current legislation which we believe would have an immediate positive impact. We therefore propose changes to current legislation as well which we believe would have an immediate positive impact. If changing current legislation was the Review's preference, we would also seek to work with the Review in later stages to improve each of the acts individually.
- We also felt it worth stating from the outset that the pandemic we are currently living through is likely to change our society and our mental health services, and wider health and care support beyond recognition. Amidst the trauma and loss of life, health services have made sweeping adaptations, almost overnight, and many of these will have benefits for patients long after the pandemic ends. The ability for mental health services to adapt and change quickly for the better should be retained and built on where possible and appropriate.

Capacity and consent

- **Definition of capacity** – With this rights-based approach in mind, it is worth stressing how incapacity is defined under Scots Law and used by clinicians to assess the capacity to consent for each medical treatment. An assessment starts from a presumption of capacity until medical evidence proves otherwise. Case law and authoritative guidance then requires the clinician to consider the adult's ability to:
    - act
    - make decisions
    - communicate decisions
    - understand decisions
    - retain the memory of decisions
- **Not all or nothing** – It is also worth adding this is not an all or nothing approach, with the recognition some people will be capable of making certain decisions but lack the capacity for others.
- **Legal versus medical capacity** – There is a risk of substantial confusion arising from how UNCRPD utilise the terms 'legal capacity' and 'medical capacity'.
- **Maintaining decision-making safeguards to prevent abuse**– While the UNCRPD includes in its general comments a presumption against measures such as substitute decision making, within the text is a call for "*all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law*". We would align ourselves with this interpretation and legal reforms towards it, rather than a more absolutist stance.
- **Disability** – On disability, it is acknowledged by members this is different to temporary states of incapacity brought on by certain conditions. For this group, there is a risk of coercion in supported decision-making which needs to be recognised, which current frameworks provide safeguards for.
- **Independent advocacy** – People who fall under the Mental Health Act, including those with Intellectual Disabilities, are legally entitled to independent advocacy free from conflicts of interest. While close family members often provide invaluable help and support and may have a role in supported decision making, the Review needs to consider how to take account of and monitor conflicts of interest. This could be achieved by making co-decision-makers or supporters subject to the principles as used for proxies under the AWI Act, with a facility for removal.
- **Impact of assumed legal agency** – Some groups our members work with are unable to take in enough information to be considered adequately informed to make a decision. This leaves any medical professional in a difficult position, questioning whether a person can consent to something if they cannot be considered as having met the good practice guidance regarding informed consent, which is current practice. Due consideration must be given by the Review to the consequences of assumed legal agency in those patient groups with an inability to be truly informed about a decision, such as those with severe dementia.

- **Changes to capacity tests under the AWI Act** – The capacity assessment test currently used under this legislation needs revision. These tests are crucial instruments used by professional medical practitioners, such as for whether guardianship applications are granted. We have previously proposed in our response to the review of the AWIA a 4-part capacity test, taking in the concept of 'use and weigh', clarifying the distinction around retaining memory, and adding belief and personal relevancy. We call for this to be incorporated, either in in the current Act or as part of fusion legislation.

Are there certain things that hinder the Act from working effectively?

- **Section 1 of the Mental Health Act** – While there is support for the provisions in this section, there remains no clear link to underpinning actions, disconnecting it from practical application.
- **Confusion around the principles** – There is a lack of understanding among patients and carers of the principles within the legislation and the rights these afford. Changes to make sure these have more teeth, that there is greater awareness of them, and that scrutiny of practices undertaken explicitly against these principles would improve the application of legislation.
- **Acknowledging issues facing those bodies those not covered in legislation** – Since the legislation came into force, new structures and bodies for delivering care, such as Integrated Joint Boards (IJBs), have come into place in health and social care. The new legislation should account for these structures and their role in delivering care and support.
- **Acknowledging those not covered in legislation –** Currently, those for whom the acts are not specifically designed for can fall into a legislative 'no man's land'. Ensuring any fusion legislation covers these groups would clarify and guarantee their rights and those who are providing treatment to them.
- **Balancing the legal and the practical** – There remains a gap between the ambitions of legal frameworks outlined in legislation and their actual feasibility in practical settings. Building in a greater adaptability to the on-the-ground experience of clinicians and patients is essential to any Review.
- **Sufficient testing of its measures** – While we would like to see fusion legislation attempted, there is a need to test the principles of the Act and any fusion legislation against a broader range of paradigms. This would ensure its applicability across different contexts, rather than using a few examples to justify widespread but not fully tested changes.
- **Responsible Medical Officer** – The proposal to reconstitute the Responsible Medical Officer (RMO) role as a responsible clinician role including psychologists within the current legislative framework is not supported by the College. The rationale for this is: the interventions this role is charged with are predominantly medical; the experience across professional bodies in Scotland in using compulsory powers is exclusively medical, and; there has been a lack of take up in England since it implemented this change, bringing into question whether there is an appetite.

- **A responsible clinician primarily responsible for the care of the patient?** – If it is the Review's determination that the RMO role be expanded through fusion legislation, we would call for the creation of a 'Responsible Clinician' role primarily responsible for the care of the patient, similar to that found in the AWI Act. This would be inclusive of non-doctors but also ensure these clinicians were fully responsible for the authorised treatment in question. In the context of mental health, this should be a consultant psychiatrist if the authorised treatment package includes non-consensual psychiatric hospital admission.
- **Resources** – The obligations for care providers and clinicians to deliver statutory services creates an additional pressure on these resources above all else and reduces the ability to meet informal patient need. Any changes to legislation should come alongside increased funding for key care services.
- **Suicidality** – Suicide continues to be a major public health concern in Scotland and those patients who are at risk require additional safeguards to allow them to maintain their safety and facilitate effective treatment. This may include hospital-based measures. We would also acknowledge there are always likely to be limitations in supporting people with suicidality, and that advice, support and care should be fully resourced to make sure people can access the help they need.
- **Expanding DMP assessments** -- We would advocate expanding DMP oversight to ensure whole care provision receives sufficient scrutiny. Having the more stringent oversight provided by these assessments would improve oversight.
- **Section 13ZA of the Social Work (Scotland) Act 1968**– We believe significant reforms of this provision is required to enable clinicians to better account for practical considerations of safety and care. These include scenarios where a person is unable to return to a care home or other safe place, making the hospital they are residing the safest place for them. There has been scrutiny where 13ZA has been used to move patients from hospital to longer term care provision where the patient lacks decision making capacity to elect to stay.
- **Guardianship powers** – A significant driver behind the use of 13ZA in this way has been the lengthy delays to the granting of Guardianship powers. We would welcome the establishment of an effective, timeous, process around Guardianship to best protect patients' rights and meet their needs.

What would improve things?

- **Fusing legislation** – The College is in favour of fusing current mental health legislation, following the template established in Northern Ireland. We feel through this process, many of the changes necessary across each act can be achieved.
- **Ensuring such legislation is fully tested** – This fusion process needs to be tested against a series of robust hypothetical scenarios, including what may be complex and difficult scenarios that are nonetheless faced by clinicians and non-clinicians. We are proposing to develop examples and are happy to work further with the Review to develop these based on members and patient experiences.

- **Retaining the current application of legislation to Autism and Intellectual Disabilities (ID)** – Currently, the College does not believe a valid case has been made for ID and Autism to be dealt with differently from other neurodevelopmental disorders. Instead, we believe everyone in Scotland should have appropriate and timely interventions for their mental health conditions and have these guaranteed through legislation.
- **Improving capacity of specialist care for people with ID and Autism** – Rather than changing the delivery of care for people with ID and Autism to a more generalist social care setting, we call for the Review to recommend the government develop more specialist capacity. Rather than placing those who are most unwell at risk, increasing specialist psychiatry training places and ID beds would ensure the specialist care these groups need is provided, ensuring their right to health is retained.
- **Ensure the Review is rooted in human rights considerations** – Ensuring the Review process retains a rights-based approach is fundamental to ensuring the legislation is brought up to date. This would keep within the legislation a patient-centred focus around what is best for them and how to enable them to access the best possible care and support.
- **The role of the Tribunal** – There is an expressed need for the work of the Mental Health Tribunal for Scotland (MHTS) to be considered as part of any potential fusion process. This includes enhancing its role in scrutinising decisions currently dealt with by Sheriff Courts under the AWI Act. The powers of the tribunal also require in depth consideration. One example our members report is that recorded matters lack authority and do not always achieve the benefit for patients that they aim to do.
- **A unified tribunal** – Our members would argue for a unified tribunal with an increased role in areas like guardianship applications, meaning an expert judgement is delivered in all such cases. It would also improve participation by giving the opportunity for patients and carers to receive an expert hearing on their perspective in a judicial but non-court setting. If adequately resourced, it could achieve more timeous decisions.
- **Retaining current principles of autonomy** – It should be acknowledged that the principle of autonomy is already included in both the MHA and the AWI Act. This interpretation, which holds it as a competing rather than absolute principle, should be retained as part of fusion legislation.
- **Clarifying supported decision making** – Ensuring the legislation is compliant with Article 12 of the UNCRPD means encouraging the practice of supported decision making. However, it is important to recognise minimising risk needs to take precedence. For this new principle to successfully influence practice, there also needs be a comprehensive range of examples in the code of practice to demonstrate what constitutes 'practical help and support'.
- **Incorporating both the UN and European human rights conventions** – Ensuring efforts are made in incorporate UN cultural and social rights alongside core conventions such as the ECHR and the UNCPD where possible will support legislation to be future-proofed.

- **Reciprocity** – There needs to be real consideration of situations where, out of necessity, methods of treatment like compulsory treatment are important and that a patient's demands to end such treatment can lead to harm befalling them. That being said, the principle that in turn they are provided with the best possible care in and out of treatment should be retained. We would welcome efforts by the Review to explore how legislation could build on the principle of reciprocity, perhaps looking to protect this right through guarantees on aftercare. We would highlight the role of section 117 aftercare in the MHA 1983, and suggest there may be a role of a power to place a statutory duty on IJBs to provide approved community care packages.
- **Championing the patient's perspective** – Following the above, it is critical where possible for the patient's perspective to be embraced, and for all decisions to be made purely in their best interests.
- **Potential for capacity-based justification for compulsion** – At the time of the MHA, using SIDMA (significantly impaired decision-making ability) as the criteria for decisions justifying compulsion was felt to be the right approach. Future legislation has used capacity, though, and that is the more widespread context used and understood by clinicians. While SIDMA remains the most appropriate framework in most cases, adapting tests to include a broader capacity test would make them more clinician and patient friendly as that is the more commonly understood system.
- **The expertise of psychiatrists** – Not only are psychiatrists on the frontline but they also carry medical expertise in implementing the legislation. That dual role of dealing with day to day realities alongside a detailed awareness of the legislation makes them key actors in any changes to mental health law. A consistent input from clinicians throughout the Review process is therefore essential.
- **Financial aspects** – As part of any fusion legislation, it would be worthwhile examining how to bring together the financial aspects, such as corporate appointeeships, under its auspices. This could allow for protection for those with small savings to be developed. This would include calling for the devolution of powers around this.

The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these?

- **What the MHA stipulates** – The Act requires a local authority to provide services for people with a mental disorder who are not in hospital, which should be designed to minimise the effect of mental disorder on people and enable them to live as full a life as possible (sections 25 and 26 of the Act). This focus on enabling capacity is sometimes forgotten when considering the rights-based approach already in place in legislation.
- **Mental Disorder** – Intellectual Disability and Autism should continue to have the provisions of a unified mental health legislation. It also continues to be appropriate that mental disorder is further defined as however caused or manifested. Diagnosis can be provisional at the time of application of the Act, as a broad definition ensures patients are afforded the treatment and protection of their rights that they require.

- **Medical Treatment Available** –The broad basis of treatment has been established in case law in England and Wales. It may be possible to ensure this is incorporated in any fusion legislation by using the wording "*treatment available*" rather than "*medical treatment available*". Further details on what is defined as treatment could then be provided in the code of practice.
- **Significant Risk to the patient's health, safety or welfare, or to the safety of any other person** – The significant risk to the other person should extend to health and welfare in addition to safety.
- **Significantly Impaired Decision-Making Ability** – As discussed elsewhere, we would be in favour of a capacity based legislative framework.

The Act requires a local authority to provide services for people with a mental disorder who are not in hospital, which should be designed to minimise the effect of mental disorder on people and enable them to live as full a life as possible (sections 25 and 26 of the Act)

Do you think this requirement is currently met? Does more need to be done to help people recover from mental disorder? You may wish to provide an example or examples.

- **Care providers** – The College would call upon these statutory rights to be imposed on those bodies which provide care and support. This would ensure these bodies are obligated to find appropriate accommodation for patients in the community.
- **Those not under compulsion** – Any human rights review could be extended to people who are not under compulsion but could be in the future, to ensure that those who do not fall under the legislation also have the same security in terms of their human rights.
- **Compulsory powers in the community** – These should not be removed. They can enable clinicians to discharge patients from hospital at a stage where compulsion is necessary to ensure treatment and services can be provided. For some patients, compulsory powers in the community support them to maintain their health and safety and avoid compulsory hospital-based care.
- **Retaining current MHO role** – MHOs should remain specially trained social workers. To split responsibility for this across other roles would dilute the quality of the care and support they are currently providing. What we would instead call for is for them to be enabled to fulfil their obligations under the legislation, whether that be through service planning or greater resources.
- **Create additional social care capacity in mental health teams** – An unintended consequence of the MHA was to create MHOs who dealt primarily with aspects of mental health legislation rather than on care in general. Our members have reported this has created situations where an individual no longer subject to compulsory measures is in danger of losing social cares support from the MHO. This has even led to many asking to continue to be subject to compulsory measures in the community to retain that professional relationship. To alleviate this, the College would call for a return to social workers embedded within mental health teams to perform a variety of care tasks based on the needs of the patient rather than fulfilling legal obligations.

Does the law need to have more of a focus on promoting people's social, economic, and cultural rights, such as rights relating to housing, education, work, and standards of living and health? If so, how?

- **Wider definition of health** – As above, the College recommends an obligation on care providers to promote the health of patients as defined by the WHO "*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*". This should be enshrined within the principles of the new legislation. The legislation needs to achieve a balance between the ideal and the realistic to ensure it carries weight and credibility, and to consider how best the needs of people with mental disorder who are not subject to detention can also be met.
- **Additional rights adoption** – One way of encouraging this would be to incorporate economic and social rights conventions into fusion legislation, including the International Covenant on Economic, Social and Cultural Rights (ICESCR).

The Review is also looking at the way people with a mental disorder are affected by the Adults with Incapacity (Scotland) Act 2003, and the Adult Support and Protection (Scotland) Act 2007.

Based on your experience, are there any difficulties with the way the 3 pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?

- **Adults with Incapacity (Scotland) Act (AWI)-relevant points**
    - *Difficulties in fusing legislation* – there is a need to ensure this process does not compromise elements like criminal disposal. There also needs to be consideration for the workloads of those who will be conducting incapacity assessments.
    - *Section 47* – At present, there is no monitoring of the use of S47 in the AWI Act, and the right to appeal is seldom used. The College's membership consider that this means there is insufficient oversight of the provision. Addressing this, whether it be in the current Act or as part of fusion legislation, should be prioritised.
    - *Applying AWIA in situations where the patient wishes to leave* – Any fused legislation could and should address the situation where a patient without capacity requires in-patient care for their physical health and wishes to leave.
    - *Use of S47 AWIA where a patient is actively refusing treatment* – Subsection 47(7) of the AWI Act prohibits the use of force or detention unless it is "*immediately necessary and only for so long as is necessary*". In clinical practice there are situations where S47 appears insufficient due to a prolonged or repeated need for use of force. Where guardianship is impracticable due to timescales, the MHA is not best suited to the situation.
- **Adult Support & Protection (Scotland) Act (ASPA)-relevant points**
    - *Need for evaluation* – We have received comments that this legislation is 'toothless'. One reason this assumption exists is the lack of evaluatory work which has been undertaken around the Act. This would ensure those who do not use it regularly, such as clinicians, are better aware of what it achieves.

- *Coercion* – The ASPA can work well for people who have capacity but face undue coercion. This includes issues around the decision-making capacity of those victims of chronic sexual abuse on staying with the abuser.
- *Tribunal composition* – This element needs to be amended with a clear and separate criterion. This could replace current capacity tests. There is also the potential for a system where someone representing the patient can ask for a review, which does exist but is not sufficiently used.
- *Safeguards* – When treatment choices are being made, it is important safeguards exist to ensure treatment choices are made in the patient's best interests.
- *Hospital to community care* – The College would urge efforts be made to ensure the transition between hospital and community care is more seamless and achievable for more patients. This can be delivered through full-funded care plans which enable people to receive appropriate support in their communities.