INDEPENDENT REVIEW OF MENTAL HEALTH LAW IN SCOTLAND

SUBMISSION FROM SOCIAL WORK SCOTLAND TO JOHN SCOTT QC

29 May 2020

Social Work Scotland is the professional body for social work leaders, working closely with our partners to shape policy and practice, and improve the quality and experience of social services.

Social Work Scotland appreciated the time taken by the Secretariat for the review to meet with the Social Work Scotland Mental Health group in February 2020, and offers this response to the discussion questions set out in Part B of the consultation paper.

> ***PART B Organisations or individuals who work with the law***
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> *The Review would like you to draw on your experience of working with Mental Health law and consider the following questions. You do not need to answer all of the questions, and please feel free to provide as much or as little evidence for your answers as you wish.*
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> • *The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") came into force in 2005 – how well does it work at the moment? In answering this it would be helpful to us if you could consider the following:*
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> - *how well the Act helps people to get the right care, treatment and support*
> - *how well the Act protects people's human rights (Please see the start of the paper for the human rights we think are most relevant here)*
> - *how well the Act maximises a person's ability to make their own decisions and give effect to them*
> - *how things have changed since the Act came into force in 2005*
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> • *Are there certain things that hinder the Act from working effectively? What would improve things?*

Reciprocity and resourcing

Social Work Scotland's experience is that while the Mental Health (Care and Treatment)(Scotland) Act 2003 is progressive in its approach regarding reciprocity, it is not in any way sufficiently funded for this to be realised in practice. We find that the principle of compulsion remains as the dominant culture, centred on clinical care planning such as medication and nursing care. The wider interests and ambitions of active citizens are largely absent from care plans.

The Review should consider general trends in the use of legislation, particularly measures of last resort. We are concerned about an increase use of emergency and short term detentions.

While short-term detentions are the preferred method of detaining a person in hospital, the increase in their use strongly indicates that the level of support available in the community is not sufficient, and we wonder if partnerships are fully cognisant of their duties with regards to community provision.

Seeing an increased use of legislative measures, we are concerned that austerity is impacting on how the act is used, particularly in relation to thresholds of risk. We are pleased that the Review is incorporating an economic perspective as we believe that this is central to understanding how the current Act is being used and the impact on people subject to legislation. Given our concerns regarding adequacy of resources to meet needs, we hope that the Review can also seek to instigate a review of mental health support services.

There is much in the current Act that is facilitative and reciprocal, e.g. duties under section 25 - 27, but these are rarely central to the provision of support. These duties require local authorities to minimise the effect of mental illness by the provision of community-based support services. The most well used provision in this duty is the provision of advocacy, but the Act allows for a much greater range of provision. However, mounting budget constraints have resulted in only critical services being provided. We also note the limited use of Self-directed Support options for people experiencing mental illness[1].

We draw the review's attention to our response to the recent Social Care Inquiry[2] which argues for early supports for people with fragile mental health, including the use of asset-based approaches, such as CPA, and a rethink of the current system of eligibility criteria.

Despite being a duty in the Act, a lack of person-focussed assessment and well executed discharge planning results in people whose mental health has been stabilised being discharged into circumstances unconducive to their continued mental wellbeing, such as poor living conditions where there is no heating and no furniture, and an absence of social supports. Consequently, other legislative duties are not met, for example the involvement of carers in discharge planning under the Carers (Scotland) Act 2016. Whilst we accept that MHOs need to exert challenge, there is too widespread a disregard of section 25 - 27 duties by partnerships and local authorities to argue effectively.

We note that there is improvement in the use and standard of Advanced Statements, but members also find resistance to their use on some areas. Often discharges are made without the MHO being contacted by the hospital. The reality is that there is often poor collaborative partnership working, especially when resources are constrained.

Integration context

We welcome the Review's systemic approach. Seventeen years on, the 2003 Act requires to be reviewed against a range of system-wide factors including the extent to which integration of health and social care has fulfilled its intended outcomes. One recent review[3] cites wide-ranging systemic failures resulting in poor outcomes for people.

It is not always clear to which part of the integrated system is delegated the local authority duties under sections 25 – 27 of the Act. We are concerned that integration authorities are

[1] https://www.audit-scotland.gov.uk/report/self-directed-support-2017-progress-report
[2] https://socialworkscotland.org/consultation/social-care-inquiry/
[3] https://independentinquiry.org/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf

not sufficiently sighted on this aspect of the Act, instead focusing largely on the provision of clinical services.

Considerable variation exists across Scotland in how mental health and social care services are delivered to people and their carers. We are interested in understanding the degree to which this variation is warranted by local circumstances and need, and to determine how unacceptable variation can be diminished in a way that respects local democracy.

We greatly welcome the Review's focus on human rights, and believe that this is the touchstone through which we can determine efficacy of approach.

Pressures on key professional groups

Social Work Scotland published a paper[4] in 2017 on the capacity, challenges, opportunities and achievements of Mental Health Officers. Whilst now three-years old, the experiences and findings of the research remain relevant in 2020.

With cumulative work pressure on MHOs, priority is given to the preparation of Community Treatment Orders, and use of Social Circumstance Reports (section 231) has largely been overlooked.

With people's needs, other than critical need, being unmet, detention is considered more frequently than it should. As officers of local authorities within partnership arrangements, MHOs are not sufficiently empowered to bring to bear their powers over the provision of assessed need. MHOs need access to community resources and good quality social supports, where people are offered choice and control.

We are concerned about the critical shortage of section 22 medical professionals, knowing that there are fewer medical trainees in the system than are required. We believe that medical decision should be made after face to face assessment of patients, but aware that due to staffing constraints, this is not always the case. We note that the Tayside Independent Review report[5] was explicit in finding that a shortage of Registered Medical Officers impacted detrimentally on the patient's journey.

Inpatient resources

Best practice in planning hospital admission fails because there is limited inpatient bed capacity. Threshold for admission is high, with people at crisis before they are admitted.

The practice of 'boarding out' results in some people refusing to be admitted voluntarily. Consequently, people may be detained and admitted to hospitals some distance away from their families and communities. When guardianship is pending, compulsion can be used to place the person in a nursing home. In this context we question how supported decision making is being used or how the best interests and human rights of people can be respected.

[4] https://socialworkscotland.org/wp-content/uploads/2018/05/TheMentalHealthOfficer_capacitychallengesopportunitiesandachievements.pdf

[5] https://independentinquiry.org/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf

We are concerned about the use of Emergency Detention Certificates without MHO consents. In general hospitals the Act can be used to stop people absconding, with EDCs made before MHOs are contacted.

We find that inpatient services remain clinical in focus and are not set up to support the whole person. Use of the Care Programme Approach has been pulled back in many areas.

As noted above, partnership focus on inpatient bed pressures results in a lack of attention to early intervention and prevention at a community level.

Specialist resources

There is a problem accessing some specialist resources, i.e learning disability in some areas of Scotland. Social Work Scotland members have noted waiting list for detentions in learning disability services, and for people who need specialist learning disability mental health services. Wards and beds are being shut, putting additional pressures on Community Mental Health Teams and MHOs. We have been told that some MHOs have been required to use Adult Support and Protection measures to force decisions about detention.

Tribunals and legal supports

Challenges from MHOs do not always land well with medical colleagues or with tribunal members, and we think this is indicative of a wider issue regarding relative weight of professional knowledge in decision making, with a higher status being afforded to medical views. It is standard practice in tribunals to excuse medical colleagues due to pressure of work in a way that others are not.

We find that tribunals are less likely to take radical decisions that support the spirit of the legislation. Proactively, tribunals could more rigorously examine deficits in the system that might have prevented unwanted outcomes. To this end, the Review might consider allowing tribunals a wider range of interrogative powers.

Tribunals might better take the perspective of the person and their carers from an early stage in proceedings (rather than at the end of the proceeding as is currently the case), and from this standpoint, inquire into all aspects of the treatment and care plans. This would ward against pathologising the person, and marry up better with supported decision making.

We wonder if a representative other than a curator ad litem would be better able to reflect a wider overview of the person's circumstances and views.

The place of the legal profession is confusing under current arrangements. Where a legal professional is appointed as curator, that professional can also act as the person's solicitor. This could give rise to conflicts of interest, and we recommend tightening of tribunal authority.

In general, we think that tribunal regulations need to be broadened with respect to compelling professionals and organisations to act in the best interests of the person.

- *Are there groups of people whose particular needs are not well served by the current legislation? What would improve things?*

There are several populations whose needs are not well served by the Act as it stands.

These include people who have recurring mental illness and in some instances people with multiple conditions, like learning disability and mental health. Welfare reform has had a notable adverse effect on mental health, with those in poverty experiencing a worsening of their mental health.

Services are not well geared to cope with the needs of people with different ethnic backgrounds, e.g. South Asian, Eastern European. The system lacks cultural awareness, with lack of timely translation of information materials/documents. Frequently, family members are called on to translate at meetings, and may project their own meaning on what is being communicated. Where translation services are commissioned, in some cases, their quality is questionable. We consider there should be a national minimum standard set for such services.

Children and young people are not well served by existing legislation and systems. There is an inconsistency of approach across CAMHS services and legislation is not always used when appropriate despite young people being significantly unwell. There may be an argument that use of legislation does not align with a therapeutic relationship, but legislation could be used more effectively in some cases.

There needs to be a recognition that CAMHS facilities are not sufficient to allow short periods of inpatient treatment that can improve prognosis. There are insufficient beds available for young people, and inpatient provision is not geared to cope with young people with behavioural challenge. There are at times inappropriate placement made of young people in adult wards. A much greater awareness and use of trauma informed approaches is required for all age groups, but especially crucial for children and young people.

Social Work Scotland is involved in the development of the national secure adolescent inpatient service in Ayrshire scheduled to start build in 2021. This resource will support a national network of clinicians providing more streamlined care pathways and management of some CAMHS referrals. However, this development will not address neurodevelopment disorders, learning disability and autism.

The current legislation does not work well for people with fluctuating capacity who fall between the various pieces of legislation. The person may be neglecting themselves, or displaying antisocial community behaviours, and could be using alcohol or substances. Obtaining medical evidence for lack of capacity is a problem if the person has capacity on their 'good days'. We find that very few guardianship orders are tailored appropriately, tending to a shopping list of actions.

- *The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these? In answering this, you may wish to think about how practical the tests are to apply and how fair they are to different groups, including people with different diagnoses.*

Of the five legal tests, there is no test for significantly impaired decision making (SIDM), which relies on the judgement of the clinician and MHO.

It is hard to argue against necessity when there is no community alternative available due to under-resourcing. This leads to detention that cause significant trauma for the person when a community alternative could ameliorate trauma.

As there are limited drug treatments for people with personality disorder, treatment protocol involves consistent care management plan for all professionals (including A&E) and family, with no deviation (so as to avoid use of manipulation by the person). Such protocols are very staff intensive and require highly effective and timely information sharing, and our experience is that they can break down readily due to lack of resourcing.

Some of regulation around specified persons has not kept pace of rapid expansion of digital platforms and social media. The legislation as it stands does not give the legal protection that should be afforded to restricting access to digital technologies.

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.*

We do not consider that this requirement is met, and would argue for a greater focus on recovery. Medical provision in communities is overstretched and there are not enough students entering medical training.

Appointment scheduling is not supportive of community treatment for those on a CTO who are not taking depo medications. Section 112 (6 hour detention) can be used to support compliance and to assess and treat. We believe that this section is not being used effectively by community consultants. There is a tendency to wait too long, the person then goes into crisis, then a longer period of detention is required. This is not timely and not proportionate.

- *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?*

We hold that legislation should have a greater focus on human rights, linked to the well-intentioned principle of reciprocity. As we noted earlier in our response, it proves difficult if not impossible for frontline staff to exert influence on authorities due to budget constraints and competing demands of stakeholders. We would want to see greater understanding and focus on the well-established social determinants of health model, which takes a public health perspective on inequalities and human needs.

- *Do you think the law could do more to raise awareness of and encourage respect for the rights and dignity of people with mental health needs? 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.*

We agree that the law could and should support the rights and dignity of people with mental health needs. There has been a lack of progress in implementing short term fixes to Adults With Incapacity legislation, which we find disrespect of people's rights.

Social Work Scotland supports the use of a short-term placement order, allowing the person to be removed to a place of safety until an urgent guardianship application could be progressed.

Lack of progress has led to unnecessary deprivation of liberty and unnecessary use of mental health legislation as only viable solution to what is a social issue. For example, a person with dementia may leave their home unaware of their safety, leaving their front door open. Adults With Incapacity legislation has no emergency provision for intervention in this case. Adult Support and Protection legislation may apply, but measures may not be appropriate, leaving the only available solution to have the person detained/admitted to hospital.

- *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?*

The three pieces of current legislation stand alone, lack effective overlap and do not align. It is not uncommon for people subject to mental health legislation also to be subject to adults with incapacity and adult support and protection legislation. We recommend that the Review considers streamlining and consolidating legislation.

Whilst we look with interest to the implementation of the Northern Irish approach to fused legislation, Social Work Scotland would support the development of pieces of discrete but well-aligned legislation.

The Adult Support and Protection (Scotland) Act (ASPA) is the safety net between adults with incapacity and mental health legislation but it does not give local authorities the power to protect particularly vulnerable people from the actions of others, for example when the person lives alone and is preyed upon by others.

ASPA does not interface effectively with other legislation. It is much wider in its scope that the MHA, and can be used as a triage mechanism for mental health legislation. We believe that if ASPA were better resourced, there would be a reduced requirement for Adults with Incapacity legislation and mental health legislation. ASPA provides the basis for effective risk management and a route to collective decision making. ASP inspections[6] were largely positive in terms of informal partnership working.

AWI timescales currently allow for extensive periods of delay for private applicants to get powers in place, with no limit to how long private solicitors take. Legal Aid is an added issue. Although it is an entitlement, it can impact on the priority given by private solicitors.

There requires to be robust quality assurance in place for private guardianships. We see poor quality guardianships, consisting of copy and paste paragraphs, which are not personalised. Consideration could be given as to how support other agencies (third sector) to facilitate process.

Whilst we agree that powers for life should not be adopted for people whose condition is likely to change, but believe that courts could make indefinite orders in some case where the person is in later life with a lifelong condition.

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6 https://www.careinspectorate.com/images/documents/4453/Review%20of%20adult%20support%20and%20protection%20report%20(April%202018).pdf

In many instances, the problem is not in the fundamental legislation, but the way it is currently being used.

Social Work Scotland welcomes the move by the Scottish Government to make Powers of Attorney more straightforward.

- *Is there anything else you wish to tell the Review? Please fill in the box below with your contribution. There is no restriction to the length of your statement. You may submit additional pages by post or use the text box below, or submit written submissions by email.*

The existing MHO contingent across Scotland is very committed and well-trained. However, as noted earlier in this response, the current funded complement of MHOs is not sufficient to work proactively in the mental health system. Scottish Government is currently providing funding to train up more MHOs where the shortages are most acute across Scotland, and we await progress with this initiative. There should be consideration of the model of MHO delivery across Scotland to ensure that MHOs are used to their best ability in statutory work, and there is a linked requirement to improve the availability of community resources to ensure that people do not reach crisis unnecessarily.

We have noted the shortage of trained medical professionals, but we also note that there are challenges in the demands on carers and on advocacy services. We consider that the lack of suitably trained professionals across the whole system is likely to impact on the success of more progressive mental health legislation, as will the lack of community resources. We feel strongly that the Review should look to implementation science[7] to determine what it would take to deliver systemic progressive mental health policy across Scotland.

Social Work Scotland welcomes the human rights-based approach to the Review, but consideration must be given as to how this can be implemented in practice within a resource framework. Considerations should include: a strengthened duty on professionals to adhere to codes of practice for tribunals; consideration of means by which consistency of good practice can be met by solicitors acting in private applications for guardianships; consideration of a more defined test for incapacity; consideration to widening the professional groups who can attest to capacity to include psychologists, MHOs and social workers.

Social Work Scotland's response to the learning disability and autism review[8] supports the view that learning disability and mental health legislation should diverge. Consistency of approach is needed if the Review is considering merging legislation.

We suggest that consideration could be given to a singularlised suite of human-rights-based legislation in linked subsections, dealt with by one legal entity, incorporating the wider duties in relation to social support. The benefits of this approach would need to be measured against the disruption of extensive legislation change and consideration of its practical implementation and application.

[7] https://www.celcis.org/knowledge-bank/search-bank/active-implementation-hub/
[8] https://socialworkscotland.org/consultation/independent-review-of-learning-disability-and-autism-in-the-mental-health-act/