SOCIAL WORK SCOTLAND RESPONSE TO SCOTTISH GOVERNMENT ADULTS WITH INCAPACITY AMENDMENT ACT: CONSULTATION

Social Work Scotland response

17 October 2024

Introduction

Social Work Scotland (SWS) 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. We welcome the opportunity to contribute to the development of the Adults with Incapacity (Scotland) Act 2000[1] (AWI Act) Amendments and recognise the need to do so in light of developments across international human rights legislation. The recommendations within the Scottish Mental Health Law Review (2022)[2] resonated with the profession and we believe this presented an opportunity to update an Act which is nearly a quarter of a century old.

In particular, the foregrounding of human rights against the backdrop of amendments which would allow for greater supported decision making and a closer consideration of the use of deprivation of liberty orders and section 47 certificates was welcomed. Alongside this, considering the extension of the Mental Health Tribunal for Scotland as a means to make procedures more accessible was appreciated and, we felt, presented a real opportunity to further align with the principles of the Act.

This response is gathered from ongoing discussions with partners, alongside the views and reflections of our membership which spans local authority and third sector organisations across the range of social work provision. We have particularly sought the views of those working directly with adults who require support under the AWI Act, as well as managers and those with strategic responsibilities.

[1] https://www.legislation.gov.uk/asp/2000/4/contents

[2] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

Key messages

The response follows the format of the consultation document and addresses all 99 questions. The key areas our members highlighted are summarised below, but are incorporated within the answers in the relevant sections of the consultation document:

- Principles need to be purposeful and should not set up false expectations. No principle should have priority but "will and preference" is a good starting point to consider and lead into the other principles. Clear guidance on the principles should be provided after implementation of amendments to ensure understanding and application for all users of the legislation.
- Investigatory power of the Office of the Public Guardian (OPG) should not be passed to Local Authorities (LAs). There are advantages to having OPG investigate financial abuse, and this should not be lost.
- Access to funds (ATF) reforms are welcomed, but still need to consider safeguards for the adult.
- Proposals in respect of Section 47 certificates need further consideration as to how they will be used if an adult does not want medical treatment or hospital admission. This needs to be compared to actions under the Mental Health (Care & Treatment) (Scotland) Act 2003[3] which may be more restrictive but may also provide greater safeguards for the adult. SWS are concerned that safeguarding may be eroded under the proposals for S47 certificates.
- The proposal in respect of the use of Deprivation of Liberty (DOL) orders causes concern, and clarification about why a Guardianship Order would not be preferred would be welcomed. Guardianship provides greater safeguards and a clear review process. If Local Authorities had to review Power of Attorney (POA) arrangements every 6 months, then this will be resource intensive.
- SWS members would also like to see a greater role for the Mental Health Tribunal, rather than the Sheriff Court.
- A significant number of the amendments will have resource implications, and this needs to be appreciated against a backdrop of service provision which is already depleted and experiencing issues in workforce retention, training and development, and vast geographical differences across the country.

[3] https://www.legislation.gov.uk/asp/2003/13/contents

Part 1:

1. Do you agree that the principles of the AWI Act should be updated to require all practicable steps to be taken to ascertain the will and preferences of the adult before any action is taken under the AWI Act?

SWS and its members generally support this proposition, but with an understanding that the system needs to be able to meaningfully consider, and where possible, address, the will and preferences of the adult. Our members offered examples of where, under the current legislation, the views of the adult are explored, but if an adult is unwell and requires medication or hospital admission, there can be limited options available to them, and even if they have previously expressed that they do not wish to be hospitalised, there are often no real alternatives.

Where Supported Decision Making (SDM) is currently being used to explore a persons will and preference, this tends to align with the 10 principles outlined by Scott in the Scottish Mental Health Law Review (2022)[4] which, in turn, produces similar answers as it would using the current five principles in the AWI Act. Therefore, our members welcome focus on the principles, but would ask for careful consideration about what this adds to the updated legislation.

2. Do you agree that in the AWI Act we should talk about finding out what that adult's will and preferences are instead of their wishes and feelings?

SWS and our members agree that will and preferences are important and can incorporate wishes and feelings within their realm. It is important that the terminology used within the principles is understandable across disciplines, and for those who may become unwell and require input from the legislation.

3. Do you agree that any intervention under the AWI Act should be in accordance with the adult's rights, will and preferences unless not to do so would be impossible in reality?

Yes.

4. Do you agree that the principles should be amended to provide that all support to enable a person to make their own decisions should be given, and shown to have been unsuccessful, before interventions can be made under the AWI Act?

[4] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

SWS and our members agree with this notion and would highlight that this is generally how things are done at present. SDM should be the default approach if autonomous decision making is not possible, until an assessment of substituted decision-making requirement is made.

We would welcome further clarity around any proposed changes to the process of evidencing that SDM has been unsuccessful and would urge that it does not become a bureaucratic, procedural led experience for all involved. Relationship based practice is important and any changes should reflect this.

5. Do you agree that these principles should have precedence over the rest of the principles in the AWI Act?

The role of an MHO includes involvement in making decisions to keep people safe and protected, and this may be at odds with a persons will and preference. Although will and preferences are an important principle, our members feel that there should be equity across all the principles. However, will and preferences (along with wishes and feelings) can be a useful starting point when considering the principles.

Our members also highlight challenges in having one principle with precedence over others in that there is an assumption that a persons will and preference automatically aligns with other people who may be involved in the delivery or outcome of these wishes, or affected by them. There needs to be consideration of the balance of rights of the person against the rights of others, and the rights of the wider population.

For these reasons, our members feel that these principles should not have precedence over the other principles.

6. Do you have any suggestions for additional steps that could be put in place to ensure the principles of the AWI Act are followed in relation to any intervention under the Act?

Individual Local Authorities (LA's) are better placed to offer examples from their perspectives, but our members have suggested that a focus on will and preferences as soon as an adult encounters health and social care services may be advantageous, and answers should be recorded in care plans/medical notes. This information can be reviewed if there are significant changes in care provision.

In line with this, it has been suggested that AWI case conferences should have an automatic focus on the principles of the Act, and that these are discussed with all present, including the person who is receiving a service, to ensure that any action is in line with the principles.

It should be noted that these suggestions **would not require legislation** to incorporate them into practice.

7. Do you agree with the change of name for attorneys with financial authority only? Please add any comments you have around this.

Yes. SWS and members believe that this will make roles easily identifiable and will be helpful for all involved.

8. Do you agree with our proposals to extend the power of direction of the sheriff?

Yes

9. Do you agree with our proposal to amend the powers of investigation of the OPG to enable, where appropriate, an investigation to be continued after the death of the adult?

Yes, this will be useful. Anything that extends the powers of public bodies to investigate potential financial abuse of vulnerable people is to be welcomed.

10. Do you agree that the investigatory responsibility between OPG and local authority should be split in the manner outlined above?

We do not agree to the proposal to split the duties and responsibilities of the investigation between the OPG and the LA. Giving LA's responsibility for continuing Power of Attorney's and investigating property and financial affairs has significant resource implications, and to ensure that LAs could cope with these additional investigatory powers and duties, training needs and resource allocation would need to be considered.

Concerns of our members also include the loss of expertise and powers which the OPG bring to investigations, for example, their ability to suspend bank accounts whilst an investigation is taking place. There is also a concern that this may erode partnership working and the clarity of roles and responsibilities. Given that the OPG may have a role in supervising POAs (if directed to by the Court), our members feel the investigatory responsibility should not be removed from them.

Our members feel that this is an area of AWI and indeed Adult Support & Protection (ASP) that **does not require legislation**. Instead, it is suggested that a focus on stronger partnership working could be enhanced through Multi-Disciplinary Team approaches, Codes of Practice, or Care Programme Approaches – all of which are models that exist and are utilised to good effect in the Scottish Social Work, Health and Social Care system.

11. Will these changes provide greater clarity on the investigatory functions of OPG and local authority?

SWS and our members feel that the current requirements in terms of the OPG being responsible to investigate concerns around POA, finance and property and the LA investigating concerns around POA and use of welfare powers is clearer than what is being proposed.

12. Will this new structure improve the reporting of concerns?

These proposed changes will not improve the difficulties members currently experience.

Part 2:

13. Do you agree with the proposals for training for attorneys?

Yes, and any training needs to reflect the needs of this population and ensure the training is supportive, user friendly and jargon free. However, members have raised concerns about the timing of this training, and the quality of the training. Clarity is required as to when this training would be provided. Will it be at the time of setting up the POA? Or will it be at the point where the POA is enacted?

Both present challenges in that the timescale between the initial setting up of the POA, and the point in which it is required, may be significant and the training may not be easy to recall. Equally, if training is delivered at the point where the POA is required to provide care and support, there may be considerable stress on the attorney which may impact on the ability to attend (and retain) training.

14. Do you agree that OPG should be given power to call for capacity evidence and defer registration of a power of attorney where there is dispute about the possible competency of a power of attorney document?

Yes, but we think this is unlikely to occur as most POAs are provided by suitably qualified solicitors. Concerns usually come to light after registration, at the point where the powers are being used.

15. Do you agree that OPG should be able to request further information on capacity evidence to satisfy themselves that the revocation process has been properly met?

Yes.

16. Do you agree that OPG should be given the power to determine whether they need to supervise an attorney, give directions or suspend an attorney on cause shown after an investigation rather than needing a court order?

Yes.

17. Should we extend the class of persons that can certify a granter's capacity in a power of attorney?

Yes.

18. Do you agree that a paralegal should be able to certify a granter's capacity in a power of attorney?

No. Our members feel that only professionals with significant training and expertise in understanding the impact of mental illness on capacity should be involved in certifying a granters capacity.

19. Do you agree that a clinical psychologist should be able to certify a granter's capacity in a power of attorney?

Yes.

20. Which other professionals can certify a granter's capacity in a power of attorney?

Any professional with a qualification in mental health, including legislative aspects, such as MHOs and CPNs, could certify a granter's capacity in a POA.

21. Do you agree that attorneys, interveners and withdrawers (under Part 3) should have to comply with an order or demand made by OPG in relation to property and financial affairs in the same way as guardians?

Yes.

22. Do you agree that the Public Guardian should have broader powers to suspend powers granted to a proxy under the AWI Act whilst an investigation is undertaken into property and financial affairs?

Yes.

23. Do you agree that the MWC and local authority should have broader powers to suspend powers granted to a proxy under the AWI Act whilst they undertake an investigation into welfare affairs?

Yes. Members feel that this is in keeping with the suggestions within the Scottish Mental Health Law Review (2022)[5] wherein more informal and reasonable means for including people in decisions using AWI is taken out of the Sheriff court, and into the realm of the LA, allowing them to act efficiently and quickly to protect service users and carers.

Part 3:

24. Do you agree that the powers and specific amounts should be decoupled?

Yes. SWS and our members believe that this simplifies a process that was too restrictive and opens access to a lesser restrictive option. OPG supervision ensures risks associated with this increased flexibility are minimised.

25. Do you agree that the withdrawal certificate should contain standard, proforma powers for the withdrawer to use?

Yes.

26. Do you agree that access should be given to the adult's current account, rather than setting up a 'designated account'?

Yes, however SWS and our members do feel that there could be safeguards added to this process for both the adult and the person gaining access to the funds. We would welcome consideration of a requirement for a bond of caution to protect the person with incapacity from any potential mismanagement of the funds.

27. Do you agree that in certain circumstances, applications where there is a guardian, or intervener with powers relating to the funds in question should be allowed?

[5] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

Yes, but only if the existing powers are not sufficient to address the matter in hand. Additionally, it should be considered as to whether ATF is the least restrictive option and one which compliments the existing order.

28. Do you agree that we should clarify that a bar to applying under this section only applies if someone is already authorised under Part 3 of the Act to intromit with the same funds?

Yes.

29. Does having an account in the adult's sole name limit organisational use of the scheme?

Yes. Additional work needs to be done to support LA/Health & Social Care Partnerships to develop ATF. There are significant problems in getting access to people's finances where there are no other relatives or adults involved in that person's care. Allowing them to operate in this way under ATF makes the scheme more attractive to organisations promoting a less restrictive option. It needs to be made clearer that LA/partnerships can more readily intromit with someone's funds to ensure that their financial affairs are being looked after.

30. Should we add the same transition provisions to intervention orders as there are for guardianships?

Yes. This promotes the least restrictive principle.

31. Do you agree that sheriffs, under certain circumstances, should be able to grant powers to access funds under our new proposal?

Yes. If Part 4 is removed, then this proposal promotes the least restrictive principle, avoiding intervention and financial guardianship applications.

32. Do you agree that authorised establishments should be able to apply under the ATF scheme?

Yes. If Part 4 is removed, then this proposal promotes the least restrictive principle, avoiding intervention and financial guardianship applications.

33. Do you agree we should split intimation of the application between organisations and lay people (OPG)?

Yes. This promotes standardisation across practice with intervention orders, guardianships, and ATF.

Part 4:

34. Do you support the proposal to remove Part 4 from the AWI Act?

If, as the consultation document proposes, this part of the Act is rarely/never used, and if finances can be managed more appropriately through other parts of the Act to benefit the adult, then the proposed removal is supported.

35. Do you think alternative mechanisms like the ATF scheme, guardianships and intervention orders adequately address the financial needs of adults with incapacity living in residential care settings and hospitals?

Alternative mechanisms are required if part 4 of the Act is to be removed. The ATF scheme is supported by our members, and it is suggested that this should be nationally funded to support people who cannot get access to their funds because of lack of capacity.

Corporate appointeeships can be costly and are difficult for care homes to manage. If the costs were managed in such a way that the organisation applying for it is not disadvantaged, and if the process was simplified, then corporate appointeeships should be a standard aspect of becoming a resident in a care home.

Part 5:

36. Do you agree that the existing section 47 certificate should be adapted to allow for the removal of an adult to hospital for the treatment of a physical illness or diagnostic test where they appear to be unable to consent to admission?

In principle, SWS and members understand the ethos behind this proposal, but there are concerns about how this will be enacted if required. If a person is unwilling to be conveyed to hospital, who has the responsibility to take them there? And if restraint is required, who must provide this? A section 47 certificate may not account for the practical challenges which will be incurred.

Taking similar actions under the Mental Health (Care & Treatment) (Scotland) Act 2003 potentially carries greater restrictions, but it also has greater safeguards built in for any adult who requires input under the legislation. In addition, there are clearer guidelines for all staff involved in terms of restraint and other training requirements. Psychiatric Emergency Plans are in place to manage detentions under the Mental

Health (Care & Treatment) (Scotland) Act 2003[6] and these contain detailed guidance on procedures, roles and responsibilities when conveying a person to hospital. Our members feel that the same would be required for the section 47 certificate.

Under this proposal, the training and support for health and social care professionals needs to be mandatory to allow this to work. Only staff of sufficient seniority and trained to a required standard in assessing capacity should be able to grant a section 47 certificate.

37. Do you consider anyone other than GPs, community nurses and paramedics being able to authorise a person to be conveyed to hospital? If so, who?

No. Only staff of sufficient seniority and trained to a required standard in assessing capacity should be able to grant a section 47 certificate.

38. Do you agree that if the adult contests their stay after arriving in hospital that they should be assisted to appeal this?

There is concern from our members that this does not fully align with the principles of the Act. The onus is placed on the adult to safeguard themselves in this scenario and there is an assumption that they will have an awareness of their right to appeal, and knowledge about how to do this. Depending on the situation, an adult might not be able to appeal their stay in hospital until after treatment, by which time the appeal may be redundant.

We support the concept of assisting an appeal but believe that additional safeguards should be included that reduce the need to appeal. Such safeguarding procedures may include the involvement of the equivalent of a Designated Medical Practitioner (DMP) to offer a second opinion at time of admission. We also believe that, upon admission, an adult should be immediately advised of their rights, including right to appeal, and be given full support to do this if they choose to.

39. Who could be responsible for assisting the adult in appealing this in hospital?

We would recommend that social workers, MHO's, and independent advocacy workers are in an ideal position to support an appeal. Social workers within hospital discharge teams already have a role in ensuring people have the appropriate support they need on discharge from hospital. They are independent of the hospital

[6] https://www.legislation.gov.uk/asp/2003/13/contents

systems and are in the right position to support someone in this appeal process. Similarly, advocacy workers are independent of the hospital system and have appropriate training to support adults through the practical and legal elements of this process.

40. Do you agree that the lead medical practitioner responsible for authorising the section 47 certificate can also then authorise measures to prevent the adult from leaving the hospital?

SWS and our members do not believe this is a decision that the lead medical practitioner should make on their own. We feel that an immediate decision to detain a person for a holding period (72 hours, for example), followed by a requirement to consult with an MHO and a second medical practitioner to agree a 28-day period detention would be more in line with the principles of the Act, and the rights of the adult. This also needs to involve consultation with the persons family, guardian or attorney prior to an enhanced section 47 certificate being granted or as soon as possible thereafter.

In addition to this, the lead medical practitioner should be required to have advanced training on AWI capacity assessments.

41. Do you think the certificate should provide for an end date which allows an adult to leave the hospital after treatment for a physical illness has ended?

Yes, it is essential to have an end or review date on any formal detention.

42. Do you think that there should be a second medical practitioner (i.e. one that has not certified the section 47 certificate treatment) authorising the measures to prevent an adult from leaving the hospital?

Please refer to the answer for question 40. A second medical practitioner should automatically be involved if an individual is effectively being detained.

43. If yes, should they only be involved if relevant others such as family, guardian or attorney dispute the placement in hospital?

A second medical practitioner should automatically be involved if an individual is effectively being detained, regardless of whether the decision is being disputed by others or not.

44. Do you agree that there should be a review process after 28 days to ensure that the patient still needs to be made subject to the restriction measures under the new provisions?

Yes. This will ensure that the patient's rights are being protected.

45. Do you agree that the lead clinician can only authorise renewal after review up to maximum of 3 months before Sheriff Court needs to be involved in review of the detention?

Our members believe that the matter of detention should be reverted back to the Sheriff Court after 28 days, which would be in line with similar processes for detentions under the Mental Health (Care & Treatment) (Scotland) Act 2003[7]. This would have greater compliance with human rights.

Our members also believe that there could be a greater role for an enhanced Mental Health tribunal system as proposed within the recommendations from the Scottish Mental Health Law Review (2022)[8]. This would be more accessible for any individual at the centre of any process under the legislation.

46. What sort of support should be provided to enable the adult to appeal treatment and restriction measures?

An MHO or social worker should ensure that the adult has access to appropriate professionals who can support an appeal and support the adult to instruct a solicitor if required. This may include access to advocacy services, but it is recognised that this may require additional investment for support services for them to meet demand and make these safeguards meaningful.

Members suggest that the creation of deprivation of liberty officer roles may assist in further protecting the rights of the adult. Safeguarders should also be made available to any individual who is a patient in hospital.

47. Do you agree that section 50(7) should be amended to allow treatment to alleviate serious suffering on the part of the patient?

Yes.

[7] https://www.legislation.gov.uk/asp/2003/13/contents

[8] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

48. Would this provide clarity in the legislation for medical practitioners?

As this applies to medical practitioners, we cannot comment.

Part 6:

49. Do you think the requirement for medical reports for guardianship order should change to a single medical report?

There is concern from members that this is purely a time saving exercise and a means to move people out of hospital at a quicker pace. At present, members are finding that GPs are increasingly refusing to do reports, and this delays applications for Guardianship Orders. Often, the reports that are received are not satisfactory in their evidence. If this was to be the case for the single medical report, members do not feel that it would suffice.

If the requirement was to move to one medical report, it would be beneficial if GP's (or other specialist medical practitioners such as psychiatrists or psychologists) were contracted to complete these reports, thus reducing potential delays. This would also require the evidence in the single report to be detailed and of a high quality.

One single report would also increase the level of assessment and scrutiny required from social workers, MHOs, solicitors, and sheriffs to compensate one medical report. Therefore, there are resource implications for other professionals.

50. Do you agree with our suggestion that clinical psychologists should be added to the category of professional who can provide these reports (where the incapacity arises by reason of mental disorder)?

Yes.

51. Do you think the Mental Health Officer form for guardianships can be improved, to make it more concise whilst retaining the same information?

As a mechanism to make the form more concise, without losing any of the essential information, this proposal would be supported.

The form for guardianship needs to be reviewed, and many of our members highlighted issues with formatting of the existing form. Any proposed amendments should involve MHOs in the design of the changes.

52. Do you think the 'person with sufficient knowledge' form can be improved, making it more concise whilst retaining the same information?

Yes.

53. Should the person with sufficient knowledge continue to be the person who prepares the report for financial and property guardianship?

Yes. Some further work is needed to clarify who the person with sufficient knowledge can be and make it clear who should be writing the report.

54. Do you agree with our proposal to replace the second part of the 'person with sufficient knowledge' report with a statutory requirement to complete the OPG guardian declaration form?

If this does not delay the application process and it avoids duplication, then members would be in support of this proposal. However, if this impinges on immediate need, then members would have concern. We feel more detail is required about how this would impact those working with the legislation and those who are subject to it.

55. Should sheriffs be afforded the same discretion with Mental Health Officer report timings as they are with medical reports?

Although time scales are in place to benefit the adult at the centre of the legislation, we do believe that MHOs should be afforded the same professional standing as colleagues in medicine and would support discretion to consider an application out with the 30-day limit.

56. Do you agree that the best approach to cater for urgent situations is to amend the existing interim guardianship orders?

Our view is that a definition for applying for an order is needed in the first instance before practical changes are suggested.

An additional category could be added which outlines that interim orders can be applied for in situations where people are delayed in hospital and have been assessed as lacking capacity and are fit for discharge. At present it is challenging to argue that applying the current criteria for an interim order works for someone in hospital who is safe but lacks capacity. This is not an urgent situation that will immediately affect the persons welfare. However, we recognise that it will assist in the medium to longer term because of the risk of institutionalisation in hospital.

57. Do you agree that an abbreviated mental health officer report together with a single medical report should suffice for a guardianship order to be accepted by the court?

Our members believe that this would be acceptable, so long as the interim application is followed by a more comprehensive, full application. Members also state that an abbreviated report is of no use if the person does not meet the criteria for an interim order.

58. Do you agree that there should be a short statutory timescale for the court to consider urgent interim applications of this sort?

There is concern from members that having a two-tier timescale will result in the number of "urgent" cases rising, thus placing additional pressure on depleted services to prioritise certain cases within a 7-day period.

59. Do you agree that further medical reports are not required when varying a guardianship to add either welfare or financial powers?

Our members highlight that this proposal is contrary to the decision specific nature of capacity as defined in the legislation. If the legislation were to be amended, and this definition within the legislation was revisited, our members feel there would still need to be robust evidence of a review which captures the views of the adult, guardian, and MDT, such as minutes of meeting, where this was discussed.

60. Does the current approach to length of guardianship orders provide sufficient safeguards for the adult?

Yes. In general orders are granted for 3 or 5 years currently. It is rare to see an order granted for longer than that timescale. That allows for appropriate time for the order to be supervised and reviewed effectively.

However, in line with the recommendations within the Scottish Mental Health Law Review (2022)[9] the principles of the Act should be at the centre of all interventions. Those involved in completing applications need to be aware that order duration is dictated by the least restrictive principle and, therefore they should seek to have shorter duration periods where applicable.

[9] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

61. Do changes require to be made to ensure an appropriate level of scrutiny for each guardianship order?

Members believe that the review of guardianship orders by social work requires more consistency for both LA and private orders. At present there are a high percentage of private guardianship orders in place which are not scrutinised because of lack of resources to meet supervision requirements.

In essence, human rights aligned practice needs additional resourcing.

62. Is there a need to remove discretion from the sheriff to grant indefinite guardianships?

This does seem to vary from one LA to the next. In some areas there has already been meaningful change in the granting of orders, meaning they are rarely longer than 3 or 5 years. However, in other areas this is not the case and the sense from members is that the removal of this discretion to grant indefinite guardianships would be welcomed.

63. If you consider changes are necessary, what do you suggest they would be?

Applications for orders need to be taken away from the Sheriff court and placed in a more informal environment where service users and carers can be present when decisions about an order are being made and they are fully involved in this process.

Our members believe that there could be a greater role for an enhanced Mental Health tribunal system as proposed within the recommendations from the Scottish Mental Health Law Review (2022). This would be more accessible for any individual at the centre of any process under the legislation.

64. We propose that the following powers should be added to the list of actions that guardians, attorneys and interveners should be expressly excluded from.

Do you agree?

- **consenting to marriage or a civil partnership,**
- **consenting to have sexual relations,**
- **consenting to a decree of divorce**
- **consenting to a dissolution order being made in relation to a civil partnership**
- **consenting to a child being placed for adoption by an adoption agency,**
- **consenting to the making of an adoption order,**

- **voting at an election for any public office, or at a referendum**
- **making a will**
- **if the adult is a trustee, executor or company director, carrying discretionary functions on behalf of them**
- **giving evidence in the form of a sworn affidavit**

It is felt that these powers are protective measures, however, it is important to point out that they do add further exclusions which may conflict with the principles of the Act. Therefore, members feel that these powers should be added to the list of actions which would exclude guardians, attorneys and interveners from involvement, but with the addition of a caveat which states “unless specifically asked at court for this to happen”.

65. Are there any other powers you think should be added to a list of exclusion?

No.

Part 7:

66. Do you agree with the overall approach we are proposing to address DOL?

There is concern from SWS and our members about the proposed overall approach to DOL, and further clarity would be welcomed.

A statement which gives advance consent to deprive the granter of their liberty appears to be a pre-emptive strategy to avoid potential delays in care at a later stage, but members have raised concerns about the ethical implications of this. An advance statement might well capture the will and preferences of an adult at the time of writing, but this then assumes that will and preferences remain static and do not change from that point on. Depending on the amount of time which lapses between the writing of the statement, and the potential enactment of it, a person’s will and preference might have changed significantly. We believe that the will and preference of an adult must be considered at the time where the advance statement might come into force.

Asking someone to voluntarily give up their right to liberty in an advance statement poses challenges when considering human rights and we recognise there may be significant resistance to this from those who work with the Act, and those who receive a service under it. We also foresee significant resource and safeguarding implications. If deprivation of liberty is sought under a guardianship, the adult has safeguards built into this and a sheriff will authorise this. Guardianship will also be reviewed in an established manner. If this process is potentially diluted through the advance statement within a POA, we feel there will be fewer safeguards for the

adult, and a review process which relies heavily on LA input in an environment where services are already stretched. Therefore, although we recognise that the proposal is less restrictive than seeking guardianship, we believe that the level of scrutiny when liberty is being deprived needs to be on a par with guardianships.

67. Is there a need to consider additional safeguards for restrictions of liberty that fall short of DOL?

Yes, our members believe that additional safeguards should be considered in this instance. This could include a review by the Mental Welfare Commission (MWC), or an MHO (or senior social worker) from the LA.

68. Do you agree with the proposal to have prescribed wording to enable a power of attorney to grant advance consent to a DOL?

Please refer to the answer for question 66.

69. What are your views on the issues we consider need to be included in the advance consent?

Please refer to the answer for question 66.

70. What else could be done to improve the accessibility of appeals?

We would suggest that all practitioners are aware of the right to appeal and can signpost clear guidance on how to do this.

Specialist DOL officer roles could be created.

The right to advocacy and legal representation/safeguarders, however, as highlighted in question 46, this would require significant and appropriate investment to ensure that additional demand can be met in a meaningful way.

71. What support should be given to the adult to raise an appeal?

We would suggest that all practitioners should be aware of the right of the adult to appeal and can signpost to clear guidance on how to do this.

Members also feel that specialist DOL officer roles could be created who could have responsibility for raising awareness, training, and supporting the appeals process.

We also believe that the right to advocacy and legal representation/safeguarders should always be considered. This will require resourcing of these support mechanisms to address potential demand.

72. What other views do you have on rights of appeal?

Appeals could be heard by the Mental Health tribunal in a similar manner to the way appeals are held under the Mental Health (Care & Treatment) (Scotland) Act 2003[10].

73. How can DOLs authorised by a power of attorney be appropriately reviewed?

In consultation with our members, we conclude that there are two options for reviewing a OL order that has been authorised by a POA.

Option 1 could see a role for the MWC and/or the OPG in having a programme of review requirement in relation to specific restrictions, or

Option 2 could see the DOL being reviewed under care management arrangements.

Either option would have resource implications which would need to be addressed.

74. Do you agree with the proposal to set out the position on DOL and guardianships in the AWI Act?

Yes

75. In particular what are your views on the proposed timescales?

SWS and our members believe that a 6-month initial review, then another review at 12 months (which could be extended if required), would be in line with the least restrictive principle. A review at 6 months would align with similar approaches under the Mental Health (Care & Treatment) (Scotland) Act 2003[11].

76. What are your views on the proposed right of appeal?

SWS and our members believe that the right of appeal is essential. All adults should be fully supported in any appeals process. This support could be provided by social workers and/or independent advocacy in order to safeguard human rights. As

[10] https://www.legislation.gov.uk/asp/2003/13/contents

[11] https://www.legislation.gov.uk/asp/2003/13/contents

mentioned in previous responses, this would require consideration of resources as the increase on demand for these professionals could be significant.

77. What else could be done to improve the accessibility of appeals?

We would suggest that access to advocacy, safeguarders, and/or independent legal representation.

Given the suggestion of greater involvement of the Mental Health Tribunal in the Scottish Mental Health Law Review (2022)[12], we feel there may also be a role for this forum in making appeals more accessible.

78. Do you agree with the proposal to have 6 monthly reviews of the placement carried out by local authorities?

Yes.

79. Is there anything else that we should consider by way of review?

No.

80. Do you agree with our proposal for a stand-alone right of appeal against a deprivation of liberty?

Yes, but it should be supported in a meaningful way by a system that is designed to assist the service user in making the appeal.

81. Do you agree with our proposal to give the MWC a right to investigate DOL placements when concern is raised with them?

Yes, as this adds a further layer of protection for the adult. We would also welcome the investigations making recommendations in relation to the DOL and exploring alternatives with care services.

82. Do you agree with the proposals to regulate the appointment, training and remuneration of safeguarders in AWI cases?

[12] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

Yes. This is a positive idea to standardise the training, pay and conditions for safeguarders.

83. Do you agree with the proposals for training and reporting duties for curators?

Yes.

84. What suggestions do you have for additional support for adults with incapacity in AWI cases to improve accessibility?

Curators should be available in any DOL situation where any of the involved parties feel it is necessary.

There should be an effort to make all supports as local and accessible as possible and this would indicate a greater role for the Mental Health tribunal system in dealing with AWI applications would improve accessibility for the adult (as per recommendations made within the Scottish Mental Health Law Review (2022)[13]).

Additional resourcing around SDM practice, tools and methods of communication would be welcomed.

85. Do you think there should be a specific criminal offence relating to financial abuse of an adult lacking capacity?

Yes.

86. If so, should the liability be the same as for the welfare offence?

Yes.

87. Do you have experience of adults lacking in capacity being supported in hospital, despite being deemed to be no longer in need of hospital care and treatment? What issues have arisen with this?

Given the difference in resources across all 32 LA's, they would be best placed to provide specific examples, however, a summary of issues from our members include:

[13] https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf

- Institutionalisation of service users and an inability to retain their existing skills. A downturn in people's quality of life.
- Prolonged periods in hospital care makes it dangerous to move vulnerable people when discharge eventually happens it can lead to further complications in a person's health.
- An inability to admit people to hospital who require it because of beds being blocked.
- At an organisational level strained relationships between colleagues making the working environment more challenging.

88. Do you foresee any difficulties or challenges with using care settings for those who have been determined to no longer need acute hospital care and treatment?

SWS and our members believe that a move to a social setting when an acute hospital setting is no longer required is to the benefit of the adult. We recognise there will be challenges, yet the benefits of such a move should not be underestimated.

However, it should be noted that there are considerable challenges on adult social work services across all LAs, and social care provision across the country resulting in ongoing difficulties in the procurement of care packages. The continued emphasis on delayed discharge, diverts attention away from those who are being maintained and managed in the community creating significant risk of further hospital admissions from those who were being managed in the community, but who now have a depleted (or no) provision of care.

Similarly, any adult who is to be moved into residential/nursing care should be done so in a sensitive and planned manner. The emotional and psychological impact of such a move is something that social workers are educated and trained to manage, and any move should not be viewed as a "convenient" option to alleviate pressure from another part of the care system.

89. Are there any safeguards we should consider to ensure that the interests and rights of the patients are protected?

Similar to other requests on safeguarding, the involvement of advocacy should automatically be considered and offered to the adult.

We would suggest that formal structures are looked at for hospital discharges into care homes for adults who lack capacity. This may not need to be legislated, but we feel this would be best practice and reduce the likelihood of decisions being made without the involvement of the full MDT.

90. What issues should we consider when contemplating moving patients from an NHS acute to a community-based care settings, such as a care home?

Please refer to the answer for question 88. Any change for the adult should be managed in a planned and sensitive manner as they are not simply a statistic on a delayed discharge spreadsheet. A significant change will be stressful and disorientating, so any preparatory work that can be done, should be done. This might include visits to the potential care home, visits from the care agency to the adult in order to assist the familiarisation process, and the inclusion of informal carers and family members in an effort to build an understanding of the adult at the centre of the intervention.

There is no one “correct” approach as social work needs to be person centred and relies on relational practice. This ethos has to be at the heart of any move – view the adult as an individual who may be finding the process difficult, and who can assist us in understanding what they need throughout the process.

Part 8:

91. Should the AWI Act be amended to allow the creation of more than one ethics committee capable of reviewing research proposals involving adults lacking capacity in Scotland?

SWS and our members are not directly involved in research with adults who lack capacity, however, in terms of safeguarding individuals, we feel that the strengthening of ethics is welcomed.

92. In research studies for which consent is not required for adults with capacity to be included as participants, should adults with incapacity also be permitted to be included as participants without an appropriate person providing consent for them?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

93. Should Scotland A REC (or any other ethics committee constituted under Regulations made by the Scottish Ministers in the future) have the ability to determine that consent would not be required for adults with incapacity to be included as research participants, when reviewing studies for which consent would also not be required to include adults with capacity as research participants?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

94. Should the AWI Act be amended to allow researchers to consult with a registered medical practitioner not associated with the study and, where both agree, to authorise the participation of adults with incapacity in research studies in emergency situations where an urgent decision is required and researchers cannot reasonably obtain consent from a guardian, welfare attorney or nearest relative in time?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

95. Should the AWI Act be amended to allow researchers to enrol adults with incapacity in research studies without the consent of an appropriate representative of the adult, in emergency situations where a decision to participate in research must be made as a matter of urgency, where researchers cannot reasonably obtain consent from an appropriate representative of the adult, and where researchers act in accordance with procedures that have been approved by Scotland A REC (or any other ethics committee constituted by regulations made by the Scottish Ministers)?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

96. Should the AWI Act be amended to permit researchers to nominate a professional consultee to provide consent for adults with incapacity to participate in research, in instances where researchers cannot reasonably obtain consent from a guardian, welfare attorney or nearest relative?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question. However, members note that the guidance for question 96 highlights “social care” workers as being one group of professional consultees and we would seek clarity about the selection of workers who could be approached from the social care workforce, and their expected level of knowledge and expertise, both in the research subject (the individual) and the research topic. We would take the opportunity to highlight the distinction of social workers, and social care professionals – both important, and unique parts of the health, social work and social care workforce and system.

97. In addition to being permitted to participate in research that investigates the cause, diagnosis, treatment or care of their incapacity, should the AWI Act be amended to allow adults lacking capacity to participate in research that investigates conditions that may arise as a consequence of their incapacity?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

98. In addition to being permitted to participate in research that investigates the cause, diagnosis, treatment or care of their incapacity, should the AWI Act be amended to allow adults lacking capacity to partake in research that investigates conditions they experience that do not relate to their incapacity?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

99. Should the AWI Act be amended to allow adults with incapacity the opportunity to participate in any research; regardless of whether the research explores conditions that relate to their incapacity or investigates conditions that they experience themselves?

SWS and our members are not directly involved in research with adults who lack capacity and cannot offer a view for this question.

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