Response ID ANON-N6XF-9BYD-T

Submitted to **Review of Mental Health Law in Scotland**
Submitted on **2020-05-29 12:36:49**

Who do we want to hear from?

Are you responding to the consultation as:

An organisation or individual who works with the law

Part B: Organisations

Please fill in the box below with your contribution. There is no restriction to the length of your statement.

Please explain your view.:
1. The Mental Health (Care and Treatment) (Scotland) Act 2003 "the Act" came into force in 2005 – how well does it work at the moment?

The Scottish Association of Social Work (SASW) – (part of BASW UK) – is the professional association for social workers in Scotland. We are here to promote the best possible social work services for all people who may need them, while also securing the well-being of social workers.

Our members are made up of qualified social workers across Scotland – many of whom are Mental Health Officers (MHOs). The response to this consultation was guided by our MHO forum, a group of front-line Mental Health Officers who work directly with mental health legislation and are able to offer invaluable insight into its impact on the vulnerable service users they work with and for.

The international definition of social work states our objectives of 'problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Social work intervenes at the point where people interact with their environments. The principles of human rights and social justice are fundamental to our work' (IFSW, 2014)

SASW welcomes the opportunity to respond to this consultation, and it is through the lens of these objectives that this submission should be considered.

Members expressed concern that the questions in this consultation do not reflect the paradigm shift they hoped would come from this review. As was argued in our response to the review of Learning Disability and Autism in the Mental Health Act, SASW feels strongly that a movement away from substitute decision making towards supported decision making is necessary to formally reduce the undue authority of strangers or professionals making decisions which may not be indicative of an individual's will, preferences and desired outcomes. Similarly, it is essential that any review of legislation looks at stronger rights of redress for patients, where rights are willingly ignored because of local practice or resource implications. Members commented that some of the questions seem to elicit intended 'tweaks' to the existing Act, as opposed to the substantive change in mental health law that was promised. SASW were extremely supportive of the ambitious, progressive aspirations within the LD and Autism review and wish to stress the importance of this same approach to embedding human rights principles and allowing Scotland to prepare for the next 20 years being applied to this review of legislative change.

Members commented that in some areas across the country, the principles of the Act are honoured and there are good community resources and hospital alternatives available. However, this, alongside the impact of understaffing and variable staffing numbers, mean that this is not consistent across the country.

Members also raised concerns about the increasing use of Short-Term Detention Certificates (STDC) and Emergency Detention Certificates (EDC) which signals that something is not going well in the community. It was felt there was not an equal increase in Compulsory Treatment Orders (CTOs), as compared with the others, due to this having an impact on treating people at home. Members felt that the steady increase in detentions over the last 10 years is evidence that the least restrictive options are not always readily available for patients.

It was expressed that the high level of Section 36 Emergency Detention Orders used in some urban areas is due to a lack of access to MHO's over many years. This is despite the intent and principles embedded in the 2003 Act, which aim to provide that a short-term detention serves as a gateway order, as it ensures patients receive the proper rights and representation upon being detained.

The Criminal Procedures Act was highlighted as a significant strength, as well as a call for the Transfer or Treatment Direction (TTD) process to be ironed out, to ensure that MHO's can be involved in joint assessment procedures in order to consent to a move, rather than just be asked to 'rubber stamp' this.

2. Are there certain things that hinder the act from working effectively? What would improve things?

The significance of resources in relation to the effectiveness of the Act was repeatedly raised. Whilst SASW acknowledge that this consultation relates to legislative change, we would argue that any discussions around this are synonymous with resources – real change cannot be realised without discussion of resources to facilitate it.

The service MHOs are able to provide has diminished significantly across a decade of austerity and as a result significantly impacts on the effectiveness of the Act.
SASW wishes to reinforce that if any review of the Act does not encourage the government to find a way to address the 'postcode lottery' of significant differences in care standards and rights across the country, then Scotland will not be able to honour the principle of 'reciprocity'. For instance, members have told us that some health board areas will state that even inpatients do not have ready access to psychological therapies, even when the person has a form of mental disorder

where best evidence indicates that this is a more pressing or equivalent need to pharmacological treatment and nursing care. The resources must be made available to ensure patients receive the right level of therapeutic care, to aid in their recovery and give them a better chance at living a normal life.

Concerns were also raised about a lack of recourse for a patient who is unable to instruct to appeal against an STDC, due to advocacy not always being available. It was suggested that (assuming the patient wishes for this) a patient's statement be submitted, along with applications/extensions/variations etc. as currently (unless there is an appeal) all the information that the tribunal receives are from the Responsible Medical Officer and the Mental Health Officer – both of whom are usually supporting the order or measure requested.

In terms of improvement, it was felt the Act would benefit from an update on strengthening the role of the Carer, and that Advanced Statements should be mandatory wherever possible.

Members were critical that many aspects of the Act do not reach into the depths of the Health Boards, Local Authorities and the Scottish Government funding associated with Mental Health. These are many of the matters that hinder real treatment for those subject to the Act who remain in hospital – whether this is in low secure female resources, forensic units or slow stream rehab. The Act would benefit from addressing the gaps in statute around delivering intervention, first presentation psychosis services and similar least restrictive measures.

There was a call for better training of health care professionals, including doctors, non-MHO social workers, CPNs and support workers, as well as better training of police, in using mental health legislation, and for mental health to become 'everyone's business' in the same way that, for example, child protection is.

Members were supportive of the change in the 2015 Act in relation to default named persons, however felt that there needs to be clarity on listed initiators; members felt that this is an underused gap in good patient representation when patients do not have capacity to nominate.

There was criticism of the tribunal and its limited powers to try to ensure that 'gaps' are filled as well as a lack of scrutiny beyond Mental Welfare Commission visits or meetings with Local Authorities that overviews the provision of services in relation to Sections 25 and 26 of the Act.

Members felt that it is essential that mental health has parity with physical health, with regards to access to emerging technologies that could aid in the diagnosis and subsequent treatment of patients and that this must be taken into consideration moving forward.

Lastly, the Act could be written in a less excessively complex way, and could be presented more clearly, concisely, and accessibly.

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

As was mentioned above, SASW met several times with the review team, formally responded to – and was supportive of - the review of Learning Disability and Autism in the Mental Health Act, and many of the recommendations within it.

Central to this review was embedding human rights, and the recommendation for Human Rights Officers. MHO's, as social workers, see their roles currently as human rights defenders, ensuring least restrictive alternatives are employed and providing an independent 'check and balance' to the medical model. The activities of MHOs span across multiple domains, intersecting the effects of structural poverty and trauma, with medico legal concerns. MHO's are often the ones following patients in their journey, as they pass between hospital and community mental health teams with no other consistent professionals. SASW members were disappointed to note that the work of around 700 MHOs across the country was not acknowledged explicitly in the context of this review, when the past president of the Mental Health Tribunal for Scotland has expressed a number of times at our annual conference for MHO's that without the enthusiastic embracing of the new Act and the tribunal system by MHOs, the service would not work. SASW wish to stress the importance of the MHO role in defending the human rights of vulnerable patients. We believe that MHOs should be better empowered to carry out this work in the context of this review in a similar model to that which was outlined in the Andrew Rome review. Patients with Learning Disabilities and Autism were repeatedly highlighted as a group that is not well served by this legislation, and we wish to reinforce the comments made in the previous review as a way of addressing and improving this gap in support.

Patients detained under Section 44 who do not have capacity to instruct do not receive automatic support (for example in the form of advocacy) for named persons, were also raised by members as a group who are not well served by the current legislation; those who could leave hospital, but for whom there are a lack of services.

People with personality disorders, were also consistently raised. As previously mentioned, the absence of psychological services or groups for patients with this diagnosis – particularly women – is troubling, with members going as far as stating that only offering pharmacological interventions to them, known not to be what is in their best interests, is backward and cruel. This is particularly pertinent to those receiving inpatient care – who need these psychological therapies to allow them to move on to supported accommodation or their own tenancy after they are discharged. It was suggested that not providing patients with this diagnosis with the relevant psychological therapies whilst in inpatient care is a 'waste of an expensive resource' and addressing this will significantly improve outcomes for these patients.

Female mentally disordered offenders requiring high secure care, were another group that was raised as not being well served. It was suggested that therapies be ramped up in prisons for people who are there. If they aren't being transferred to the forensic estate, these groups should be getting the appropriate care before going back into the community. Substance misuses in prisons, and addressing the root causes of substance misuse, was suggested as a means of addressing this. By addressing root causes, and freeing up mental health nurses who administer methadone to dual-diagnosis prisoners to undertake psychological therapies with these groups could stop the 'revolving door to prison' experienced by so many of these patients.

The Matrix Guide to delivering evidence based therapies in Scotland, which outlines effective therapies such as mentalisation, attachment, cognitive analytic therapy and DBT groups are not always equally available to people who are either inpatient in the community or in prison, and should be more widely accessible – and would help many patients who are currently not well served by the legislation.

Young people who are transitioning from a young person service, with first presentation psychosis, receiving support through (CAMHS) were also mentioned.

CAMHS teams are said to be well resourced, but there is a stark contrast when people first move into adult services and they see the lack of resources that are available in adult community mental health teams, and this can be a real challenge for people when they make that step.

SASW believes it is essential that for high risk populations – such as care experienced young people –that health boards implement clear policies on corporate parenting and the types of support they would offer to those who have been through the care system. That includes young people transitioning into adult services.

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

Members were particularly concerned about vast variations in definition of 'significant risk' from simply having an untreated illness with no evidence, or minor public disturbances, and feel strongly that this must be addressed. There are concerns around the impact of interpretation and values around the word 'significant', that are not unpacked - even in the guidance - and that often this can lead to a very low barrier for compulsion. The impact of regional disparities was also raised, and how different areas have different thresholds.

MHOs said they were concerned that if a medic decides on compulsion, it can be hard not to support them, even if they believe that this is not the best route for the patient. MHOs can often come into disrepute with medics who strongly advocate for compulsion on the basis of low thresholds and a lack of clarity around what constitutes 'significant risk'. Tight timescales around CTO applications was also raised as particularly problematic and do not support what the Act is trying to achieve in terms of a human-rights based approach.

SASW recommends that tests be more clearly articulated and that MHOs be afforded appropriate time to go through these. These must be linked to nationally agreed, measurable standards, where MHOs can contribute to these assessments.

Members emphasised advanced statement and feel that this is an underutilised means of supported decision making, to empower the patient to explain what best suits their needs – greater clarity or use of this could help improve things.

Members said that significantly impaired decision making (SIDMA) would benefit from change/clarification as often evidence is 'no or little insight', which they feel is not sufficient. Members tell us regularly that psychiatrists views in tribunals are often complicated by treatment disagreements, and therefore, this is offered as evidence of this.

Some members felt that social workers should be more recognised in a role for joint capacity assessments. Whilst they can do this now, this is in custom only, medical opinions are accepted however these are still often global impressions of capacity and have not taken account of specific capacities or fluctuating capacities, and still tend toward a conservative view rather than a presumption of capacity.

5) 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

Once again, the issue of available resources was raised in relation to this question. Whilst SASW note this is not necessarily about the legislation itself, we wish to stress once more that the review team have some responsibility to bring this to the attention of sponsors.

Members felt that more support services are needed to help people recover from mental disorder, and that these services have been reduced as local authority budgets have been cut. Members also raised the issue of insufficient resources in community mental health teams and a need for more effective and responsive community mental health support.

Members said that as is the case with many resource constraints, it is not wholly possible for the pre-discharge rehabilitation to be thoroughly undertaken and in turn means people either receive inadequate supports to assist their recovery or receive more unnecessary inpatient care.

There was a call for better resources per capita, supporting undiagnosed people in the community whereby mental health support is difficult to access.

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

Whilst there was acknowledgement that, realistically, the law cannot cover everything, it was stated that decent housing, a reasonable income and access to health and social services are basic human rights – but that, support can only be offered, and cannot be imposed on individuals who choose not to use it. Changes to DWP benefits and PIP was said to have caused a lot of stress for people.

SASW feel that the principle of reciprocity, and a definitive duty to provide the full range of treatment identified through evidence as best to manage someone's disorder, be enhanced to become a requirement within the law. This should be an absolute condition to the loss of liberty, and enforced pharmacology, which is arguably the most severe peacetime breach of human rights and individual dignity and must not be allowed to continue if the state is not acting to get the person well. Otherwise, we are simply medicalising and locking up those – for extended periods – who are often the most traumatised in society, and from generations of structural poverty.

There was criticism that the Act focuses on the end part of the journey, rather than looking further up-stream about towards what support and resources are needed to take affect and its important the review considers this. A need to better streamline the discharge planning process, to ensure that plans are put in place to support patients once they leave hospital, would improve things.

It was suggested that widening / strengthening the powers of the Tribunal or Mental Welfare Commission could mitigate this.

7) Do you think the law could do more to raise awareness of and encourage respect for the rights of people with mental health needs?

It was raised that in some instances, the medical model vs the social work model continues to be prevalent, which often leads to conflict amongst professionals. These matters can become the debate, and this can create barriers to effective communication, that unconsciously disregards the need to keep the person at the centre.

It was said that if any application or detention required clear detail on the impact on individual human rights and the justification as to why/how these were being limited, and whether tribunal could insist on services (similar to excessive security provision) that this would require additional funding for mental health services or would impact on patients/clients who are not subject to the Act.

Some said that this is not necessarily the role of the law and can be addressed elsewhere with other policies procedures and guidance.

Members raised the positive community spirit, and community-based work that has arisen in the context of the COVID-19 pandemic. Patients that otherwise wouldn't have come to the attention of mental health services have been identified as a result, due to community groups checking on people they otherwise wouldn't and raising the alarm to ensure people get the support they need. Many of these people would have risked 'slipping through the net' if this wasn't the case.

It was suggested that, if an individual has a short term order revoked, it is important that the MHO be told about this, to ensure the proper supports are put in place once they leave hospital and that this be added to the legislation as a way of raising awareness and encouraging respect. It is essential that, under the principle of reciprocity in the act, that a certain level of service is provided to patients. Ensuring MHOs are informed of this could allow people to be signposted to services that could help them after discharge.

8) 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 three pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?

Members said that the Adult Support and Protection Act has been given a very high profile nationally although it has less legal authority than the mental health or adults with incapacity acts. They also raised the issue that there is a huge amount of inappropriate adult support and protection referrals received by social work and this is not a good use of resources when budgets are being reduced. Ensuring that mental health is 'everybody's business', in the same way that adult and child protection is, could work to mitigate this.

Regarding the Adult Support and Protection Acts and the Adults with Incapacity Acts, it was said that a fusion of both these Acts would be beneficial for the adult to ensure best outcomes. With the Mental Health Act, they felt it should stand alone and not be subject to fusion law, as the legal tests that must be met offer a clear and definitive safeguard as to when the Act can be applied.

It was said that there are certain persons who are subject to both 2003 Act and Adults with Incapacity Act, and felt there would be benefit in considering a 'combination' of these Acts (although there are a small number of guardianship applications (less than 1% due to inability to communicate due to physical impairment). They felt that AWI applications should also be heard by the tribunal, but felt less clear about how Adult Support and Protection would fit, as this covers a far broader range of circumstances and also, a very low rate of orders sought in comparison to number of duty to enquire/adult protection case conferences.

Some members were of the view that there should be one Act, whilst others were of the view that this be dealt with by separating the Act. They felt that in order to fully address the adult support and protection act, the provisions need to increase significantly as it is viewed as a toothless act that is impacting heavily on Adult Intake services, with limited benefit to those involved.

SASW once again wishes to stress the emphasis on supported decision making, and the importance of this in 'moving forward' with mental health legislation. This change will require resources to allow that support to be available and to help make this a reality.

About you

What is your name?

Name:
Emily Galloway

What is your email address?

Email:
emily.galloway@basw.co.uk

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Scottish Association of Social Work

The Review would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

Do you want to have more involvement with the Review in the future? We may send you an email to follow up.

Yes

I confirm that I have read the privacy policy and consent to the data I provide being used as set out in the policy.

I consent

Evaluation

Please help us improve our consultations by answering the questions below. (Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?:
Neither satisfied nor dissatisfied

Please enter comments here.:

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?:
Neither satisfied nor dissatisfied

Please enter comments here.: