Royal College of Nursing Scotland

RCN Scotland response to the Scottish Government's consulation on

Scottish Mental Health Law (Scott) Review

Scottish Mental Health Law Review consultation | Scottish Mental Health Law Review

https://www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-consultation/

Contents and summary of response

Our submission to the review (29 May 2020)

A recap highlighting our three broad areas for reform: legislative clarification; an enhanced role for nurses, modernisation of Scotland's approach to mental health.

Our approach to the consultation and a response to section 1 'Introduction and Background'

We acknowledge the aspects of the consultation which have shaped, and the criteria that we have applied to shaping, our response, the latter essentially being the potential impact on nursing, both as a profession and a workforce.

2 What is the purpose of the law?

We agree that 'the purpose of the law should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled' and that it should 'seek to ensure that the wider needs of people with mental disorder are met' and with the four attendant principles. We caution that the various rights of staff must also be accounted for; that they require support; and we emphasise the need for safe staffing (including implementation of the Health and Care (staffing) (Scotland) Act 2019) and the proper resourcing of services.

3 Supported decision-making

We support the introduction of supported decision-making; highlight the existing role and responsibility of the registered nurse in this regard under the current NMC Code and Standards; support the proposal to introduce a 'statement of rights, will and preferences' to replace advance statements; suggest the review may choose to 'tidy up' the current cluttered landscape of those with a role in supporting an individual's decision-making or who hold a decision-making power on that person's behalf.

4 The role and rights of carers

We support the proposals but choose not to comment further as this is a matter beyond our area of expertise and they do not seem to raise any significant concerns for our membership.

Contents and summary of response

5 Human rights enablement – a new approach to assessment

We support the principle of human rights enablement in health and social care but have concerns about the extent to which the process as described is pragmatic, operable or appropriately overseen. We cover issues of practicality, bureaucracy, responsibility accountability, governance, outcomes and of creating a different rights-based process from that proposed more widely for Scotland.

6 Autonomous decision-making test

We offer supportive comment on the proposal for an autonomous decision-making (ADM) test to replace current tests for incapacity and impaired decision making but we are limited by the lack of detail provided. We suggest that nurses are appropriately placed to conduct an ADM test.

7 Reduction of coercion

We set out some of the issues affecting the position of the nurse in regard to 'coercion', with reference to the NMC Code; we critique the way coercion is characterised (and caricatured) and the basis on which the consultation asserts the existence of the issues requiring to be addressed but we nevertheless accept that there is value in reducing the use of coercive and compulsory measures; we question whether changes to the law will make the difference that the review aspires to as opposed to properly staffed and resourced services, particularly highlighting the duty in the unimplemented Health and Care (staffing) (Scotland) Act 2019 on Scottish Minister to endure a sufficient supply of health care staff.

8 Accountability

We agree that there must be a strong accountability framework; note that we are comfortable with what is proposed including with what we see to be the underlying human rights 'driver' and with the possibility of making the recommendations of certain bodies enforceable; we remind the review that employees and workers have rights too and 'there should never be a situation where the rights of employees or workers are considered to be of secondary importance to those of anyone else or, worse, of no importance at all.'

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9 Children and young people

We support the proposals but choose not to comment further as they do not seem to raise any significant concerns for our membership, with the exception that we comment on staffing with respect to perinatal mental health services, CAMHS and otherwise.

10 Adults with Incapacity proposals

We choose not to comment on the proposals on guardianship and powers of attorney as these are matters beyond our area of expertise and do not seem to raise any significant concerns for our membership but we argue for clear communication to health and care staff as to who has final decision-making powers about the care and treatment of an individual; we reiterate our earlier point about tidying up the landscape; we challenge the assertion that current law, regulation and practice 'allows' for an inappropriate approach to care and treatment but agree that clarification of language regarding the concepts and place of supported decision making and of an autonomous decision-making test will, in due course, be necessary; we comment that audit of section 47 certificates must be underpinned by appropriate technology; that further safeguards on the appropriate use of force and detention may be necessary including more frequent review of section 47 certificates.

11 Deprivation of Liberty

We support the proposals but choose not to comment further as they do not seem to raise any significant concerns for our membership.

12 Mental disorder

We suggest that, for an overall term, 'mental health condition' might be the least stigmatising of those posited in the consultation and note that there will be a need for differentiated definitions of that term for the practical purposes of care and treatment.

13 Fusion or aligned legislation

We support fusion legislation for reasons of accessibility and legal coherence and a single judicial forum for reasons of the more informed, and faster, administration of justice.

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Additional Comments

We deal with five matters not otherwise dealt with above: conflicting rights, an enhanced role for nursing; shifting care from hospital to the community; the introduction of a National Care Service and mental health care and treatment pathways.

Our submission to the review (29 May 2020)

https://www.rcn.org.uk/about-us/our-influencing-work/policy-briefings/sco-pol-independent-review-of-mental-health-law-in-scotland

In our original submission to the review we highlighted:

- The importance of nurses' views and experience
- Workforce issues, particularly ongoing and seemingly intractable staff shortages, the solution to which requires the proper implementation of the Health and Care (Staffing) (Scotland) Act 2019
- The results of an RCN membership survey in 2019 showing the prevalence of overwork, pressure at work, and the extent of the physical and verbal abuse to which nursing staff were subject. Since then, Covid-19 has also had an impact on work related pressure. *NB our more recent surveys show little change in this picture* https://www.rcn.org.uk/news-and-events/news/rcn-scotland-employment-survey-260122

We stated that this meant that any change to mental health law must be backed by proper communication, resourcing and training & development.

We welcomed a human rights-based approach to reform but cautioned that legal reform 'needs to provide a framework to enable transparency, fairness and proper process to manage situations where rights come into conflict with each other' and that 'the rights of staff need also to be upheld'.

We reiterated our six enablers for the transformation of adult mental health care in Scotland (established in 2016) which, in summary are that:

1. Change should be well led, managed and funded
2. Health and wellbeing are defined by the individual
3. People using services are involved both in decision-making about their care and at a strategic level
4. Real relationships are developed as the foundation of effective teamwork
5. An environment is created which enables people to take risks proactively
6. Services have the right staff, with the right support and training, to meet identified needs

We then suggested three broad areas for reform:

1. Legislative Clarification (including guidance,) on issues such as a more robust definition of 'medical treatment' and a rights-based approach to advance statements
2. Enhanced role of nurses, essentially enabling and empowering nurses to make a greater range of decisions to do with care and treatment
3. Modernisation, of Scotland's approach to mental health including using more inclusive language, recognising social, economic and cultural rights, ensuring the provision of supported decision making and shifting care from hospital to the community.

Our approach to the consultation and a response to section 1 'Introduction and Background' pp. 1-28

We acknowledge:

- That 'the principal aim of the Review is to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and to remove barriers to those caring for their health and welfare.' (p. 3-4)

    - That this consultation 'does not reflect all the work the Review has undertaken… cannot say precisely which provisions should be in mental health and capacity law, and which provisions should be in laws which applies to everyone' and that some recommendations may be non-legislative and that 'targeted consultation will take place on (other) issues over the coming months before recommendations are made for the final report' which includes:
        - 'the interface between criminal and mental health legislation, and what is needed to change in that field'
        - 'the way compulsory treatment orders in hospital and the community are currently used and how this might be approached differently in the future'
        - (It is not clear if this list is exhaustive or illustrative).

    - That the review is 'not attracted to having different legal frameworks for particular diagnostic categories and (is) aiming for a law which protects and supports anyone who has a mental health condition of whatever type.

    - The timescale for the review to report to Scottish Government (September 2022)

Consequently, we offer additional comments at the end of this document that deal with some of the issues that the consultation does not cover but on which we would expect the review to ultimately take a view and/or offer a recommendation.

Despite the above limitations, the scope of the consultation remains very wide, and it is in the interests of our members for us to respond as clearly as we can on the matters which are of most concern to them. We have therefore focused our response on a consideration of the extent to which any given discussion or proposal:

- addresses the matters raised in our original submission
- accords or does not accord with the ethos and professional practice of nursing (primarily mental health and learning disability nursing)
- appears likely to operate to the benefit or detriment of nursing as a workforce

Our approach to the consultation and a response to section 1 'Introduction and Background' pp. 1-28

We have not commented on the proposals otherwise, with some minor exceptions, as our areas of expertise do not extend to matters which are, for example, essentially those of jurisprudence, including the precise nature 'rights' in our present society.

The questions asked in the consultation do not always correspond to, or follow directly on from, the detailed discussion which precedes them. We have therefore answered them directly where we felt it was in our interests of our members for us to do so but have made broader comment beyond the questions on the same basis.

We note that the mental health of the Scottish population and of the nursing workforce was a key component of our manifesto for the 2021 Scottish Parliament elections in which we called for 'renewed urgency (on the part of Scottish Government) around reform of mental health legislation, with an emphasis on improving services and embedding the rights of people using them'.

2 What is the purpose of the law? pp. 29-44

RCN does not disagree with the opening propositions in this section, that 'the purpose of the law should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled and that it should 'seek to ensure that the wider needs of people with mental disorder are met' or with the four attendant principles:

- Respect for dignity.
- Respect for autonomy.
- Non-discrimination and equality.
- Inclusion

Nor do we disagree with the potential inclusion of a principle of respect for carers, a specific principle concerning the rights of children and a principle of reciprocity.

In pursuit of the realisation and accessibility of rights we understand the need to consider what duties should be placed on delivery bodies and we accept the review's 'current thinking' (p. 37) concerning core minimum obligations; reframing health and social care duties in terms of human rights standards; monitoring; and recasting the Scottish Mental Health Strategy.

However, at this point we wish to sound a note of caution. The centrality of the rights of people with mental disorder to the review's thinking is accepted as entirely appropriate but the way the review expresses itself risks, perhaps inadvertently, characterising the relationship between people in receipt of care and treatment and those providing that care and treatment as inherently and typically adversarial. We are only mandated to speak for nursing, but we can categorially say that, for nursing, this is absolutely not the case. Alongside the personal ethos of individual nurses and the way that nursing is taught and regulated as a professional discipline, nurses are charged by both the NMC's Code of Practice and its Standards of Proficiency to be partners in care with the people for whom they care and not adversaries who wish to impose treatment upon unwilling individuals.

It is also the case that many nursing staff (as well as other health and social care staff) will have direct or indirect experience of mental health issues in their personal capacity (particularly as a result of the Covid-19 pandemic) and will have as much of an interest in there being rights based mental health law from that perspective as they will do from a professional perspective. In our 2021 manifesto, cited above, we noted that 'working under (the) sustained pressure (of the pandemic) is having a devastating impact on the physical and mental health of staff'. The Scottish Government's NHS Recovery Plan 2021-2026 https://www.gov.scot/publications/nhs-recovery-plan/ stated that staff 'are only human' and provided for 'additional support for staff, to ensure that they can recover and recuperate' which included 'a new Workforce Specialist Service that is providing tailored, confidential mental health support to regulated staff across the NHS and social care workforces'.

2 What is the purpose of the law? pp. 29-44

For all these reasons, we therefore suggest that the 'current thinking' on p. 37 comprising this proposal: 'the development of these core minimum obligations and the framework for progressive realisation should be carried out with the full participation of people with mental disorder and their representative organisations' should also 'be carried out with the full participation of health and social care staff and their representative organisations'.

We do not question the need to address the multiple matters listed under 'Requirements which follow from particular human rights' (p. 38-42) and there are proposals to commend here, for example, the proposal 'that sections 25-27 of the 2003 Act should be extended and reframed to set out clear and attributable duties on NHS Boards and local authorities to provide mental health support to individuals with significant levels of need, reflecting the core minimum obligations.' However, it is not always clear what precise form the suggested reform might take, whether non-legislative (how exactly will the social determinants of good and poor mental health' be addressed by a recast Scottish Mental Health Strategy?) or legislative (what changes are necessary to section 26 of the 2003 Act that are considered truly capable of ensuring 'inclusion in society'?). Accepting that these matters are the subject of questions posed in the consultation, they would benefit from greater clarity and precision from the review on its own thinking but, in our view, the utility of the law alone in tackling stigma, discrimination and culture change is already established through, for example, the operation of the equalities legislation and the mandating of more appropriate types of specific services (as in sections 25-27 of the 2003 Act). Whilst, overall, the proposals for tackling elements of the social determinants of mental health are reasonable, to truly do so would require changes to law well beyond the remit of the review. For example, changes to the provision of 'residential accommodation' in mental health law is only part of the housing reforms that one might argue are necessary to address the social determinants of mental health in the preventative sense.

We very strongly agree with following: 'Community and inpatient services: both forms of services must be adequately resourced, not one at the expense of the other.'

This includes being properly staffed. In our original submission to the review, we referred to the need to implement the Health and Care Staffing (Scotland) Act 2019 and noted there that 'no changes in the law can improve patient outcomes if the workforce to implement these changes is not in place'. We also argued in our original submission that 'any change to the law must be cognisant of the current workforce challenges in the sector and the fact that there are insufficient mental health nurses to meet demand in mental health pathways' and pointed out that 'mental health nursing has one of the highest vacancy rates out of any nursing job category in Scotland', which remains the case (see https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/).

2 What is the purpose of the law? pp. 29-44

The Scottish Government's current position as contained in its Health and Social care National Workforce Strategy (https://www.gov.scot/publications/national-workforce-strategy-health-social-care/?msclkid=07332be7d03d11ecacb12261a6bbebdb) is that the Health and Care (Staffing) Scotland Act 2019 may not be implemented for another two years. That can only serve to make this situation worse. On page 71 of that same strategy there is a pledge that reads 'following the refresh and re-focus our Mental Health Strategy in 2022, develop a mental health workforce plan in the first half of this parliament'. This is something that we called for in our 2021 manifesto ('A commitment to undertake modelling to project the growth required in the mental health nursing workforce and develop a fully-costed and transparent workforce plan by the end of 2021'). That this mental health workforce plan is realistic and effective could not be more crucial to the improvements to mental health provision that the review envisages. In fact, it is obvious that many of the existing gaps, identified by the consultation, in service provision as it currently should be, are due to insufficient staff being available.

We also strongly agree with following:

- The need for 'Co-ordinated professional training and development… across health and social care services to develop a consistent understanding of a human rights-based approach to mental health care. Staff training should include lived-experience led training.'

There then follows this proposal:

- The need for 'more support to professionals to ensure they have the knowledge, resources and authority to give full effect to the human rights of individuals. Implementing human rights treaties including the UNCRPD may require a different skills-mix and different balance of specialisms, and a redistribution of responsibilities between professionals, to remove barriers which disable people and to empower them.'

Our support for this proposal is contingent upon our reading of the word 'authority' as a reference to the moral authority that comes from new knowledge, rather than describing a new 'legally bestowed' authority or power, and on our reading of the references to 'a different skills mix and different balance of specialisms, and a redistribution of responsibilities between professionals' as referring to creative, equitable, multi-disciplinary team working, with professionals working to the top of their competencies, rather than as a suggestion that any single group of professionals is currently proving especially inadequate when it come to the enabling or empowerment of people in receipt of care. In the case of nursing, we would reject such a suggestion as invalid and could not support proposals that were based on deskilling nursing staff and/or denuding them of, or preventing them from taking on, the responsibility for matters for which they are trained, qualified and regulated.

3 Supported decision-making pp. 44-60

The consultation states (p. 44) that: 'we have heard from many, that individuals' views must compete with other principles, practices and cultures that might be more favourable to non-consensual intervention and that inadequate service provision has an impact as well.'

Whatever 'principles, practices and cultures' may have grown up organically in specific situations there are no 'principles, practices and cultures' inherent in, or proscribed for, the ethos and professional practice of nursing that are inimical to the concept of supported decision making nor should there be any detrimental effect on the nursing workforce from its wider introduction. In fact, the NMC Code of Practice (https://www.nmc.org.uk/standards/code/) and the Standards of Proficiency for Registered Nurses (https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/) make it unequivocally explicit on multiple occasions throughout, that nurses have a key role in providing such support to decision making, including requirements to balance their own decision making accordingly.

For example:
Code par. 2.3 'encourage and empower people to share in decisions about their treatment and care'

Code par. 2.4 'respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care'

Code par. 4.3 'keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process'

Standards par. 1.9 'understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions'

Standards par. 3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages

Standards par. 3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

Standards par. 4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate

3 Supported decision-making pp. 44-60

In our original submission, we pointed out that the wider implementation of supported decision making 'without clear rules and guidance… can lead to risk aversion or accusations of professional influence' and that 'nursing staff would require protection against this, as well as clarity, both in the law and in the guidance, if their role is to be changed to include analysis of capacity in a supported decision-making model'. Clearly this remark refers to a formalised and mandated model that might be significantly different from current practice (such as the Human Rights Enablement (HRE) model proposed by this consultation, on which, see below). Current practice in nursing may not be specifically badged as a 'supported decision-making model' but, as can be seen from the extracts from the Code and the Standards above, it is already very much part of the ethos and professional practice of nursing.

On pp. 48-57, the consultation considers some of the more formal processes and tools that might serve as expressions of supported decision-making. Bearing in mind what we say above about the nursing workforce requiring 'clear rules and guidance' and clear law we offer the following:

Given that our original submission said that 'the legislation (on advance statements) could be more rights based and the importance and implications of making an advance statement strengthened', we are comfortable with the proposal to introduce a 'statement of rights, will and preferences' to replace advance statements, for the reasons given. We cannot see that the proposal will, as described, present any challenges for nursing. However, we note that this proposal is to be the subject of a 'targeted consultation'; and trust that we will be included in that consultation so that we can properly examine and comment upon the detail.

We do not have any comment on the sections 'powers of attorney', 'decision-making supporter', 'independent advocacy', 'specialist support in legal and administrative proceedings' (including appropriate adults), 'aids to communication, non-instructed advocates'.

On the matter of named persons, it is obvious that the current law, particularly as it operates across the Mental Health (Care and Treatment) (Scotland) Act 2003 Act ('the 2003 Act') and the Adults with Incapacity (Scotland) Act 2000 ('the 2000 Act') is, put bluntly, something of a guddle, with a number of apparently duplicative roles likely to cause confusion for those being supported by them, those having those roles and those who have to interact with these 'role-holders', whether that is during a person's care and treatment (medical or other), at a Mental Health Tribunal, in the Sheriff Court or otherwise.

3 Supported decision-making pp. 44-60

We note that this matter is to be the subject of another 'targeted consultation' (in which we would also wish to be included) but if we understand the intentions of the review correctly, we agree that its recommendations are the right place to 'tidy up' concepts such as 'advocacy' 'named person', 'safeguarder', 'listed initiator', 'curator ad litem' and so on and so forth, primarily from a person-centred perspective. It can only be to the benefit of that person if those responsible for aspects of their care and treatment, including the nursing workforce, have real clarity about the person's needs, wishes and interests at various stages of that care and treatment and do not have to try to establish them from multiple overlapping assertions as to what the person actually wants, coming from different supporters.

The profession of nursing is already attuned to the matters of undue and controlling influence, as the extracts from the Code and Standards already given make clear. This includes taking cognisance of some of the matters raised on p.58 of the consultation, for example, the Standards par. 1.14 require a nurse to 'provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments.' We agree with the proposals on pp. 58-59 to facilitate the successful implementation of supported decision-making, particularly with the acknowledgment that 'work needs to be taken forward with practitioners and people with lived experiences' and the need for 'appropriate resources'. We suggest that, for efficiency in terms of practice, people and resources any Centre for Excellence may form part of a relevant existing body.

Bearing in mind the question '…given that advocacy is a form of (supported decision making), what should be the relationship between that and the existing duties in respect of advocacy?', we would suggest that any recommendation for 'a duty on public bodies to ensure that anyone who requires it has access to support for decision making' sets out:

α) whether this new duty replaces the duty to provide independent advocacy under sec. 259 of the 2003 Act, perhaps becoming an appropriate 'amalgam' of the two duties

β) if it does not replace that duty, how precisely the review considers that 'support for decision making' differs from 'independent advocacy' and how it is anticipated that the new duty will operate alongside the existing duty, including what value each duty would add to the other in terms of those people who are supposed to benefit from the operation of the duties (although we doubt that having two possibly/probably overlapping duties is a sensible approach).

4 The role and rights of carers pp. 61 – 65

We deplore the fact of the negative experiences of carers cited and that the provisions of the Carers (Scotland) Act 2016 are not always being complied with. We support the proposals made to support carers, including for 'Carer Awareness Training' to be mandatory for all mental health staff.

5 Human rights enablement – a new approach to assessment pp. 66 – 77

In our original submission we stated that 'a human rights-based approach to (the) review has been welcomed by our members' and that the review could improve the law's recognition of social, economic and cultural rights. We are pleased to see, from the consultation, that the review has proceeded very much along these lines.

That being the case, and given the nature of our response so far, we are broadly supportive of the 'proposed recommendation' (p. 66) for 'the inclusion in law of a framework which enables respect for human rights; to ensure a focus on respect for the will and preferences of people with mental disorder, whilst at the same time ensuring appropriate support and protection. The framework applies irrespective of diagnosis and would be applied in situations currently covered by mental health, adults with incapacity and adult support legislation'.

We also broadly support the new concept of 'human rights enablement (HRE)' informing processes such as those outlined on p. 68 (community care assessments etc.). However, we note that the language of the consultation, despite talking about HRE as 'not a one-off or discrete event but rather an underpinning process' (p. 67) quickly turns HRE from a verb into a noun ('an HRE' pp. 68 & 69) and this is a matter of real concern to us, albeit one of execution not of principle. This is because, regardless of the exact situation now with respect to which professional undertakes which process, we see an enhanced role for nursing in the long term in the provision of mental health care and treatment, as per our original response. It is therefore inevitable that nursing will find itself involved with HREs on that basis and, of course, the nursing workforce will be involved with the implementation of HREs within the parameters of its present role, from the moment that HREs are introduced.

'An HRE' will inevitably mean the introduction of a process distinct from existing processes and additional to them and this appears to be precisely what is proposed on p 75: 'we are proposing a Form, clearly marked as HRE, on which there are guided sections for completion.' We see that the review's intention 'is not to add 'yet another assessment' but to build on what exists now, to ensure there is meaningful consideration of an individual's human rights when decision-making, to ensure a holistic view of the person's needs' but, with respect, little of what is contained in this section (a) explains how 'building on what exists now' will avoid the increase in bureaucracy that always attends such innovations, as represented by the proposed form and the proposals for its dissemination (see below) or (b) supports the review's contention that it genuinely 'appreciate(s) the huge burdens on services, particularly now, and the administrative load that is imposed by any assessment'. If this was the case, the review might have suggested introducing the HRE once digital systems were able to accommodate it but since 'current inadequacies in the digital healthcare record network make this impossible' (p. 75) the proposal is to go ahead anyway, including that there 'should be a statutory requirement to ensure that, with consent, the record is placed in all relevant health and social care files and a duty on those who have made or been involved with the assessment to inform others.'

5 Human rights enablement – a new approach to assessment pp. 66 – 77

This is not to argue against the introduction of an HRE per se. We understand the review's imperative (and that there is an obvious argument that if we waited for public sector digital provision to catch up with what we needed it to do we might never do anything at all) but we must ask whether, in this particular instance, it is sensible to make legal provision for something that is going to prove either undeliverable because of inadequate resources or, perhaps worse, end up being a half -hearted 'tick box' exercise because those who have to undertake it have no real appreciation of what it is supposed to be about or to achieve. The consultation paragraph that most obviously encapsulates the problem is the one on p. 69 under 'Things to consider as part of an HRE evaluation are', which reads: 'Have all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment? A record should be made of this consideration. This record should be easily accessible for ease of later review.'

Even if the HRE is limited to the list of European Convention on Human Rights (ECHR) and International Covenant on Economic, Social and Cultural Rights (ICESCR) and the derived rights contained in recommendations 1(a), 1(b) and 2 of the National Taskforce for Human Rights Leadership (NTHRL, https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/pages/4/) this still amounts to twenty-one rights. Will they all be listed on the form, with a requirement to explain how each has been assessed as being met or not being met, how and to what extent?

It is unfortunate that the review has not found itself in a position to set out in much greater detail at this stage how an HRE would or could work for those who would be required to undertake it and exactly which existing processes the HRE would 'build upon', rather than providing a few examples (on p. 68). We note that that the consultation asks a question about the 'triggers' for an HRE but the review is better placed than any respondent to take the overview of which processes the HRE would 'build upon' because only the review has the clear picture of what its own proposal (the HRE) is intended to achieve. Much more detail is required if any truly useful detailed comment is to be offered. As the proposal stands it is impossible to understand what an HRE form would look like to, for example, a nurse making a decision to detain pending medical examination under section 299 of the 2003 Act or a nurse seeking to safeguard or promote the physical or mental health of an adult under section 47 of the 2000 Act or for an approved medical practitioner conducting a medical examination of a patient for the purposes of an application for a compulsory treatment order under sections 57 and 58 of the 2003 Act. Delaying this detailed thinking until such time as a Code of Practice is written (as is implied by the proposal for a code on p. 76) is an inadequate approach in the circumstances.

5 Human rights enablement – a new approach to assessment pp. 66 – 77

The proposals for a requirement for there to be action on the outcomes of the HRE (pp. 72-73) and rights of remedy and appeal (p. 74) only make the provision of greater detail all the more important. If an employing body has responsibility for the former and liability for the latter, that body will want to be sure that every HRE form is watertight by way of ensuring that everyone who has to complete it understands human, economic, social and cultural rights to the same extent. Under the NMC Code of Practice nurses must already 'respect and uphold people's human rights' (par. 1.5) but we wonder whether the review is guilty of understatement when it notes on p. 76 'that to develop a coordinated, formal HRE structure will require a strategy of training and awareness raising to realise the progressive change needed'. We suggest that a considerable programme of enhanced education, including adding to the content of university degrees, would be necessary to ensure the national consistency of practice across professions that will be required.

We have three other significant concerns with the HRE proposal:

1. The lack of detail provided on how responsibility and accountability for an HRE works as between its 'initiator', those 'additional practitioners' (both referenced on p. 70) who may 'review and revise' it (presumably this counts as 'formal updating' as per p. 73), those 'different practitioners (who) become involved and consider the person's needs from their specialist perspective' (also p. 70) and whoever is responsible for storing the HRE 'accessibly in the patient record' and ensuring that 'the record is placed in all relevant health and social care files' (p. 75, apparently this is to be done manually given the issues with IT cited and on which, see below). Which one of these people is or should be the 'identified professional responsible for ensuring that there is proper coordination, and that a coherent HRE plan is developed?' (p. 70). Might this person be the 'holder' of the HRE? Will this person be empowered to act if someone who has 'made or been involved with the assessment' fails to 'inform others', as per their proposed duty (p. 75)? The impression given throughout this section is that there is to be created a towering paper-based bureaucracy without any clear lines of accountability or governance (clinical governance and otherwise), to compensate for the fact that we cannot yet create a shared digital record to which a HRE could more straightforwardly be added. We cannot support this poorly expounded approach to implementing in practice what we otherwise support in principle. It is incumbent upon the review, not upon respondents to this consultation, to set out a far clearer process and set of relationships, responsibilities and accountabilities as between those who will have to operationalise the HRE in practice.

2. The lack of detail provided about how a person (or body) responsible for undertaking an HRE is expected to action its outcomes (p. 72-73) when to do so involves matters outwith the control (in whole or in part) of the person or body.

5 Human rights enablement – a new approach to assessment pp. 66 – 77

2. (cont). The risk and implications of creating a two-tier system associated with providing a greater level of support for the advancement of the human, economic, social and cultural rights of people with a 'mental disorder' than that available to others in general but more especially over other groups demonstrably subject to perceived vulnerability or unequal treatment. We appreciate that that the review may consider that the National Taskforce for Human Rights Leadership (NTHRL)'s recommendations https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/pages/4/ once implemented, will create a universal system to which the review's proposals will add a necessary extra support for an especially vulnerable group. However, aside from it being the review's remit to focus on a particular part of our society and group of people, it is not clear why this group is more or less vulnerable (and so should have support for it prioritised) than other vulnerable groups.

3. To make use of the same example from the consultation involving 'suitable accommodation', why should a housing related HRE issue be prioritised for a person with a mental disorder and with 'repeated chest infections', solely as a result of that person 'qualifying' for an HRE, when, for example, a person of colour without a mental disorder but also with 'repeated chest infections' may be equally in need of 'suitable accommodation' but cannot avail themselves of the benefits of having somebody responsible for actioning the outcomes of their HRE because they do not qualify for an HRE. This, if anything, is an argument for extending the concept of an HRE to all public services, not least because all public authorities are already required to operate their services under the current law in a way that is compliant with human rights at all points. If we need an HRE in mental health, it is arguably an indication that those services are somehow failing to comply with their current responsibilities via-a-vis human rights and if that is the case might there not be a similar problem across all public services that a 'universal HRE' would solve? The proposals for remedy and appeal also create a parallel structure whereby one group may be able to access a sympathetic, supportive and ultimately more effective process, perhaps run by the Mental Welfare Commission (p. 74), whereas other equally if differently vulnerable or discriminated against people may only have recourse to the 'main' system, whether this is an 'overarching framework for the protection of everyone's human rights' created in line with the NTHRL recommendations (p. 107), or the existing system. There is an argument that what we need is a universal system capable of accommodating all situations and of providing 'extra support' to a range of vulnerable groups, perhaps defined using on equalities law. Alternatively, we may need a range of extra supports outside the main system to accommodate those groups. The review's recommendations should set out much more clearly how it envisages the interdependency (or any other relationship) between its own proposals and those of the NTHRL to make it clear why both sets of proposals need to be implemented.

6 Autonomous decision-making test pp 78-90

We understand this section to be concerned with what any given test is attempting to demonstrate rather than being concerned with the substance of a test, which will, in any event, involve professional judgement. Existing tests seek to identify 'incapacity' and 'significantly impaired decision-making ability' and so may be said to be preoccupied with a 'deficit-based model' of mental health, that is, trying to identify what the person cannot do rather than what they can do.

We can see the value of the change of emphasis in the 'Proposed Alternative Test' described on p.80. We appreciate that what a person can and cannot do are two sides of the same coin and that a decision on this matter is a question of emphasis, rather than of absolute difference. Nevertheless, we can see that 'a new autonomous decision-making (ADM) test' may indicate a move to an 'asset-based model' of mental health that tries to identify what a person can do rather than what they cannot. We consider that this would be a good thing.

However, whilst there is some helpful detail provided about the concept of the test, and the context surrounding it on p. 80- 87 (including non-urgent and urgent situations, who performs the test, conflicts of will and preferences, recording, review, renewal and appeal) the change of emphasis as it would be experienced by the person whose capacity is being tested is not clearly made out and this makes it difficult to offer more detailed comment.

The nursing workforce is already involved in testing for capacity or for significantly impaired decision-making ability and may, as we proposed in our original submission, come to enjoy an enhanced role in matters of mental health care and treatment. We do not consider that a move to an autonomous decision-making test presents any challenges for the ethos and professional practice of nursing or will operate to the detriment of nursing as a workforce, but we offer the following brief comments:

Given nurses' professional responsibilities as outlined in our response to section 3 we consider that a nurse would be competent to identify and account for matters of controlling influence such as 'the impact of a person's illness or condition' and 'crisis'.

Given the current role of nurses under s.47 of the 2000 Act and the expertise that resides within the nursing workforce we see no reason why mental health and learning disability nurses should not be empowered to undertake an autonomous decision-making (ADM) test. We appreciate that it may be appropriate for a person taking on that role to require an element of training, just as training is required (under the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 https://www.legislation.gov.uk/ssi/2007/105/contents/made?msclkid=e9da8624d03e11eca75104a4560b3d7d before registered nurses (and other health professionals) may use their powers under s.47. Any implications that taking on this task would have for pay and banding would need to be appropriately considered.

6 Autonomous decision-making test pp 78-90

We agree that it is not sensible to always require that 'the person who has completed the HRE (to) be the person completing the ADM test'. Until the matters of responsibility and accountability for the HRE discussed in our response to section 5 are clarified there can be no guarantee that there will even be a single identifiable individual with primary responsibility for the HRE who can be called upon to conduct the ADM (or for any other reason, for that matter).

7 Reduction of coercion pp. 89-105

Your views on how the Review understands coercion
Whether you think that "coercion" or some other word(s) should be used to describe the use of force, the possible use of force, and the experience of coercion

Under the Code of Practice nurses themselves 'must respect and uphold people's human rights' (as noted in our response to section 5) but they must also 'make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged' (see the section 'Prioritise People https://www.nmc.org.uk/standards/code/read-the-code-online/). Thus, a nurse has a wider responsibility than merely their own to see that a person's rights are upheld. This is a useful illustration of the fact that whatever a nurse may be empowered to decide or to do at law, or whatever care and treatment they are obliged to deliver as the result of the decisions of others, they must act in accordance with regulatory requirements that may serve to provide greater protection for the rights of those for whom they are caring than may otherwise be the case (even accepting that mental health law contains similarly protective governing principles of its own). This extends to actions that might be termed 'coercion'. Although we understand how the review seeks to use this word (as a 'catch all' and in a more literal and academic than a popular sense) it remains an unfortunate choice because it is a loaded word which does not account for the governing duties to whish nursing are subject (as are other professions). The word suggests an inherently adversarial relationship between the person in receipt of care and treatment and the professionals providing that care and treatment. The relationship is typically anything but adversarial. We recognise that, sadly, there will always be cases of poor practice, but this is not the norm, and the word coercion plays to a stereotype of mental health and learning disability care and treatment that owes more to the past and to portrayals on film and television than current reality. The relationship is most egregiously caricatured by the imagined line from an imagined professional: 'if you try to leave, or if you don't take your medication, we'll detain you and make you take it' (p. 93). We need to get beyond these stereotypes in publications such as this consultation. We are not clear why coercion is preferred to the term 'compulsion' given its use in the current law. No term is perfect, but compulsion seems less loaded.

Nonetheless, if we accept use of that word for present purposes, we accept that nurses have a role in actions that may be classified using it. They can sanction 'coercive' measures under s.299 of the 2003 Act or s.47 of the 2000 Act. They will be required to deliver compulsory care and treatment, exercise force (including restraint), and enforce detention, once any such measures have been deemed necessary but always subject to various common law provisions and safeguards in the legislation, including the guiding principles, such as those of minimum restraint (2003 Act) and minimum intervention (2000 Act). It is on the basis of this role for nursing that we respond to the questions set out under this section of the consultation.

7 Reduction of coercion pp. 89-105

What you think about the Review's proposed approach to reducing coercion, including reducing the use of involuntary treatment
Your views on whether law reform could drive changes which could reduce the use of coercion. Changes might include: changes to physical environments; changes to resourcing and better valuing of staff; addressing attitudes and culture; and acceptance, participation and activities on wards, for example.

The review says that it recognises that 'some use of coercion can be necessary and proportionate as part of promoting and protecting all of a person's relevant human rights' and (consequently) that it is 'proposing that future law should require changes to the mental health system which make it less necessary for coercion to be used'. It then sets out to characterise those changes, including 'develop(ing) a well-stocked basket of non-coercive alternatives in practice' (p. 95) and having services featuring (p. 96-98):

1. Sense of belonging, connection and trust in society
2. Support, services and approaches which reduce the use of coercion
3. Stronger safeguards when compulsion is authorised
4. Monitoring and scrutiny

At the same time, the review admits that 'much more work is needed' to find Scottish evidence that different models of hospital and community services can dramatically reduce the need for coercion' (p. 95); and that 'more work will be needed to define various forms of coercion' (p. 99). Under the heading 'work in progress', the consultation recognises that it is not currently possible to definitively explain rising rates of detention and so whether they are rising for the 'wrong' reasons and, in providing an overview of compulsory treatment orders (CTOs), it presents evidence of both their pros and their cons (including their disproportionate use amongst certain groups perhaps because of racism p. 104) without coming down definitively in favour of CTOs or against them.

This makes it difficult for the reader to track a clear line between 'the problem' and 'the solution'. It may well be that coercive and compulsory measures are, in a majority of cases, used either inappropriately or for lack of any alternative, but this is not made out by the information provided in the consultation. Nevertheless, we can see why there is value in reducing the use of coercive and compulsory measures because the alternative to such measures implies a more constructive relationship between the individual in need of support and the professionals and others who may give it, as well as between the individual and wider society.

7 Reduction of coercion pp. 89-105

Therefore, we must ask if the review's proposals at p. 95-98 can work and to what extent they can be established or promoted by changes to the law. It seems to us that the latter can only be achieved if certain types of services, including the stated the ethos of such services, are mandated at law and regulated (and inspected) on that basis, although we suspect that, at law (i.e., 'on paper'), most such systems would provide for such things already and it is in the breach that problems arise. Care services would be the obvious comparator. That said, much law (including the 2003 and 2000 Acts) now contains principles, which do assist in the interpretation and implementation of the law and so have value. The question remains, however: if we already have such law why do our services continue to operate in problematic ways? We would suggest that this is typically a question of under-resourcing, including in terms of staffing, and that meeting resource challenges will see faster improvements than will recasting legal principles. The duty in the unimplemented Health and Care (staffing) (Scotland) Act 2019 on Scottish Minister to endure a sufficient supply of health care staff is likely to improve services faster and more effectively than repeated and relatively minor recasting of the principles governing those services, from one piece of legislation to the next.

Whether you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened, including the current responsibilities of the Mental Welfare Commission and 'Designated Medical Practitioner', and ways in which the patient or their supporters might challenge particular interventions.

The review is on somewhat surer ground when it posits 'stronger safeguards when compulsion is authorised' (p. 97). Unfortunately, its proposals are not especially precise, and we are not in possession of sufficient information about the way the law is operating in practice at the moment to offer a view in the absence of that information being provided in the consultation. For example, with respect to 'Designated Medical Practitioners (DMP)' under Part 16 of the 2003 Act; is this a question of requiring more the one DMP to certify certain matters in writing before treatment can be given or of extending the list of such matters and in either case, is this because current provision is failing to safeguard individuals and, if so, in what way? More detail is required before the review can make robust recommendations.

Your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action. Any suggestions that you have for the Review's ongoing work on understanding rising rates of detention and on community-based Compulsory Treatment Orders

7 Reduction of coercion pp. 89-105

Despite purporting to seek to address 'the use of coercion as a systemic issue' (p. 89), the consultation does not make out that inappropriate coercion is a systemic issue or that current safeguards are inadequate (and in what way). We therefore cannot take a view on whether the Mental Welfare Commission needs stronger powers. As for the point on compulsory treatment orders (CTOs); if the data on rising rates of detention and increased use of CTOs is incapable of demonstrating whether these rises and increases are for 'good' or 'bad' reasons then, either the review has to recommend that the Scottish Government begins to collect such data on them as is capable of demonstrating that, and any changes to the law must wait for the results, or it must recommend that the Scottish Government accepts the principle that coercion in all but the most extreme case should be eliminated and that the law is changed to reflect that principle in all cases of coercion for which the law currently provides or may come to provide for. The problem with the latter approach is that there is almost certainly an argument that this is what the current law already does and so changing the law won't solve the problem. The former approach is more precise in identifying the exact failings of the law but is obviously more laborious and time consuming. Nevertheless, it may ultimately prove to be the better alternative in terms of creating effective legislation.

8 Accountability pp. 106-131

We agree that there must be a strong accountability framework enabling 'people (to) know what their rights are…what they can do and where they can go if they feel their human rights are being violated (with) clear and accessible ways for people to challenge this and seek a remedy or solution' (p. 106).

In keeping with our comments on section 5, on the risk of creating a two-tier system, we consider that the review must provide much greater clarity in its final recommendations than is present in this consultation on how the review's proposals should marry up with the recommendations of the National Taskforce for Human Rights Leadership.

The 'recommendations and ideas for strengthening the accountability framework for mental health and incapacity laws' (p. 110) contained in this section are quite specific to what would be elements of any future framework and, in fact, several of them could be introduced as additions to the current system even if the much greater surrounding change being proposed was not being proposed.

In terms of this consultation, the specifics of what is proposed under the headings of this section:

- Investigating deaths
- Recorded matters
- Excessive security appeals
- Complaints, including collective complaints
- Independent advocacy, including collective advocacy
- The scrutiny and regulatory landscape (including (a) the 'very provisional' recommendation that 'the Scottish Government should develop a comprehensive and effective improvement and assurance framework for mental health services and (b) proposed improvements to the collection and use of data)
- the Mental Welfare Commission

do not conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make any greatly detailed comment other than what follows:

We are broadly supportive of what we see to be the underlying 'driver' of everything that is proposed here, which is to improve accountability by threading human rights more effectively through a variety of processes, some of which may also usefully be strengthened in favour of those seeking to hold others (including organisations) to account.

8 Accountability pp. 106-131

We are supportive of the idea that powers of certain bodies to recommend actions (or to make statements that equate to recommendations for all practical purposes) are underpinned by enforcement powers and that resource allocation (including appropriate staffing both in terms of roles and levels of qualification and competency) accounts for the fact and the likelihood of services being required to change and adapt in response to such recommendations. Having said that, we agree with the review that any such powers should not 'be used to require professionals to deliver care which they do not believe can be clinically justified'.

We are supportive in the manner described above because we consider that it is the principled position to take but, given the prevalence of nursing in mental health services, and as an organisation that represents a group of people comprising both a profession and a workforce, we are bound to point out that those people have human, social, economic and cultural rights too, in that capacity , as well as in their capacity as citizens. In the context of accountability, the right to a fair trial (which is, of course, applicable to processes akin to court processes and not to those processes alone) is perhaps most obviously applicable but many other rights are potentially exercisable by an employee or worker with respect to an employer and a workplace. Whatever system eventually results from the review's recommendations it must account for the need to balance the rights of different parties to the same processes if the most effective person-centred care and treatment is to be widely promulgated. There should never be a situation where the rights of employees or workers are considered to be of secondary importance to those of anyone else or, worse, of no importance at all.

9 Children and young people pp 132-150

In terms of this consultation, the specifics of what is proposed under the headings of this section:

- Principles
- Rights to support
- Crisis services
- Age-appropriate services including 16- and 17-year-olds
- Relatives and families
- Capacity and supported decision making
- Advocacy
- Accountability
- Autism, learning disability and neurodiversity
- Safeguards for treatment
- Perinatal mental illness
- Relationships between parents and children
- Exploring integration of child law and mental health law

do not conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make detailed comment beyond what we have already said about any one of these matters in previous sections (for example, on principles, capacity and supported decision making, accountability) other than what follows.

Perinatal mental illness: we reiterate what we said in our written evidence to the Scottish Parliament's Health, Social Care & Sport Committee's inquiry into Perinatal Infant Mental Health, in late 2021, which was that 'the single biggest different the Scottish Government can make to improve perinatal mental health services in Scotland is to ensure that existing services are adequately staffed'.

The points about staffing and resources that we have made in this response under section 2 and otherwise (including to do with staff training and education) particularly apply to all services for children, including the workforce of Child and Adolescent Mental Health Services (CAMHS) and for those types of nurse who will encounter children and young people most regularly and have a 'frontline' role' in supporting their good mental health and well-being, for example, School Nurses, Health Visitors.

10 Adults with incapacity proposals pp150-171

In terms of this consultation, the specifics of what is proposed under the headings of this section

- Guardianship (including decision-making framework, decision-making supporter, co-decision maker, decision-making representative, support and supervision, application process, emergency provision, access to funds and management of residents' finances, codes of practice and guidance, transitional provisions)
- Power of Attorney

do not conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make detailed comment other than what follows.

Any changes must be very clearly communicated to health and care staff. They must never be in any doubt as to who, of the individual themselves, the roles proposed to replace 'guardianship' and the existing role of the person who holds a Power of Attorney ('the attorney', a role which the review does not appear to propose to abolish, replace or fundamentally change), has final decision-making powers about the care and treatment of an individual as it will be those health and care staff who will have to provide that care and treatment.

Based on the consultation document and our understanding of the law (which we acknowledge is not that of an expert) there seems to be a considerable overlap between existing roles such as guardians, attorneys, advocates and named persons and proposed roles such as decision-making supporter and decision-making representative. It also seems that one or more these 'role-holders' could be involved with an individual at any one time with the attendant possibility of conflict between role-holders that would be more likely to compromise the core principle of 'respect for autonomy' than to promote it. We therefore wonder whether the review might consider a more fundamental tidying up of this landscape, in pursuit of that principle.

We have more substantial comments on the matters set out from p. 164 under the heading 'Part 5: Medical Treatment and Research'.

10 Adults with incapacity proposals pp150-171

Section 47

The consultation does not ask a question that relates to the information provided in this section, so we offer comment on the points made as we understand them:
We do not agree that the language in 'Section 47 which currently states that, once a certificate is granted, the practitioner may do 'what is reasonable in the circumstances … to safeguard or promote the physical or mental health of the adult'' is necessarily 'too broadly worded and suggestive of a paternalistic best interests approach' particularly given that:

- in the case of nursing, the language of the statute itself merely serves to guide regulated practitioners who, as we made clear in our response to section 3, are comprehensively governed by their Code of Practice and Standards as much as (and in some instances more so) by the provisions of mental health law in any particular jurisdiction of the UK. We are aware of no firm evidence to suggest that nurses are typically or systematically adopting 'a paternalistic best interests approach' and no evidence to that effect is provided in the consultation;

- the current Scottish Government Code of Practice that covers Part 5 of the 2000 Act https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/ (including s.47) provides much more detailed guidance to nurses and others on how to properly apply the legal provisions and makes it clear that the nurse or other 'authorised person' is expected to have considered many matters when reaching a decision on capacity/incapacity. The provision in the Code might be taken to mean that 'the autonomy of the adult and respecting their will and preferences' is already being maximised.

In the case of nursing, therefore, we consider the review's concern to be disproportionate. The existing provision is, as the review acknowledges (p. 164), intended to allow for pragmatic and timely action to ensure appropriate medical treatment and the consultation does not suggest that this overarching purpose has been so badly compromised by the operation of the law in practice to date that the language of the law requires to be changed.

Be that as it may, we are supportive of the principle of supported decision making (see our response to section 3) and of an autonomous decision-making test (see our response to section 5) and we acknowledge the review's position that 'We believe the wording of the legislation should reflect our approach to maximising the autonomy of the adult and respecting their will and preferences.' (p. 64).

10 Adults with incapacity proposals pp150-171

It may be that it would be more effective to change the language of the above Code rather than of the law itself, but this is a not a point on which we have a strong view. In any case, we do agree that, whether it is in the Code or in the law, there is merit in amending the language to make it clear that the authorised person is expected to have considered the will and preferences of the adult concerned as that will and preferences have been determined in whole or in part as a result of any supported decision making process / autonomous decision making test (whether taking place prior to or as a part of the circumstances giving rise to the need to certificate) to the extent that it is reasonable and practical in the circumstances.

Otherwise, there may be merit in exploring whether or not treatment might be differentiated so that a requirement to account for the results of any supported decision-making process / autonomous decision-making test is dependent on the nature of the treatment and the circumstances, in a similar way to the way that Part 16 of the 2003 Act operates. That said, we have not given the matter of differentiation detailed consideration and we recognise that it may unnecessarily overcomplicate the law to no useful effect, which is why exploration of the matter is all that are prepared to advocate for at this point. Again, changes to the Code of Practice may be preferred to changes to the law.

Who can grant a section 47 certificate?

We have no objection to the proposal to authorise other suitably trained and supervised practitioners, including psychologists, to issue a section 47 certificate relating to the treatment that they offer.

Audit

We suggest that introducing any audit or analysis of section 47 certificates is entirely reliant on 'technology making it possible to build in checks during completion to ensure that practitioners address themselves to the right issues, and for the certificates to be electronically recorded' (p. 165) and that no such audit or analysis should be introduced until such time as that technology can be made available to practitioners.

We also consider that if 'a huge number of (section 47) certificates' (p. 165) are already being created it is very likely that 'Part 5, with its requirements for proper certification and a clear treatment plan' is already 'generally be(ing) preferred to common law powers', regardless of the cause of the incapacity.

10 Adults with incapacity proposals pp150-171

Force, detention and the relationship with the 2003 Act (including the p 170 question 'What are your thoughts on the provisions within s47(7) on the use within the AWI Act of force and detention, and the relationship with the 2003 Act?')

We appreciate that the current law operates so as to create a risk of the lengthy use of force or detention under s.47.We acknowledge that compulsory treatment given because of a 'mental disorder' (in the current language) and treatment given when the person may not have agreed to it because they lack the capacity to do so, are two different bases for treatment and it may be difficult (perhaps impossible) to simply apply 2003 Act type safeguards to 2000 Act type situations or to draw up a single set of safeguards that can apply to both bases. Nevertheless, as we support 'fusion' legislation (see section 13) we suggest that drawing up a single set of safeguards should be attempted as part of the law reform that will result from the review's recommendations.

An alternative approach however, in the context of the proposed HRE (section 5) and the introduction of supported decision-making (section 3) and an autonomous decision-making test (section 6), may be to alter the provisions of s.47(6) so as to formally build in more frequent reviews of the basis on which incapacity has been certified, beyond that which is advised in the Part 5 Code of Practice referenced above. A review could require an autonomous decision-making test to take place before incapacity could be 're-certified'. Based on information provided in support of completing the certificate https://www.gov.scot/publications/section-47-certificate/?msclkid=0e032bebd04011ec8d487c2f37eebe82 we can see there is an assumption that some reasons for incapacity may be considered to be essentially permanent, but that doesn't obviate the requirement for a review of some sort as that is already provided for in the current law via the limits set on the length of a certificate. That being the case, the requirement for review is not at issue, merely its frequency and who conducts it. As far as we understand the proposed operation of the HRE (see section 5), it will not be possible to ensure that the authorising person under s.47 (or its new equivalent) and the person responsible for initiating or 'holding' the HRE are the same person. Nevertheless, it should be possible to make provision either for someone who is not the authorising person under s.47 to undertake the supported decision-making process / autonomous decision-making test or for the application of safeguards of the type already present in the law (often involving a 'second opinion') to ensure that the authorising person is not 'marking their own homework'.

Access to justice

No comment.

Section 48: Exceptions to authority to treat

No comment.

10 Adults with incapacity proposals pp150-171

Sections 49 and 50: Guardians, welfare attorneys and disputes

Section 49
We agree 'that this restriction on treatment is too wide, particularly given the length of time many guardianship applications can take'.

Section 50
We agree that 'the procedure works reasonably well and does not require to be substantially amended'.

Given our comment above, with respect to the nine proposals on p 168-169 our position is as follows:

Part 5 and associated guidance and forms should require a certifying practitioner to demonstrate that they have considered and adhered to the principles of the AWI when issuing a section 47 certificate.

Agree.

1. Revised guidance should give greater clarity on the support that is required to be given to the person in assisting them to make an autonomous decision, before engaging section 47. Please see chapter 3 on supported decision-making.
Agree.

2. There should be a review of training of doctors and other professionals who are authorised to grant section 47 certificates, which should include an understanding of relevant human rights issues, and the principles of the legislation.
Agree.

3. The authority currently granted by section 47 should be reframed to make clear that treatment which is authorised should be that which would reflect the best interpretation of the adult's will and preferences.
Agree

4. The legislation or associated guidance should more clearly set out the limits of the use of common law powers, as an alternative to Part 5.
Agree but only insofar as it is necessary to clarify that the use of / reliance on Part 5 should be preferred to the use of / reliance on common law. We do not anticipate or support an attempt to codify all relevant common law.

5. Section 47 and associated regulations should be reviewed to widen the categories of healthcare professional who can assess incapacity and issue a section 47 certificate.
Agree.

10 Adults with incapacity proposals pp150-171

6. There should be a process of electronic recording and auditing of section 47 certificates. We believe the MWC may be best placed to oversee this.
Agree but it should only be introduced at such time as the enabling technology can be made available to practitioners.

7. We wish to consider stronger safeguards for the provisions within section 47(7) on the use within the AWI Act of force and detention, and to clarify the relationship with the 2003 Act
Agree.

8. There should be a simplified process whereby an adult can challenge a decision to grant a section 47 certificate, or a treatment authorised under that certificate. Views are sought on how best to achieve this.
No comment.

9. It should be lawful to give treatment which is reasonably necessary to a patient under Part 5 (section 49) where an application for a Decision-Making Representative is in train, provided the application does not involve a dispute regarding the particular treatment.
Agree on the assumption that section 49(2) would still apply to any treatment that was the subject of dispute. We do not take this proposal to be seeking to sanction the withholding of treatment 'authorised by any other enactment or rule of law for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition'.

11 Deprivation of liberty pp. 172-177

The proposals in this section do not appear to us to conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make comment.

12 Mental disorder pp. 178-182

There will always be disagreement over the most sensitive language to use in areas such as mental health law, often most vociferously amongst the group of people being 'labelled'. For example, at the time of the closure of long stay hospitals for people with learning disabilities (in the late 1990s) the term 'learning difficulty' was seen by those subject to the term as far more progressive than the term 'learning disability', which those same people had fought hard to reject and yet which is now generally preferred. Within the disability movement at present there remains disagreement between activists over whether the term 'disabled people' or the term 'people with disabilities' is to be preferred.

It strikes us that whatever overall term is used in mental health law, there will have to be further differentiated definitions of that term (including diagnostic definitions) to do with the extent/profundity of a person's 'condition' and its effect on them, and which serve to identify the appropriate/permissible care and treatment pathways for that person (including compulsory care and treatment, force and detention). Such differentiated definitions will inevitably, but not necessarily wrongly, affect the extent to which any given person may enjoy their rights.

The review's commendable aim to move to a system more focused on autonomous decision making will, if realised, still sit in the context of system where, as is clear from the consultation's discussion in section 7, some element of coercion will have to remain 'as a necessary and proportionate… part of promoting and protecting all of a person's relevant human rights' (p. 90). It is arguably those cases involving elements of coercion where the language applied is most stigmatising because it seeks to capture more extreme situations and therefore becomes more extreme, or at least emphatic, itself (as in 'significantly impaired decision-making ability').

That being the case, we hesitate to offer a view on the 'best' term to use, but we suggest that, for an overall term, 'mental health condition' might be the least stigmatising of those posited in the consultation. In any case nursing staff have adapted and will continue to adapt their language in order to most appropriately support those for whom they care and whom they treat in accordance with the wishes of those people and with the ethos of nursing as a profession and as a workforce.

13 Fusion or aligned legislation pp183-188

Acknowledging the challenges to doing so we nevertheless support fused legislation. That is because it brings the opportunity for clarity as to core concepts, which are presently applicable across separate pieces of legislation, and the opportunity to bring a strong internal, intellectual logic and coherence to the law because a single Act, in terms of standard approaches to legislative interpretation, will be a mutually reinforcing guide to itself, at least in part.

From the point of view of nursing, whilst practitioners must, and do, familiarise themselves with the law applicable to their practice, and then act accordingly, wrestling with multiple pieces of legislation, regulations and codes of practice can hardly be said to be a task to be relished or one the necessity of which stems from an entirely logical arrangement of law.

We are attracted to the proposition that 'a single judicial forum should deal with all mental health, incapacity and adult protection cases', (a) because we support fusion legalisation and (b) for the same reasons that any specialist legal forum is valuable: it comes to understand the issues in a similar depth as those who appear before it and the administration of justice is therefore improved.

It appears to us that if this forum is a tribunal, rather than the Sheriff court (which operates in a permanent state of high volume and intensity of cases), access to the administration of justice full stop, and, more importantly, *timely* access to the administration of justice, will be improved.

If the law is changed so that the system it mandates leads to legal decisions that are, on average, of better intellectual quality (overall) and made faster than at present, and which will naturally shape mental health provision and services going forward, then this could be a concrete example of how a change to the law can genuinely lead to the type of culture change that the review alludes to throughout this consultation.

Additional comments

Conflicting rights

The consultation only mentions 'conflicting rights' briefly (on p. 74) in the context of its discussion on Huma Rights enablement (in section 5) and notes that limiting the rights of what is understood to be the person in receipt of care and treatment should only be possible 'if this does not discriminate on the basis of the mental disorder and will demonstrably lead to more respect, protection, and fulfilment of the person's rights, or other people's rights. Any limitation on rights must only be to the extent required to achieve these protections.' This does not address in detail the point made in our original submission that legal reform 'needs to provide a framework to enable transparency, fairness and proper process to manage situations where rights come into conflict with each other' and we do not consider that the HRE framework that is set out does so either. We would hope to see this point addressed in detail in the review's final report.

Enhanced role for nursing

This consultation does not address the matter of an enhanced role for nursing other than insofar as it is implied, in some small degree, by the changes to practice that some of the proposals will, if implemented, inevitably require on the part of a wider group of professionals or all professionals, as the case may be. It does not consider enabling and empowering nurses to make a greater range of decisions to do with care and treatment, in pursuit of the review's purpose and principles or otherwise. We remain hopeful that the review will offer a more detailed view on this matter in its final report but, in any case, it is a matter upon which we will further consult with members in order to make an appropriate contribution to the legislative proposals from Scottish Government which we anticipate will eventually follow on in response to the review's ultimate recommendations.

Shifting care from hospital to the community

It is not entirely clear from the consultation the extent to which the review advocates shifting care from hospital to the community but such specific changes as it does propose (e.g. 'sections 25-27 of the 2003 Act should be extended and reframed to set out clear and attributable duties on NHS Boards and local authorities to provide mental health support to individuals with significant levels of need, reflecting the core minimum obligations') and the way that it characterises future services throughout gives us confidence that the review is travelling in the direction of such a shift.

Additional comments

National Care Service

The consultation acknowledges the proposals for a National Care Services (NCS) but, because those proposals are at such an early stage, beyond noting some of the potential interconnections between the review's recommendations and whatever is ultimately proposed for an NCS, the review is understandably unable be specific about how they may cohere or be interdependent. It also notes (on p.5) that 'by the time our final report is published we anticipate that legislation to create a National Care Service for Scotland will have been introduced in the Scottish Parliament. Our final report will reflect on this and its impact on the matters the Review is concerned with.' In RCN's response to the NCS consultation we acknowledged the review noting that 'any changes to delivery of mental health services must coincide with renewed urgency around reform of mental health legislation, with an emphasis on improving services and embedding the rights of people using them'. We also noted that 'the implications of the creation of a National Care Service for mental health provision require greater thought and the people who use and deliver those services deserve a more detailed consideration of the current situation and the options available to improve access and outcomes… far more detailed work is required to ensure that mental health services are an integrated and valued part of whatever structures emerge from this consultation and that people of all ages who require mental health support and treatment can access that appropriately and timeously.' Our view is that it is absolutely essential that the Scottish Government does not legislate for an NCS in any way that could unreasonably jeopardise, delay or frustrate the recommendations of the review purely because the Scottish Government chooses to legislate in advance of the recommendations being published. It is one thing for a government not to take matters forward on principle, but it is quite another not to take them forward on the basis of an arbitrary administrative timetable.

Mental health care and treatment pathways

We understand that a review and revitalisation of mental health care and treatment pathways is not strictly within the review's remit, but changes to the law will inevitably require consequent changes to such pathways, with a view to ensuring that they are aligned with the rights-based focus of fresh legislation. Some of this will follow naturally as services adapt to the new legal context and some of the review's proposals as contained in the consultation (for example, about service resourcing) will, if implemented, support that review and revitalisation. Assuming the review would agree with our view, we would welcome a specific reference in the review's final recommendations, to the need for the alignment between the law and the pathways to which we refer.

Additional information on the consultation

Scottish Mental Health Law Review consultation | Scottish Mental Health Law Review

https://www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-consultation/

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