**Scottish Mental Health Law Review**

**RCGP Scotland consultation response**

**May 2022**

**What is the purpose of the law**

**We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would be particularly interested to know:**

**What are your views on the purpose and principles that we are proposing?**

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

RCGP Scotland is supportive of these aims. They align with RCGP Scotland’s ambition to deliver the highest standards of general medical practice and excellence in patient care.

**What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?**

The College agrees with this approach and the effort to address the inequalities and disadvantages experienced by many of the people we provide care for, including in relation to health, economic, social and cultural rights.

Fulfilling economic rights is a particularly challenging but important area. We welcome recent Scottish Government commitments to rolling out welfare rights advisors within 150 GP practices across Scotland. Poverty is a fundamental cause of persisting health inequalities, and we would welcome ongoing assessment and further expansion of this scheme.

There is also a need to balance both individual human rights and community human rights. The mandated delivery of minimum obligations for the many should not reduce the care that healthcare services are able to provide to those most in need.

**What are your views on our suggestions for reforming sections 25 to 27 of the 2003 Act?**

The proposals state: “We think 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”.

RCGP Scotland believes terms found in sections 25 - 27 would need clear definition for their delivery to be achievable, namely ‘significant levels of need’ and ‘mental health support.’

Like much of the health service, general practice is facing unprecedented workload and workforce demands, including significant challenges with recruitment and retention within the profession. In order to continue providing the highest standard of care to patients, there must be a common understanding of what the expectation on general practice is of delivering the

proposals and what further support can be provided by mental health care providers (including general practice) to deliver this within the context of existing, significant demands.

Sottish Government has identified additional resource to support mental health services in primary care, but increasingly the problem is lack of staff, and a growing inability to recruit and retain even with the additional funding.

**Do you have suggestions on how law could be reformed to address stigma, discrimination, and issues with attitudes towards mental disability?**

We recommend an impact assessment at the time of writing and reforming this legislation to consider any unintended consequences on those with mental ill-health.

**Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?**

RCGP Scotland is aware, especially, of the impact of earlier life trauma on mental health. The prevention of mental ill-health would need policies and legislation to address early-years trauma and poverty.

We are very supportive on extra training on these issues. These needs require all members of the multi-disciplinary primary care team to be better informed and that can only be achieved with practice protected learning time (PLT) which would enable the team to come together to discuss and embed any new policies or legislation.

We are also keen to support our members and services in addiction and would always see mental health care as integral to that. We are currently involved in a number of workstreams, including;

* Delivery of the Certificate in the Management of Problem Drug Use course Parts 1 and 2
* Member of the Drug Deaths Taskforce
* Member of the National Drugs Mission Implementation Group
* Member of the Drug Enhanced Services SLWG
* Member of the Scottish Mental Health Partnership
* Member of the Mental Health Quality and Safety Board
* Member of the National Review of Eating Disorder Services
* Member of the National Suicide Prevention Leadership Group
* Member of Scottish Health Action on Alcohol Problem

**What are your views on our proposals on adequate income, housing and independent living, inclusion in society, and accessible information?**

The proposals for the fulfilment of these social and cultural rights are welcome.   
 **Are there other economic, social or cultural rights which you feel are particularly relevant to mental health?**

We would highlight the right to equal education opportunities as particularly relevant.

**Do you have views on the system-wide changes which we think are needed?**

RCGP Scotland agrees the system-wide changes proposed are needed, but questions how to achieve them within current workforce and workload restraints.

**What do you think law reform can do to achieve culture change in mental disability services?**

Our further recommendations for culture change in mental disability services would be to legislate on:

* Teaching and training requirements for staff (e.g. trauma-informed services)
* That it be made illegal to decline mental health input to someone affected by addiction, so that the silos between these services are broken down.
* Lived experience input in service development and delivery
* Minimum staffing levels, maximum waiting times, inclusive appointment systems

**Supported decision making**

**We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would also particularly be interested to know:   
  
What are your thoughts on our recommendations for a wide-ranging supported decision making scheme?**

RCGP Scotland agrees in principle that SDM (Supported Decision Making) is key in the care of those struggling with mental health issues. It is a core part of how GPs work with their patients.

It makes good sense for advance directives to be included in the legislative framework rather than based on case law.

Realistic medicine should be promoted. People must be supported to make the decision that’s right for them. Currently the lack of suitable preparations with regards to anticipatory care planning is a big problem.

**What do you consider would be the barriers to this?**

While RCGP Scotland is supportive of shared decision making, we recognise that undertaking shared decision making is a resource-intensive process and this must be taken into consideration in the context of the extremely high workloads of GPs and their teams.

In the same way that Power of Attorney documents require doctor or lawyer participation, thought needs to be given about how this additional service would be supported and resourced within general practice – through the GMS contract or through a fee structure.

GPs are extremely involved in anticipatory care planning, but advanced decision making where legal costs can be incurred may lead to patients with financial disadvantages being less likely to engage. For those who have no obvious person who can act in a SDM role, there will be a requirement to find and allocate one, and there is the question of funding for those undertaking SDM roles for persons who do not have an identified carer or family member.

There is potential confusion as to the legal position of the SDM role (they will be easily confused

with Power of Attorney and Welfare Guardian unless explicit education around this), and literacy will also be a key factor.

**How do you think the SDM scheme should be taken forward?**

Educational resources will be required for GPs, Supported Decision Makers, and the public alike.

High quality training and refresher courses will be required to educate service providers, and GPs will require protected learning time in order to participate in this. A Centre of Excellence for SDM as proposed in the consultation would be one option.

Professionals involved in Supported Decision Making needs to be accompanied by clear training/guidance to inform the purpose and limitations of the role, and this must be informed by those with lived experience.

Consideration should be given to a register of SDMs, held centrally. This information should also be shared with a person’s GP practice and Mental Health team.

The roll out of a public facing education campaign will be required.

**How do we mitigate against undue influence or pressure in SDM generally?**

This should form part of the training and guidance provided to GPs and service providers.

Feedback and evaluation from patients should be gathered to inform best practice.

A mechanism for reporting concerns should be designed for instances where coercive behaviour is witnessed, for example during a health appointment.

**Should there be legal duties on public bodies to secure SDM for people who need it? If so, given that advocacy is a form of SDM, what should be the relationship between that and the existing duties in respect of advocacy?**

No comment on this section

**What are your thoughts on the creation of a Centre of Excellence for Supported decision making?**

RCGP Scotland agree a Centre of Excellence could be an option for the delivery of training. It is crucial that this is provided and of high quality. Creating a Centre of Excellence would be one way of doing this, assuming it is cost-effective and accessible to all through a mixture of online and in-person learning.

**Supporting carers**

We welcome any comments, suggestions or thoughts you have on what we have said in this chapter. We would also be interested to know:   
  
**What are your views on mandatory Carer Awareness training for all mental health staff?**

Carer awareness is crucial, and GPs are regularly involved in working with both professional and unpaid carers.

We would like to see more discussion about the vehicles for mandatory training. Questions remain about when it should start in the professional journey, whether it should it apply to all staff or a lead staff member, the time it is expected to reasonably take, whether there will be contractual elements, and how much the training will cost.

**What are your views on information sharing with unpaid carers of all ages?**

Care planning should formally identify carers and young carers. Consent and contact details should be stored in a person’s notes. GP practices often have existing systems in place to code for carers and offer proactive support, but these are difficult to maintain, particularly when details rapidly change.

There can be a conflict of obligations between information sharing with unpaid carers and patient confidentiality. Remote consultations make this harder. Clinical judgement can be required when information sharing may cause unintentional distress, especially to young carers.

**If an unpaid carer, what are your views on sharing information with mental health practitioners?**

N/A  
  
**What is needed to ensure mental health services identify and engage with young carers?**

We suggest a specific question during assessments or care planning to identify young carers. There may also be information available from the GP referral into the service if the practice has collected this information. GP practices often have systems in place to code for carers, allowing them to proactively offer carer support, although this can differ between practices.   
 **What are your views on including unpaid carers in discharge planning and processes, as stated in the Carers (Scotland) Act 2016?**

Guidance should include discharge planning. It would be good practice to include unpaid carers in these discussions where consent has been given and the carer is available. However, guidance should also cover instances in which involving a carer creates undue delay, or if their views conflict with those of the person with the mental health condition.

We must also be aware that staff are currently working under severe pressure and this will bring additional workload.

**What needs to happen to ensure unpaid carers of all ages are respected and valued?**

The views of unpaid carers should be routinely sought and considered in care planning processes, where appropriate.

Carers should be formally identified by the systems supporting the person with mental health condition, and also by the system providing support for them (e.g. their GP practice), in order to facilitate a proactive approach to their care and support.

**Human Rights Enablement**

**What are your thoughts on the proposed HRE framework?**

We consider the proposed HRE framework a laudable aspiration, and the holistic approach of these principles is already at work in GP practices, with a focus on patient rights and the delivery of patient-centred care.

However, any extension of duties impacting on GP workload would not be feasible. The greatest challenge will be the significant existing constraints of declining workforces and increasing workloads in both general practice and mental health services.

**How do you see the framework as proposed working in practice?**

This more formalised approach at multiple points in the patient journey will not be achievable within the current workload and workforce constraints, particularly among deprived practices or those practices which are responsible for entire care home populations.

More detail on the framework would be useful.

**What barriers do you see to its operation in practice?**

The key barrier is lack of time within our current workforce and workload constraints to undertake additional formal assessment.

A secondary barrier is digital infrastructure. A new system would need to be put in place to deliver the HRE as proposed. The proposals suggest the HRE should be readily accessible to anyone involved in the care of the person with mental disorder, subject to consent. This will be difficult to achieve within existing NHS infrastructure – Mental Health Care Plans are currently often paper based, not shared widely, and therefore not readily available in a crisis situation.

The existing mechanism – the Key Information Summary (KIS) – isn’t visible to social care and has functionality limitations. Currently there are significant challenges within the NHS with the transfer of patient details when people move addresses, e.g. students or cross border transfers. Advanced Care Planning (ACP) in the KIS disappears when the patient moves practice, although there is a warning message that the patient used to have an ACP. The ACP is also not available in the GP records of Temporary Residents.

Throughout the consultation document there is insufficient discussion of digital approaches and digital data sharing between systems. This should be fed into Scotland’s digital strategy for health and social care.

**What are your thoughts on who should initiate an HRE?**

The clinician/professional planning care for the person should initiate an HRE, but only at significant decision points, e.g. care planning or compulsory treatment. This more proportionate approach, applying the HRE framework only at key points of decision making, may be more feasible.

**What are your views on the triggers for an HRE? Is there anything not included which should form a trigger?**

We believe the triggers for an HRE – e.g. multiple chest infections/yearly review/ a new referral - are set too low. In practice, every time there is a community detention this will need to happen.

This is simply not feasible with our current major workforce shortfalls in both general practice and mental health staff in the face of immense service pressures.

We suggest the key triggers should be care planning conversations, discharge planning conversations (after a period of admission) and admission conversations (especially if involuntary).

**What are your views on the right to request a review and the right of remedy and appeal as proposed?**

Where a new formalised process is introduced, it would be important to include these, but we reiterate our points above in terms of proportionality.  
  
**Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?**

No  
  
Please offer any relevant views. You do not need to limit yourself to addressing these questions

Prior to roll-out of this aspect of the proposals, RCGP Scotland would strongly recommend that it be piloted in ‘real life’ to see how workable and useful it is. The practitioners most likely to be having these conversations are GPs, Mental Health clinicians, Medicine of the Elderly clinicians, and Emergency Medicine clinicians. It may need trialled in different clinical settings and different clinical scenarios.

The HRE proposals rest on the supposition that all patients are registered with GPs – this isn’t the case, particularly within deprived areas, among vulnerable people or people without housing. Out of Hours services see many patients who aren’t registered.

Public messaging and education would be vital - explaining the HRE could take considerable time in short appointments and the people in need may decline as they don’t understand it. There is potential to widen health inequalities if not adequately addressed.

**Autonomous Decision Making Test**

**Please share your views on the concept of autonomous decision making**

RCGP Scotland is supportive of the concept of autonomous decision making (ADM) – autonomy should be protected as a far as possible, for as long as possible.

**What are your views on the skills and experience required for someone to competently undertake a test of a person’s ability to make an autonomous decision?**

ADM is a core part of the work of a GP and a highly skilled process. It takes a lot of time, requires clinical judgement, often in a time-pressured situation. The new requirement for a HRE in this situation, particularly where there is medical urgency, will potentially add a significant workload burden to the GP. We would be keen to see an assessment of this additional workload.

Increasingly as Scotland becomes a more diverse country, English may not be spoken as a first language, and that affects every process in this consultation from shared decision making to being culturally sensitive in areas of coercion where understanding is key. Some deprived practices may have a large minority of their population requiring translated consultations and this is a big workload but also a concern for equality of care. Literacy (and health literacy) are also profound determinants of health inequalities, and again need consideration at every step of the consultation.

**What are your views on the ADM appeal process?**

No comment

**We seek your views on the following questions.**   
  
**1. Are you in favour of the current capacity and SIDMA tests remaining – unchanged?**

No comment  
  
**2. Are you in favour of the current tests remaining, distinctly – but with one or both reframed, if possible, to address the current problems articulated above? If you would prefer a reframed definition, please feel free to comment on what you would wish to see adjusted.**

No comment

**3. Are you in favour of the current tests remaining but reframed as a single test? If so, would this include additional matters, or be a reworking to conjoin the current tests?**

No comment  
 **4. Do you see little value in the current tests, preferring to see one or both of them replaced?**

They have value but need to be improved.

**We seek your thoughts on the skills and experience required by an individual in order that they may competently carry out an ADM test**

We require more detail to be provided on what the ADM would entail in practice. However, it seems that those who are currently able to work within existing mental health legislation should be able to competently carry out an ADM test.

**We seek your views on a discrete ADM test appeal procedure. Things you may wish to consider are:**

**What qualities should the appeal have? - for example, it needs to be accessible and speedy.**

We agree the appeal procedure needs to be accessible and speedy, with minimal bureaucracy.

As before, we note that these proposals rest on digital infrastructure that does not currently exist, namely file sharing infrastructure between health and social care.

**Who can trigger an appeal? – the person themselves or any other party with an interest?**

We suggest the person themselves, the named person, or the legal proxy decision maker could trigger an appeal.

**Should it have escalation – for example, commence with an internal review before secondary or external review?**

Yes, there should be the option for escalation, where it cannot be resolved locally. We suggest a national collation of all reviews to allow learning from themes.

**Should there be any limit on the frequency with which one can dispute an ADM outcome?**

Yes, because of impact on state-funded services.

**Should there be access to a judicial process?**

Yes, if local resolution measures fail, and person’s liberty has been significantly impacted.

**Reduction of Coercion**

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would be particularly interested to know:

**Your views on how the Review understands coercion**

We agree that we need to consider actively, as described in the consultation, more subtle forms of coercion in clinical work, always respecting the autonomy of the patient.

**What you think about the Review’s proposed approach to reducing coercion, including reducing the use of involuntary treatment**

We support the proposed approach to reducing coercion, especially the suggestion of better access to peer support communities and the focus on compassionate, supportive, comfortable environments in which to receive care. This will require significant investment but be highly beneficial.

We also support the proposal for national shared learning from events when coercion has been deemed necessary.

**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**

The College has no suggestion for alternative to term “coercion” - it is an uncomfortable word because it is an uncomfortable thing to consider, and so perhaps it is best to keep it to remind us all that coercion is a last resort.

**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.**

Changes to reduce coercion levels are likely to be possible only if the resources follow, and if change is guided by those with lived experience and by the practitioners on the front line. Poor access and delays in specialist treatment because of the workforce crisis can only lead to worsening clinical condition.

RCGP Scotland would also like to take the opportunity to raise our concern around the challenge of GPs being asked to undertake emergency detentions of patients in the community, especially when they are already known to mental health services.

There is a huge amount of variation in how this scenario is managed across Scotland. Some GPs have no sector psychiatrist and no access to intensive home treatment teams (IHTTs).

When GPs are expected to undertake this work, this means that clinicians who are less familiar with the paperwork and processes are put in a position where they are having to arrange a joint visit with a Mental Health Officer (and often police and ambulance too) to assess a patient who may be unpredictable, extremely distressed and potentially dangerous. Sometimes police or ambulance services are reluctant to be involved, especially where the guidance for that is not clear, leaving the GP in an even more difficult position.

This often takes several hours, with no mechanism for managing the ongoing workload that is building up within the GP surgery. Rural areas have further issues with transportation and time delays.

Out of Hours (OOH) is of particular concern – workforce shortages can see one OOH GP covering a whole local population, who can be then removed from service for a substantial time by one acutely mentally ill patient.

We suggest is more appropriate that a standardised approach is taken for this complex and sensitive work. GPs all need access to Psychiatry teams – IHTT colleagues can make assessments at home that can reduce coercive care. This should be an emergency, responsive, and nationally-defined service that is fit for purpose.

Reforms must be data driven – considering where there is best practice and correcting the uneven spread to design a system that is least restrictive, but crucially it needs to be safe for patients and staff.

**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.**

No comment

**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.**

We are supportive of the proposals around national shared learning. The Mental Welfare Commission should have a role in national oversight and shared learning and to identify areas and pathways 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**

It is crucial to speak to those with lived experience and practitioners on the front line. To illustrate our points from this section, we present an anonymous GP’s diary of an emergency detention. Included in appendix.

**Accountability**

**We welcome any comments, suggestion or thoughts you have on what we have said in this chapter and on any other aspect of accountability you wish to let us know about. We would also particularly be interested in the following:   
  
What do you think about our proposals to give the Mental Health Tribunal increased powers to order that specific care and / or support be provided for a person?**

RCGP Scotland is supportive of a strengthened accountability framework, provided there is proper resourcing and accessibility. We do have concerns regarding a mandate for GPs attendance at a mental health tribunal. These would be very difficult for GPs to attend in the working day as it is very difficult for GPs to leave their practice due to a shortage of GPs to cover their work.

**What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?**

No suggestion offered

**What are your thoughts on collective advocacy groups raising court actions?   
What about our idea of creating a way for them to escalate unresolved human rights issues to an identified scrutiny body?   
Is there an existing organisation you feel should take on that role?   
Should these proposals also cover individual advocacy organisations?**

No comment

**Do you have any suggestions to make the scrutiny landscape for mental health services more effective?**

RCGP Scotland notes that complaints are often about a system which is understaffed and under-resourced.

We support a culture of transparency around learning from error, data gathering and inspections – all shared for wider learning and to best improve outcomes for patients.

**What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended? Do you have other ideas?**

No suggestion offered

**Children and young people**

**We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would also be interested to know:**

**What are your views on reforming crisis services for children and young people experiencing acute mental distress, and about safeguards for emergency detention?**

Our RCGP Scotland members tell us that there has been a significant rise in the number of crisis mental health presentations across all ages to General Practice, and resources available are insufficient to meet this demand. General practice ‘holds’ much of the risk around child and adolescent mental health conditions because there are simply no other services available. It is a particular issue in more deprived areas.

**What you think about law reform to ensure access to CAMH services up to at least the person’s 18th birthday, and to ensure age appropriate services more generally?**

We are supportive of the CAMHS age increase to at least the person’s 18th birthday, and further believe consideration should also be given to the transition between children and adult services.  
  
**What are your views on our ideas about relatives and families?**

In general practice, when dealing with Gillick competent young people, we try to encourage the involvement of parents or relatives as far as possible, but an important balance has to be struck between the potential harm to the young person from their mental ill-health, and the potential harm to them from a breakdown in trust if confidentiality is breached

**What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?**

While we agree the same principles could apply, it must be noted the same significant challenges will apply to making it feasible as an approach.

**What are your views on autism, learning disability and neurodiversity, and the possible law reforms for children and young people?**

We would object to the wording in the consultation document “…limited support from primary care and community services.”

It is concerning that throughout the consultation, the role of GPs is rarely mentioned, yet the majority of mental health management is carried out in general practice.

The diagnostic process is very cumbersome. If a child is referred to CAMHS, they are often ‘rejected’ by the service and referred back to the GP, often with resultant damage to inter-professional and doctor-patient relationships, and an understandably negative impact on the patient and family. In other cases, they remain on a waiting list for up to 2 years, with an ‘opt-in’ postal appointment system which often fails them at the last hurdle – when they are then discharged for ‘non-engagement’.

Our members reflect that there has been a very significant rise in the number of presentations to general practice from young parents and young adults concerned about a possible neurodiversity diagnosis.

Waiting lists for specialist reviews can be ~2 years, so if proposals are to be brought into law this will need to be brought down. Additionally, it should be noted that there can be the wait for diagnosis, and then a further wait for treatment.

Furthermore, these proposals make no specific mention of the vital role of community midwives or health visiting, and the needs of these perinatal mental health professions to be supported.

There is undue focus on specialist services which is only relevant for a minority of cases, the ‘tip of the iceberg,’ whereas many GP consultations have a mental health component - one third being the traditional estimate but many GPs recount higher levels now.

**What do you think about our proposals on safeguards for treatment, and on services and safeguards to protect the relationships between children and parents?**

We support these proposals.  
 **At this time, Scotland’s mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?**

No suggestion offered

**Adults with Incapacity Proposals**

**We seek your views on the new model. For example, what do you see as its advantages? What do you see as its drawbacks? What adjustments, if any, would you suggest?**

We are supportive of the rationale for the new model, especially around replacing guardianship with a Decision Representative. However, we anticipate this will be confusing for patients, carers, and healthcare professionals alike. Changes will need succinct explanation, and training/guidance should be provided for official proxy decision makers so they are fully aware of their role.

GPs undertake a huge workload of certification for Adults with Incapacity – many relating to dementia – and any changes in legislation requiring new learning or adding to workload will need to be accounted for in that setting.

**Will the proposed change address the issues currently experienced with guardianship? Please explain your answer.**

We agree the proposed changes may reduce undue complexity and repetition, but questions remain around cost. Guardianship processes can be very costly for families.

**What are your views generally on PoA and the recommendations we are proposing? Particularly we welcome your thoughts on:**

**What measures should be taken to increase the awareness of a PoA?**

**Key points of guidance that need to be given to attorneys.**

**What support should be given to attorneys – by whom, when?**

**The reporting structure for someone with concerns**

**The investigations structure**

**Authorities being able to supervise an attorney, on cause shown, following a statutory inquiry.**

**Attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the PoA). We will be taking into account comments submitted to the 2018 AWI consultation so you do not need to repeat earlier opinion, unless you wish to**

RCGP Scotland fully supports the increased use of Power of Attorney – but this is not currently a funded NHS service for GPs. Power Of Attorney will become increasingly important going forward because of our ageing demographic. GPs are frequently approached to oversee PoA, but it is often offered as a private service – which then has the potential to create inequality for those with less financial security, and adds to high workload. This can - and has – sometimes led to practices simply ceasing to offer this service in the face of huge other workloads, and despite GPs being well placed to offer this service because of their long-term relationships with patients.

**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?**

Clinicians who are not using this legislation on a regular basis (e.g. GPs) can find the relationship between these Acts confusing, especially in a crisis situation. It is not easy to know where to gain specialist advice quickly.

Consideration should be made of any unintended consequences of making use of Section 47 more complicated for simple healthcare needs e.g. wound care, routine vaccination, pain relief, antibiotics. If processes are made unduly burdensome within existing workload constraints then patient care may suffer.

**Is any change needed to the list of special treatments requiring additional safeguards (section 48) or the procedures by which they are authorised?**

We suggest useful additions could be IVF treatment and organ donation.

**It has been suggested that Transcranial Magnetic Stimulation (TMS) should be added to the list of special treatments requiring additional safeguards in section 48. What are your views?**

No suggestion offered.

**Is any change needed to the dispute resolution procedure in section 50?**

No suggestion offered.

**Deprivation of Liberty**

**We welcome your views on any aspect of this chapter but in particular we would like you to consider the following questions :**

**What are your views on the deprivation of liberty proposals?**

We believe the proposals seem reasonable and proportionate.

**Who do you think should be able to apply for a deprivation of liberty order?**

We suggest the treating clinician, PoA, designated decision maker, and designated social worker.

**What are your views on the safeguards in the process?**

No specific suggestion

**How can we ensure that there is a real, effective and accessible ability for the adult and / or their representative to challenge the lawfulness of a deprivation of liberty order?**

No specific suggestion

**What do you see as potential barriers to its operation?**

As above, the current workload and workforce limitations are a barrier to new processes.

**What else may you wish to see included?**

In addition to the four means of authorisation of deprivation of liberty, a fifth option could be included - by way of a valid advanced directive.

**Mental Disorder**

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would also particularly be interested to know your views on:

**Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion?**

Yes

**If so, what should that gateway be and what terminology should we use?**

RCGP Scotland agrees that ‘mental disorder’ is not an acceptable term. There is not an obvious answer that is inclusive enough, but we suggest “Mental Impairment, such that autonomous decision making is affected and cannot be restored quickly.”

Mental incapacity may better reflect the technical definition but is probably stigmatising and open to misuse and misunderstanding, in common with some other descriptors.

**Fusion of Legislation**

**We welcome any comments, suggestions or thoughts you have on what we have said in this chapter. We would be particularly interested to know:**

**Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward? Please provide explanation for your answer.**

In theory a single piece of legislation for mental health, incapacity and adult protection law is the ideal. However, we know that both patients and clinicians can find it difficult to find information and navigate the system and this might be worsened if all the legislation (which covers scenarios as diverse as PoA to coercion in the acutely mentally ill) were unified.

We suggest an overarching legislation with common principles and then readily accessible sub-sections. This would mean that people would not be burdened and hampered with having to seek an aspect of legislation in wider settings, which might prove confusing.

The legislation will be complex and difficult to navigate, whatever approach is taken, so training and access to 24/7 support will be required for clinicians.

**Finally please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases, and:**

**If that forum should be the Sheriff court or a tribunal**

**If there should be a single forum only in the event of fused legislation, or if a single forum is your preferred way forward regardless of wider changes to the legislation.**

**If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?**

No suggestion made.

**Appendix**

The below is an anonymised diary from a GP involved in an emergency mental health detention.

|  |  |
| --- | --- |
| 10:05 | Patient’s partner requests GP call-back re concerns for pts mental health |
| 13:30 | I call back. Partner is describing hx that sounds like psychosis. Pt crashing  about in background, refuses to speak to me, come to see me at surgery,  or allow me to visit as I am not her usual GP. I feel she needs acute psych  assessment. I call Intensive Home Treatment Team (IHTT) – told nurse is  with a patient and she will call back |
| 15:02 | IHTT call me back but I have a patient in the room. |
| 15:13 | I call IHTT back and explain the situation, they say they will assess pt. I email referral to IHTT |
| 15:35 | IHTT call back to GP surgery to say they have phoned pt (not visited) and  she sounds acutely psychotic, aggressive and not agreeable to any help.  Family at crisis point. IHTT email of assessment reads…..  “From my short interaction with X her insight appears questionable and it may be unlikely she would be agreeable to any form of treatment due to her current mental state. I would advise that a GP visit alongside a Mental Health Officer (MHO) is completed today, police assistance may be required due to her levels of agitation/unpredictability. Please contact [tel number] if any further discussion is required.”  I consider calling back to ask why IHTT cannot arrange for detention themselves  as they have the resources for this (psychiatrists and psychiatric nurses), but  from past experience I am put off doing this as I know they will say I have to do  it, and I don’t want to waste more time, so decide to go see the patient, who is  clearly very distressed. |
| 15:45 | Decision made that I will visit patient. I finish the calls I am doing as I know this visit will take a long time. |
| 16:15 | I try to call MHO to arrange for him to meet me there. Spend 40 minutes trying to get through |
| 16:50 | Get through to correct department, to be told that it will now have to go to evening MHO, who doesn’t come on duty until after 5pm |
| 17:03 | MHO calls me back and we agree to meet at patient’s house at 6pm (to allow MHO time to travel from Edinburgh) I call police and request they meet us there at 6pm too – agreed |
| 17:50 | (while I am standing outside pts house with MHO talking to son, waiting  for partner to arrive) Police call back to say they will not be attending as  we should have sufficient resources to gain access to the house and get  patient to hospital, citing family should help with this. |
| 18:00 | Assessment of patient in her house – overtly psychotic, verbally aggressive, no insight |
| 18:40 | Decision made with MHO to detain patient under emergency detention. I  call 999 to request an ambulance, and as police had previously refused my  request for assistance MHO calls Duty Police Inspector for our area.  Ambulance advises me they will not dispatch a crew until police are already on site.  Police inspector tries to help but advises there are no police available and he does not know when this will change. |
| 18:58 | I call Flow Centre to see if they can help me organise an ambulance – they  say they cannot help as ambulance dispatch will say the same to them, so I  should just call ambulance dispatch again myself.  Following this the MHO asks if he can leave to get back to Edinburgh for  other work. Patient can be heard crashing about in room next door.  Despite knowing I still had no way of getting patient to hospital I felt I  could not ask MHO to hang around with me. Patient’s partner was with  me in room, so I said MHO could go as I was not alone.  Within a couple of minutes of MHO leaving patient storms into room,  shouting at me, very close to my face, and then throws a full 500ml bottle  of juice at my head, bounces off side of my head then right shoulder.  Minor injury, a little sore, but mainly gave me a fright.  She grabbed a ladder from the same room and went off to climb into the  loft space to look for her hallucinatory figures.  At this point I left the house and went to sit in my car. |
| 19:05 | I call ambulance dispatch again – again advised they will not send an  ambulance without police presence. I become upset on phone having  been a bit scared, but mostly due to the fact that I cannot seem to obtain  any help for this patient.  Ambulance dispatch say they will call police themselves to try to organise  a rendezvous time. |
| 19:18 | Police control call me back. Advise me “I have put myself in a vulnerable  position… why did I do that?”, “we should have the resources to get mental  health patients to hospital”, “it is not the police’s job to taxi patients”,  “there is only one police car on for the whole of [the town]”.  I again become upset and somewhat angry by this point. Police control  agree they will get a car to come but cannot give me a time  Just after I hang up a police van drives up, and I explain the situation to  the two large policemen. |
| 19:36 | I call ambulance control to let them know police have arrived. They  dispatch a vehicle and advise me it will arrive in 13mins. |
| 19:50 | Police and ambulance both on site, and patient escorted into ambulance.  Police leave, and ambulance move off to take patient to Royal Edinburgh  Hospital (REH). |
| 19:51 | Unclear as to who to call in psych to advise she is on her way I call the  Psych SpR on-call for Edin – she is kind but advises me to call the Mental  Health Assessment Service (MHAS) base at REH |
| 19:56 | I call MHAS – advised as patient is already on her way there that is fine,  but will not take any details of referral, advise I must call local IHTT  to ask them to go to REH to assess her. |
| 20:15 | I call local IHTT, and speak to the same team who were on earlier in the  day. I advise them that pt is on her way to REH under emergency  detention. They agree to go assess her there. |
| 20:30 | I go home. |

**Reflections**

As a GP I felt alone, vulnerable, unsupported and held solely responsible for the patient’s care. Rightly or wrongly I ended up feeling if I didn’t help her no one else was going to.

In the whole of the seven hours I spent on this case (to the detriment of my other patients) I only spent about 40 minutes actually “being a doctor”. The rest of it was spent in a bureaucratic tangle.

In 12 years as a GP I have only had to emergency detain patients about 3-4 times. Every time the story of admission has been similar to above.