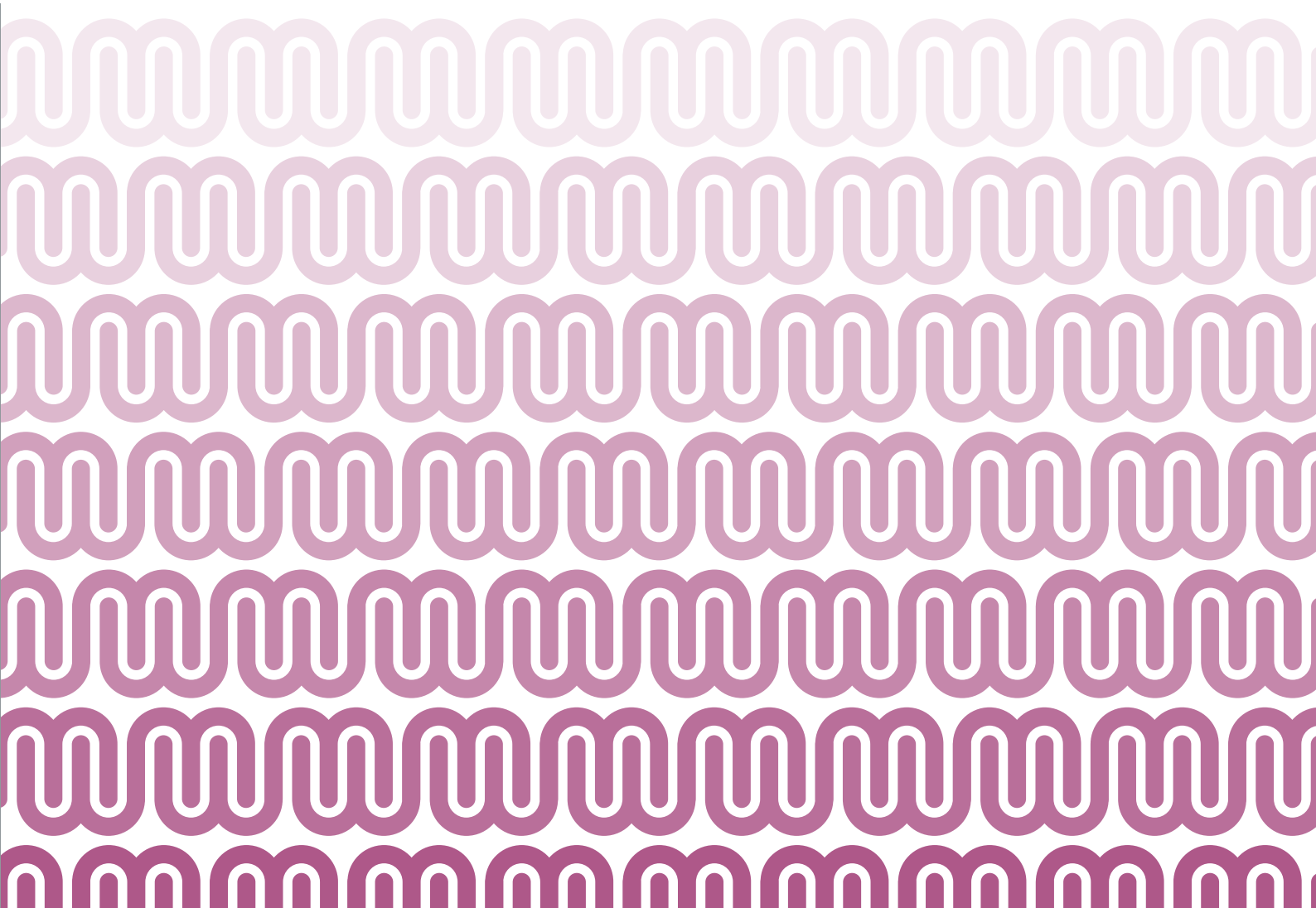
mental welfare commission for scotland

COVID-19
FAQs for practitioners
(version 1, 24 March 2020)

Advice notes

March 2020



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

1. Introduction

The current pandemic is raising many questions, as practitioners face new challenges and dilemmas in a rapidly changing environment. The unprecedented circumstances and the risk to health mean that some individuals' human rights may be restricted, and it is important that any restriction is carefully considered, legal and ethical. This advice addresses a range of issues.

This advice will be updated frequently as the situation develops, and we advise that you do not print it out, but check online to ensure you have the most up-to-date advice and information.

Emergency legislation that 'relaxes' some of the current Mental Health Act (MHA) and Adults with Incapacity Act (AWI) legislation requirements will be introduced later this month and we will keep you fully updated on this over the next few weeks.

If you have any questions relating to this advice please email the Commission at enquiries@mwcscot.org.uk .

2. General principles

2.1. Human rights-based approach (20 March 2020)

There will be many questions in relation to the implications of COVID-19 for individuals where there are no clear right or wrong answers. Using a human rights based approach can be helpful. In the current situation we may see a lot of "blanket policies" being introduced, particularly in residential and hospital settings.

Some human rights can be limited or restricted, as it is sometimes necessary to restrict one person's rights to ensure that the rights of another person, public safety and public health are protected. Such is the situation just now.

When considering scenarios where there are no clear right or wrong answers, you should consider if what is being proposed is:

- Reasonable
- Proportionate
- Justifiable

No human rights can be limited or restricted without good cause and certain conditions must be met if restrictions on human rights are to be justified. A restriction must not discriminate against a particular group of people and any restriction, if it is to be justified, must be necessary and proportionate. Decisions should be kept under regular review.

Proportionality means that a right can only be restricted so far as is necessary to achieve what is being sought. Consider if there is a less restrictive alternative that could have be used.

The principles of the Adults with Incapacity Act and the Mental Health Act provide a good ethical decision making framework against which to consider any potential restriction or decision.

3. Emergency legislation

3.1. Emergency powers allowing temporary changes to mental health legislation (20 March 2020)

The Coronavirus Bill currently going through Parliament in Westminster includes emergency provisions relating to the Mental Health (Care and Treatment) Scotland Act 2003 and Criminal Procedure (Scotland) Act 1995. The Bill allows the new provisions to be put into effect by the Scottish Government, which may also suspend the provisions or put them into effect again as required. **Note that the provisions are not yet in effect at time of writing.**

Schedule 8 contains temporary modifications of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Criminal Procedure (Scotland) Act 1995 and related subordinate legislation, to provide measures including:

a. The modification of forms that are used in connection with the Mental Health (Care and Treatment) (Scotland) Act 2003 and Criminal Procedure (Scotland) Act 1995 or for such forms to be read as if they were so modified.

b. Extending maximum period of emergency detention to 120 hours.

c. Permitting a short term detention certificate (STDC) to be granted without the need to first consult a mental health officer in certain circumstances; and permitting a second STDC to be granted.

d. Enabling a mental health officer (MHO) to apply for a Compulsory Treatment Order (CTO) under section 63 of the 2003 Act founded on only one mental health report, provided the MHO considers that it would be impractical or involve delay to obtain two mental health reports.

e. Where a serving prisoner is found to be suffering from mental disorder and requires medical treatment, Scottish Ministers may make a transfer for treatment direction (TTD) under section 136(2) of the 2003 Act. Paragraph 6 permits that Ministers may be so satisfied on the basis of one report from an approved medical practitioner (AMP), where they consider that to obtain two reports would be impractical or involve delay.

f. Extending the limit on the length of time nurses can detain patients in hospital from 3 to 6 hours.

g. Allowing for a prisoner to be transferred to hospital by a TTD.

h. Sections 136(3) and (6) provide that where a prisoner is to be transferred to hospital by a TTD they should be so moved within 7 days of the date the direction was made. Paragraph 8 provides that the transfer may be made as soon as practicable after that period.

i. Enabling reviews of certain orders and directions at certain specified intervals carried out by responsible medical officers (RMO) to be suspended.

j. Suspending the requirement imposed on Scottish Ministers in certain circumstances to make a reference to the Tribunal in respect of hospital directions or transfer for treatment directions.

k. Allowing that, where certain conditions are met, the RMO may administer medication to someone being treated under mental health legislation after the 2 month period laid out in the 2003 Act without the need to seek a second opinion from a designated medical practitioner (DMP) if the RMO has made a request for a DMP visit and it would cause undesirable delay to wait for the DMP's assessment.

l. Allowing a Mental Health Tribunal panel to operate with a reduced number of members where it is not practical to proceed with the required three members, as long as one of the members is a legal member or Sheriff Convener.

m. Allowing the period of extension for assessment orders to be increased at the discretion of the court, from 14 days to 12 weeks.

n. Enabling detention on the advice of just one medical practitioner (instead of the two required under the 2003 Act), if the court considers that it would be impractical in the circumstances to secure the second recommendation and the court is satisfied that the evidence of the single practitioner is sufficient.

o. Providing that the conveyance or admittance of accused or convicted persons to hospital may be achieved as soon as is practicable after the end of the prescribed time limits in the 1995 Act.

p. Allowing the Tribunal to decide a case without a hearing in the circumstance where the patient may have requested oral representations or oral evidence to be heard. In those circumstances, relevant parties could make written submissions to the Tribunal before a decision is reached.

q. Allowing medical practitioners in Scotland who are not independent (e.g. are in the same hospital, or with a supervisory relationship, or working in an independent hospital where the patient is being treated), to examine a patient for the purposes of the 2003 Act.

Bill:
https://publications.parliament.uk/pa/bills/cbill/58-01/0122/20122.pdf

Explanatory note:
https://publications.parliament.uk/pa/bills/cbill/58-01/0122/en/20122en.pdf

3.2. Potentially infectious person (20 March 2020)

It is clear from the emergency legislation bill that the public health powers that were available for England will now extend across the UK once the legislation is in operation. These powers allow for a public health officer to detain someone, and to require them to stay at a suitable place, and return them to that place, as they deem necessary. They can inform a constable as needed to enforce. The bill contains necessary powers to enter premises. These are separate powers from the Public Health (Scotland) Act 2008, which was not designed for a pandemic. The emergency legislation is designed for this purpose.

If considering how to manage someone with impaired capacity who is a 'potentially infectious person' , practitioners should consider what is the primary problem that presents and whether they are detainable under mental health legislation or not. If not, then contact the public health officer via the local health promotion team. Where the individual is managed is for public health to determine, with input from mental health services. The legislation used will be the 2020 emergency legislation.

If the individual is detainable under mental health legislation they would be admitted and care provided in the appropriate setting that meets their needs. Mental health services should lead on determining this with support if needed from public health and the acute hospital.

4. Safeguards

4.1. Extending a community compulsory treatment order (CCTO) by phone if care home is in 'lockdown' (18 March 2020)

Where a care home refuses access to an RMO to carry out a review for the extension of a CCTO, due to coronavirus, the Commission advises a pragmatic approach. The RMO should ensure that the care home manager understands the role of the RMO and that they are not a visitor but have a role within the Act; discuss any concerns with named person; and discuss with the MHO. If it remains not possible to visit, the RMO should conduct a phone conversation with the patient if possible, and ensure they understand why they are not being visited.

The RMO should make a decision about whether to extend the order on the basis of these conversations, and send the report with a cover note.

The Commission's view is that RMOs are not required to do something that would put them or others at risk, but should aim to visit as soon as is practicable.

4.2. Second report for CTO application (23 March 2020)

There may be a situation where a second report is needed for a CTO application but it is not practicable for a GP or approved medical practitioner (AMP) to visit the patient due to Covid-19 infection on the ward,

The Commission's view is that the examination by the GP or AMP should take place if possible by video or phone; or alternatively, an assessment from a colleague who is available on the ward, but declaring this conflict of interest. The patient and relevant others should be informed of the issue. It is for the Tribunal to make its decision in the light of the available evidence presented.

4.3. Moving someone without 13ZA process being completed (19 March 2020)

The Commission was consulted about a situation where assessment for 13ZA to move an individual into a care home in an urgent situation due to the carer's terminal illness was partially completed. However, the MHO was self-isolating and not able to complete the assessment. Three meetings had already taken place in relation to the situation with no objections.

We advised checking whether another social worker was available. Failing this, due to the urgency of the situation and the current lack of alternatives for care provision, and given the consultation which had already happened, they could consider the move taking place in the best interests of the individual. The decision and rationale for the move should be clearly documented along with the consideration given to the principles of AWI.

Scottish Government guidance on 13ZA
https://www.sehd.scot.nhs.uk/publications/CC2007_05.pdf

Commission note on 13ZA
https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf

4.4. Moving adults with incapacity - Adults with Incapacity Act easements (20 March 2020)

The Scottish Government is currently developing guidance to go along with the provisions in the emergency legislation under the Social Work (Scotland) Act 1968 that allow for an easement of the requirements of the local authority to conduct a needs assessment.

The Commission is supportive of the need to allow health services to maximise the efficiency of available resources, but is concerned to protect the human rights of individuals moved without the normal legal authority.

The Commission has therefore proposed that a record should be kept of individuals moved under these arrangements (rather than under 13ZA or proxy powers). This would be basic data including name, DOB, current placement, new location and date of move. It is likely that local authorities will be asked to do this and that the Mental Welfare Commission will keep a register of these moves.

4.5. Expiry of section 47 certificates giving legal authority for medical treatment - Adults with Incapacity Act easements (20 March 2020)

The Commission is receiving calls regarding the expiry of s47 certificates which give legal authority for physical healthcare treatments. We would like to see arrangements for the extension of existing certificates where renewal is impractical due to the pandemic situation.

Pending such easement, our view is that treatment should be continued where it is not possible for a s47 certificate to be renewed.

4.6. Moving an individual to a care home without family agreement (19 March 2020)

Until emergency measures are in place the situation has not changed. Moving an individual without capacity to a care home under 13ZA requires the agreement of the family, that the individual is not refusing, and that there is no proxy with relevant powers.

The Commission was consulted in relation to a situation where a case conference had been held and use of 13ZA was agreed, with an application for guardianship by the family to follow. However the family were not in agreement with the proposed temporary move, and arranged for a solicitor to visit the individual, who signed a power of attorney. This is challengeable due to the individual's lack of capacity. Note that the power of attorney is not effective until registered, and if there are concerns about the capacity of the granter it is important to contact the Office of the Public Guardian so that they can examine this before it is registered (see Common Concerns with Power of Attorney).

Until emergency measures are in place there is no authority for the proposed interim placement as family agreement is required for a move under 13ZA. We suggested taking legal advice from the CLO.

They should record clearly the reasons for making the decision that they go with, which should be based on individual assessment of rights and risk, especially if a move may be needed despite dissent from the family.

4.7. MHA and AWI assessments and examinations by video technology or by telephone (24 March 2020)

Both the Mental Health Act and the Adults with Incapacity Act envisage direct, in person interviews as being the expected method for medical examination.

(In normal times, our advice would include: an interview in person must be considered to be the envisaged method of examination; an interview by remote video-link must be regarded as an exceptional situation; it would be a matter for the Tribunal or Court to decide whether evidence based on a remote interview is acceptable.)

In the current COVID pandemic situation, exceptional circumstances will clearly arise more frequently. Our advice during the pandemic is as follows:

We appreciate that professionals will need to do what they can do in the circumstances. If a face to face interview cannot happen or is impracticable, an assessment/interview using videotech (preferable) or over the telephone should be conducted if possible. Where a doctor is satisfied that they have conducted a full enough assessment, and considers that the grounds are met to complete a report or issue a Certificate, they should do so. This includes EDC and STDC. They should record on the form/certificate information about how the interview/examination was conducted and any limitations of the assessment. MHO assessments and interviews might also be undertaken this way.

Clearly, for an application to the Tribunal (e.g. for a CTO) or to Court (e.g. for a welfare guardianship), the Tribunal or Court will decide whether the evidence is acceptable.

We recommend that any such interview is followed by a face-to-face interview when that is practicable.

5. Designated medical practitioners (DMPs)

5.1. DMPs and self-isolating patients or patients in care homes (18 March 2020)

Where a patient has symptoms and is self-isolating in line with Government advice, or a care home has concerns about possible risk of coronavirus infection, a DMP may carry out an assessment using alternative means, where face-to-face assessment is not practicable, and issue a T3.

The Commission's view is that a telephone or video conference interview which allows the DMP to consult the patient meets the requirement under s245 of the MHA for the DMP to consult the patient unless impracticable.

At present each situation should be individually considered. The Commission will ask about any risk when a DMP visit is requested, and will also check with the DMP about any issues.

5.2. Guidance to DMPs (19 March 2020)

The Commission's current guidance to DMPs is as follows.

BEFORE emergency legislation measures kick in

1. If a request or planned visit is for ECT or nasogastric then try to do this by phone if possible.
2. If an ECT/nasogastric request cannot be done by phone, consider with appropriate ward if it is still safe for you (and others) to visit OR if the visit can 'reasonably' be made safe. If a visit cannot be done because it's unsafe - don't do it. Inform RMO if you can and advise them to speak to the Commission medical team AND/OR let the Commission know that the visit isn't safe to do and it can't be done by phone.
3. If visit is planned for medication then do this by phone (until emergency measures kick in). This will require calls to the patient, RMO, named person, and other caregiver, etc., as usual. If these cannot be done then regard as not possible. Discuss with Commission medical staff as above.

AFTER emergency measures come into effect

4. Once the emergency measures kick in the same process applies for ECT and nasogastric requests as above, using whatever means can be done reasonably that is safe, such as phone or video. As the situation gets safer with time DMPs should consider face to face visits if they are safe for the patient, DMP, and others. (Reserving the right to go ahead and visit if this is absolutely necessary and can be achieved reasonably.)
5. The Commission will also aim to prioritise DMP visits for young people using phone or video-conferencing authorisation but if this is not possible then these requests will fall into the same category as point 6. (Under the emergency legislation these are not legally required in the way that the above safeguards are).
6. For all 'routine' medications requests, the Commission will take the request, and the RMO has authorisation to treat without a DMP safeguard. No visits by a DMP will be needed until the situation is safe enough to return to visits.

5.3. Clozapine monitoring when patient self-isolating (18 March 2020)

We have been asked whether it could be acceptable to continue clozapine treatment but suspend routine monitoring of full blood count (usually done every 1-4 weeks), in situations where a patient is stable on clozapine and self-isolating in the community. This would be off-licence and in breach of the specifications of the T3.

Normal rules apply. The RMO must seek DMP approval for a material change to a treatment plan.

The Commission will attempt to arrange a DMP visit as soon as is practicable. The DMP would examine the notes and speak to the patient by phone if it was not possible to visit.

The Commission would not endorse a clinical position for suspending routine monitoring for clozapine treatment unless there are extreme reasons for this. This would be primarily for the clinician to determine with the monitoring authority, and then be able to demonstrate this to a DMP to show the rationale and seek authorisation.

Note that for emergency treatment a T4 can be used in hospital but not in the community). No changes to this are planned in the emergency legislation.

6. Restrictions

6.1. Advice on care home resident who lacks capacity and requires restrictions for self-isolation (18 March 2020)

A care home sought advice in relation to a resident with dementia who required self isolation in line with Government guidance. The resident had a welfare attorney, but family were currently not visiting. The welfare attorney and family were consulted on the measures taken. In line with guidance the resident was moved to a ground floor room, with more space and a garden view. A small stair gate was placed at the door to prevent him leaving and additional distractions placed in his room. He enjoys, folding, rummaging and going through boxes, so these have been added. Staff are interacting frequently.

The Commission's view is that in circumstances of this kind, care homes should carefully consider the benefit to the individual of any proposed restrictions and restraint measures, in line with the principles and guidance in Rights, Risks and Limits to Freedom and the new Scottish Government guidance on social care (Annex 1) Any restriction should be the minimum possible in the circumstances and should aim to minimise any distress to the individual, ensuring frequent staff interaction.

See also section 6.3 on Visitors to care homes.

6.2. Visitors to inpatient wards (18 March 2020)

Units may be considering closing access to visitors to reduce the risk that patients, staff or visitors spread the Covid-19 infection. The Commission accepts it may be necessary to take a general view on such restrictions during the pandemic while national guidance incudes maximizing social distancing.

However, such a restriction must be balanced with the human rights of patients, in particular the right to family life. Specific situations should be individually risk assessed and risk managed. Examples include:

- where a patient might go outdoors with family members, in circumstances where the risk of infection is assessed as low
- where a visit is considered essential, for example significant family news which needs to be delivered in person.

6.3. Visitors to care homes (18 March 2020)

The new Scottish Government guidance on social care (Annex 1) advises reducing visitors to care homes apart from essential visits, seeking to reduce external visitors by 75%.

Where a resident has symptoms of COVID-19, Health Protection Scotland *COVID-19: Information and Guidance for Social or Community Care & Residential Settings* published 12/3/20 states that visits should be restricted to essential visitors only:

> 'Local risk assessment and practical management should be considered, ensuring a pragmatic and proportionate response, including the consideration of whether there is a requirement for visitors to wear PPE. These visitors must not visit any other care areas or facilities. A log of all visitors should be kept.'

6.4. Guidance on restricted patients (20 March 2020)

The Scottish Government restricted patient team has circulated specific guidance for practitioners on restricted patients and COVID-19. Restricted patients are persons who are subject to a Compulsion Order and Restriction Order; Hospital Direction or Transfer for Treatment Direction. It is also relevant in relation to patients on remand who are subject to an assessment order, treatment order, temporary compulsion order or interim compulsion order.

The guidance sets out information in relation to restricted patients on the proposed emergency legislation. It will be updated regularly.

If you have not received a copy, or have any queries about the guidance, email forensicmentalhealthpolicy@gov.scot

If you have a question about a particular restricted patient email restrictedpatient@gov.scot.

7. Mental Health Tribunals

7.1. Hearings to be held by teleconference (19 March 2020)

Mental Health Tribunals Scotland (MHTS) intends to hold all hearings by teleconference from Monday 23 March 2020 onwards. Specific instructions on taking part in a hearing by teleconference will be sent to those involved. MHTS has asked care them to support patients by assisting them to participate in proceedings. Where the patient is in hospital and wishes to take part in their hearing, a member of the hospital staff would be expected to accompany the patient for the duration of the hearing. For patients based in the community, support for a patient could be provided by an MHO, an advocacy worker or a solicitor.

See https://www.mhtscotland.gov.uk/mhts/News/News for further information.

8. Information governance

8.1. Scottish Government guidance on data sharing (19 March 2020)

The Scottish Government has published new COVID-19 information governance advice in relation to data sharing:

https://www.informationgovernance.scot.nhs.uk/

https://www.ehealth.scot/resources/information-governance/

9. Other useful information

The Royal College of Psychiatrists has produced information for clinicians in the community and in hospitals, which includes specific advice around different patient groups and information for patients: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19

Their advice re care on inpatient wards is here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians/community-and-inpatient-services-covid-19-guidance-for-clinicians

10. Glossary

AWI	Adults with Incapacity (Scotland) Act 2000
MHA	Mental Health (Care and Treatment) Scotland Act 2003
STDC	Short Term Detention Certificate
MHO	Mental Health Officer
CTO	Compulsory Treatment Order
TTD	Transfer For Treatment Direction
AMP	Approved Medical Practitioner
RMO	Responsible Medical Officer
DMP	Designated Medical Practitioner
CCTO	Community Compulsory Treatment Order
13ZA	Section 13ZA of the Social Work (Scotland) Act 1968
Proxy powers	Powers held under the Adults with Incapacity Act on behalf of someone unable to take their own decisions – power of attorney, guardianship or intervention order
Section 47 (s47) certificate	Certificate under the Adults with Incapacity Act which gives legal authority for physical healthcare treatments
T3	certificate for medical treatment, where a patient is incapable of consenting to treatment, completed by a designated medical practitioner
T4	Notification of urgent medical treatment given

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