Investigating deaths occurring during compulsory care and treatment under mental health legislation in Scotland

Section 2: Summary of revised process proposed by the Commission

Q1. Q1: Do you agree that the Commission should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases?

Yes

Q2. Q1a: Do you foresee any difficulties with this arrangement?

• The range of scenarios the Commission envisages will be included in this process means a variety of approaches will be essential, each with different purposes. This includes in the case of 'natural causes', including among our Old Age population, and ensuring that the care they received met their needs and that the quality of life provided for.
• Related to the above, we would expect distinct processes for reviews and investigations. This would reflect the fact that, despite suggestions that legislation uses the two terms interchangeably, clinicians perceive the two as very separate and different processes. Investigations are seen as potentially accusatory and focused on apportioning blame, compared to a review which is more focused on learning lessons and improvement. One example of how these are seen differently is the likelihood of seeking defence union representation if asked to participate in an investigation versus a review.
• That there is a lack of clarity on the process between an initial review by the Commission and when an investigation will be triggered therefore not only creates potential confusion, but places clinicians in a situation where they will be having very different responses to the Commission's engagement depending on what stage of the process they are engaged. By creating a defensive approach from clinicians from the outset, it makes the process much less likely to produce learning outcomes.
• The issue of clarity also applies to incidents of suicide. Assessing the interventions made/provided for and whether they were sufficient to engage the patient would be critical in these cases.
• While we support this process in principle, the communication of it has alienated some of our members. In delivering this process, efforts to ensure staff are involved and that this is not perceived as something done 'to' them are required.
• More widely, lessons for health services should not be simply limited to mental health settings. Where there have been failures to provide appropriate physical health care, these should be within the scope of such review processes.
• We would also suggest that, with the Commission involved at all stages, it needs to flexible and proactive in bringing in the necessary expertise at each stage of the process. This includes bodies like Healthcare Improvement Scotland.
• Involvement in these 'investigations' cannot be expected to become simply an additional duty for clinicians to fit in. Resource should be in place to secure time for them to input.
• Communication overall regarding this process will be critical for our members. This cannot be perceived as purely punitive, or staff will refuse to participate and engage. Engagement with clinical staff should be one of the key priorities in implementation, with immediate concerns already emerging around how this will be delivered and the language used (see above).
• The current circumstances mental health services find themselves in, of pressures exacerbated by the pandemic, means significant change like this will struggle to be heard and understood. That increases the importance of getting that communication right, and for it to be as widespread as possible. It also means that ongoing consultation is likely needed to capture people's views as this process is introduced. To not do so risks harming staff morale further and these new processes being received in a worse light.
• Currently, there is a gap between the incident-focused nature of the Commission and the quality improvement focus of HIS (as identified in the Strang Review of Tayside services). The proposals would suggest the Commission is seeking to fill this gap, for which it will need to be able to take a systems approach where necessary.

Q3. Q1b: How could such difficulties be addressed?

• Recruiting the right staff and resourcing time for clinicians to participate if necessary will be key to ensuring the right level of expertise and time is devoted to these processes.
• A considered and continual effort by the Commission to communicate and consult to address concerns will be critical to this process being introduced successfully.
• In order to more widely improve the Review processes around such incidents, it was suggested developing good-practice guidance and/or quality standards for delivering such reviews would ensure for greater consistency.

Section 2: Summary of the revised process proposed by the Commission

Q4. Q2: Do you agree that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations as described in paragraph 30 of the consultation document?

Yes

Q5. Q2a: Do you foresee any difficulties with this arrangement?

• There remains an issue with being able to assess whether an incident presents urgent implications that need actioned immediately, rather than waiting for an annual report.
• More widely, the enforceability of recommendations in this annual report will need to be considered. This includes how the delivery of these are monitored in addition to site visits, and the potential escalation options should a healthcare setting not be delivering recommendations made.
• In order to ensure recommendations are enforced and lessons are learned, the Commission should also expand its knowledge base and become able to take a systems approach to these inquiries. Recommendations that can improve settings in general can and should be developed and disseminated as widely as possible where appropriate.
• We would also suggest the presentation of this report will need to reflect a quality improvement focus, as well as highlighting issues found. While data on performance is helfpul, comparisons that pitch health boards against one another is unlikely in these situations to be particularly helpful.

Q6. Q2b: How could such difficulties be addressed?

• The potential benefit of outlining an initial review process could be to create space to evaluate any immediate issues which emerge from an incident that can be acted on, to the benefit of patients.
• As quality standards for secondary mental healthcare develop, there is an opportunity to evolve the current regulatory landscape (through new measures of care quality and through a greater focus on reviewing services) and enable system-wide reviews to take place where appropriate.
• The capacity as part of this reporting process to fast track the disseminating of recommendations will be critical to ensure urgent issues can be addressed.

Section 2: Summary of revised process proposed by the Commission

Q7. Q3: Do you agree that the Commission should develop guidance and standards for use by local services when undertaking investigations into deaths during compulsory treatment?

Yes

Q8. Q3a: Do you foresee any difficulties with this arrangement?

• In developing guidance, there is a need to dovetail with current guidance and standards in health and social care generally, as well as regional and national networks. These standards cannot sit in isolation, and should complement what is already in place.
• While accepting many of the guidance and standards will relate to procedures that absolutely should be in place, there will be potentially aspects where a more quality improvement focus instead of a 'pass-fail' approach would be beneficial to their adoption.
• It was also suggested governance processes can inhibit review processes like this, and that any guidance could address this in terms of responsibility to act.

Q9. Q3b: How could such difficulties be addressed?

• Standardisation alongside other partners, and dovetailing with work underway like the quality standards work in Scottish Government.

Section 2: Summary of the revised process proposed by the Commission

Q10. Q4: Do you have any comments on the revised process as set out in Section 2, paragraphs 34 to 43, of the consultation document?

• As stated previously, there remains a gap in the process where wider learnings beyond the initial setting investigated can be delivered. This needs addressed throughout the process, with clear communication and subsequent monitoring.
• Identifying appropriate cases in a seamless manner was said to be a challenge. It was suggested additional resource may not be enough, and the systems by which adverse incidents were reported may need to be revised.
• Our members highlighted that the engagement of staff in the process was not sufficiently detailed. Considering the moral injury they may be suffering as a result of a death and their role in delivering any recommendations from the process on the frontline, the success of the process depends on meaningful staff engagement.
• Related to the above is the issue of how an investigation vis perceived versus a review, which we have already highlighted will impact engagement.
• We have had suggestions from some members the timescales proposed to complete an investigation may be too long for this purpose, in particular for families directly affected who may have their suffering prolonged. They also do not match up with the current expected timelines for a review process.
• It was suggested that, in seeking clinical input, ensuring for impartiality in who was participating may be difficult due to the size of specialties. We would also reemphasise the need for resource to secure staff time to be involved.
• Clarity on the support structures provided by the Commission for these reviews, including administrative support, were felt to be missing. Without such support, the delivery of these investigations will be difficult.
• The involvement of local health boards was welcomed, but frontline clinical representation in the process was said to be critical.
• There remains a gap in the enforceability of recommendations. Consideration needs to be explicitly given to when services fail to respond to direct or indirect recommendations in response to incident reviews.
• A number of members found the language used to describe the process concerning. It was felt that it painted the process as an arbitrary attempt to identify responsibility for failings, rather than how those failings could be avoided. It was said such language made it difficult to engage in good faith with the proposed system.
• Finally, we would also highlight a Commission process is one strand of number of issues being dealt with in the aftermath of a death. The victims support, criminal justice and ongoing reviews of the perpetrator are all taking place simultaneously across different agencies and settings. Communication between each is critical.

Q11. Q4a: Do you foresee any difficulties with this process?

• In order to identify the 7% of cases which currently aren't being picked up, a range of options for identifying cases will be needed. This includes potentially when someone subject to compulsion 6 months previously is involved in an adverse incident. Due to anonymity, a service may not pick up on their previous enagegment with mental health services.
• Relatedly, consideration should be given to the twin needs to ensure confidentiality for individuals is retained where appropriate and the potential to miss cases that could lead to lessons learned for the better.
• It was also suggested that investigations ideally needed to take place as local as possible, to utilise the knowledge of the system and to enable better engagement with its work.
• Timescales were said to not match those currently in places for processes like this in health boards, and it was also noted that delays to the process, like post-mortems, did not currently seem to be accounted for.
• It was suggested by some members that process for the MWC compiling information necessary to establish the terms of reference for its investigation could place undue strain on services, as well as requests for staff with specific expertise when they may not be available. The importance of administrative support to deliver aspects like this was said to be critical.
• It was also noted some areas may not have sufficient staff or the right staffing expertise to contribute fully to the MWC investigation process. In that instance, discussions as to how this expertise could be brought in externally may be required.

Q12. Q4b: How could such difficulties be addressed?

• A duty to inform the Commission of a recently detained perpetrator with mental illness was suggested by some members. Who that duty fell to was less clear, with the health service or the procurator fiscal among those suggested.
• New reporting and tracking frameworks would be needed to proactively identify incidents of relevance, rather than relying on current reporting networks. A review during implementation of the timescales and their appropriateness.
• Expanding and outlining clearly the engagement which will take place with clinical staff.
• Some members highlighted there remain a lack of clarity around the practical delivery of the process. It would be worthwhile potentially engaging with partners on the detail of this once established.

Section 3: Involving families and carers

Q13. Q5: Do you think that the role of the Commission Liaison Officer will help to improve the involvement of, and communication with, families and carers during investigations of deaths?

Yes

Q14. Q5a: Do you have any concerns about this type of arrangement?

• Our members highlighted there are a number of roles like this already in place. It was suggested there needs to be clear communication and a defined job description for the role, so that its core purpose did not duplicate what was already available.
• It was felt by some members a more ideal system would be a ‘one stop shop‘ for accessing victims support. It was recognised, though, that different experiences may require different kinds of support in response, and that the system as it works now did require different bodies to develop their own support roles.
• While it should not be the duty of the Liaison Officer to advocate on behalf of families (though in seeking information, that may be what is required), it was emphasised that signposting to advocacy services would be important. Relatedly, building the capacity of independent advocacy services to support families and victims was suggested
• The role the Liaison Officer would play in engaging secondary victims was also said to be a gap. These include the family of a perpetrator and clinical staff who were providing care. They will also need support during such a process, and it would make sense for the Liaison Officer role to provide it.
• More widely, thought is needed to the support available for staff. This could be provided in health services, but would need to reflect the potential impact of incidents on morale and also individual staff member mental wellbeing.

Q15. Q5b: How could your concerns be addressed?

• Fundamentally, these roles need to be clearly defined, with expectations managed as to what the role can deliver, and staffed by independent, experienced and knowledgeable staff, potentially from established support services.

Section 4: Other matters for consideration

Q16. Q6: Do you agree that the revised process, described in Section 2 of the consultation document, will meet the values and principles set out in paragraph 50?

Yes

Q17. Q6a: Please explain your answer.

• We would urge that principle 3 is changed to "Involve families, staff and carers in a meaningful way". As suggested previously, it is important meaningful engagement takes place.
• These principles should not sit in isolation. They should account for those principles used in assessing the quality of mental health care in the quality standards work, as well as refer to and be cognisant of victim’s support legislation.
• They should also be consistently assessed, with underlying actions to deliver them across mental healthcare settings. In doing so, the quality improvement ambition of any process will be likelier to be achieved.

Section 4: Other matters for consideration

Q18. Q7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics?

• Based on the Commission’s own work in this area, racial inequality needs considered as part of this work. The Commission’s previous findings around the potential negative perceptions of people from our ethnically diverse communities in mental health settings, and the inability by services to engage particular communities would all inhibit the process outlined.
• The Commission should also continue to assess the equality implications of its work in relation to these incidents. This includes ‘risk factors’ around risk of self-harm/suicide, as well as the well-established links between socioeconomic inequality and severe mental illness.

Q19. Q7a: Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

• The Liaison Officer should play a critical role in addressing this. Also critical is working with other organisations to address particular groups with communication needs.

Q20. Q8: Do you have any comments on the potential impacts of the revised process on children and young people?

• There will need to be particular sensitivity to secondary victims who are children, including from the Liaison Officer. The stipulated procedures for engagement with children in victims support legislation should be incorporated into this process.

Q21. Q8a: Please explain what you think could be done to minimise any negative impacts on children and young people.

• Training and support for the Liaison Officer and other participants in the process to engage with children and young people will be necessary.

Section 4: Other matters for consideration

Q22. Q9: Do you agree that the revised process for investigating deaths during compulsory treatment (as described in Section 2 of the consultation document) is human rights compliant?

Yes

Q23. Q9a: Please explain what you think could be done to ensure that the new process fully complies with human rights standards.

• We would suggest these new procedures will need to be cognisant of the Scott Review into Mental Health Law, the ECHR and efforts to incorporate the UNCRPD.

Section 4: Other matters for consideration

Q24. Q10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services?

• This will require carefully calculated funding, and cannot be expected to be delivered from within existing allocations. In relation to the Liaison Officer role, a service-level agreement with established providers would provide stability and ensure the roles were able to be effective from the introduction of the process.
• It was also suggested there will need to be recognition of exceptional years where there needs to be additional funding and staffing resource. This included when a more extensive inquiry was required, with different specialist inputs.

Q25. Q10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.

• Extra staffing, training and administrative support needs to be budgeted for, as well as the impact of longer and more detailed inquiries requiring continuing specialist input.

Section 4: Other matters for consideration

Q26. Q11: Do you have any other comments or concerns in relation to the revised process?

• Confusion around how these changes are communicated has the potential to harm this process from the outset.
• Taking into account the settings in which these investigations seek to positively influence, communication with clinicians that explains aspects such as the usage of investigation versus review will be necessary.
• There will need to be a clear timeline on commencement to enable services to prepare for this new process.
• It was also emphasised arrangements will need reviewed on a regular basis, and changes will need to be implemented following initial implementation. This will reflect the fact that the actual delivery of this process will likely lead to unresolved operational issues emerging.
• There were also concerns highlighted around the potential confusion for services and those commissioning reviews of a 2-tier system, with those "detained" being part of a very different system and approach to those who are not.
• Finally, members highlighted there did not seem to be sufficient evaluation of what the current system got right that could be carried forward with these proposals. We would therefore urge the Commission to engage with what would be lost in the current system by the proposed changes and to consider how this might be avoided.

Respondent Information Form

Q27. Name of person submitting the response

Aidan Reid

Q28. Email address of person submitting the response

aidan.reid@rcpsych.ac.uk

Q29. Are you responding as an individual, or on behalf of an organisation?

I am responding on behalf of an organisation

Respondent Information Form - individual responses

Q30. Are you a family member or carer of a person who has died whilst being treated under mental health legislation in Scotland?

No Response

Q31. Do you wish your response to be published?

No Response

Respondent Information Form - Organisational responses

Q32. Organisation name

Royal College of Psychiatrists in Scotland

Q33. Organisational responses will be published unless otherwise requested. Please tick the box below if you do NOT want your organisation's response to be published. Note that the name of your organisation will be listed as a respondent to the consultation even if you request that your response not be published.

No Response