mental welfare commission for scotland

COVID-19 FAQs for practitioners (version 24, 19 March 2021)

Advice notes

19 March 2021

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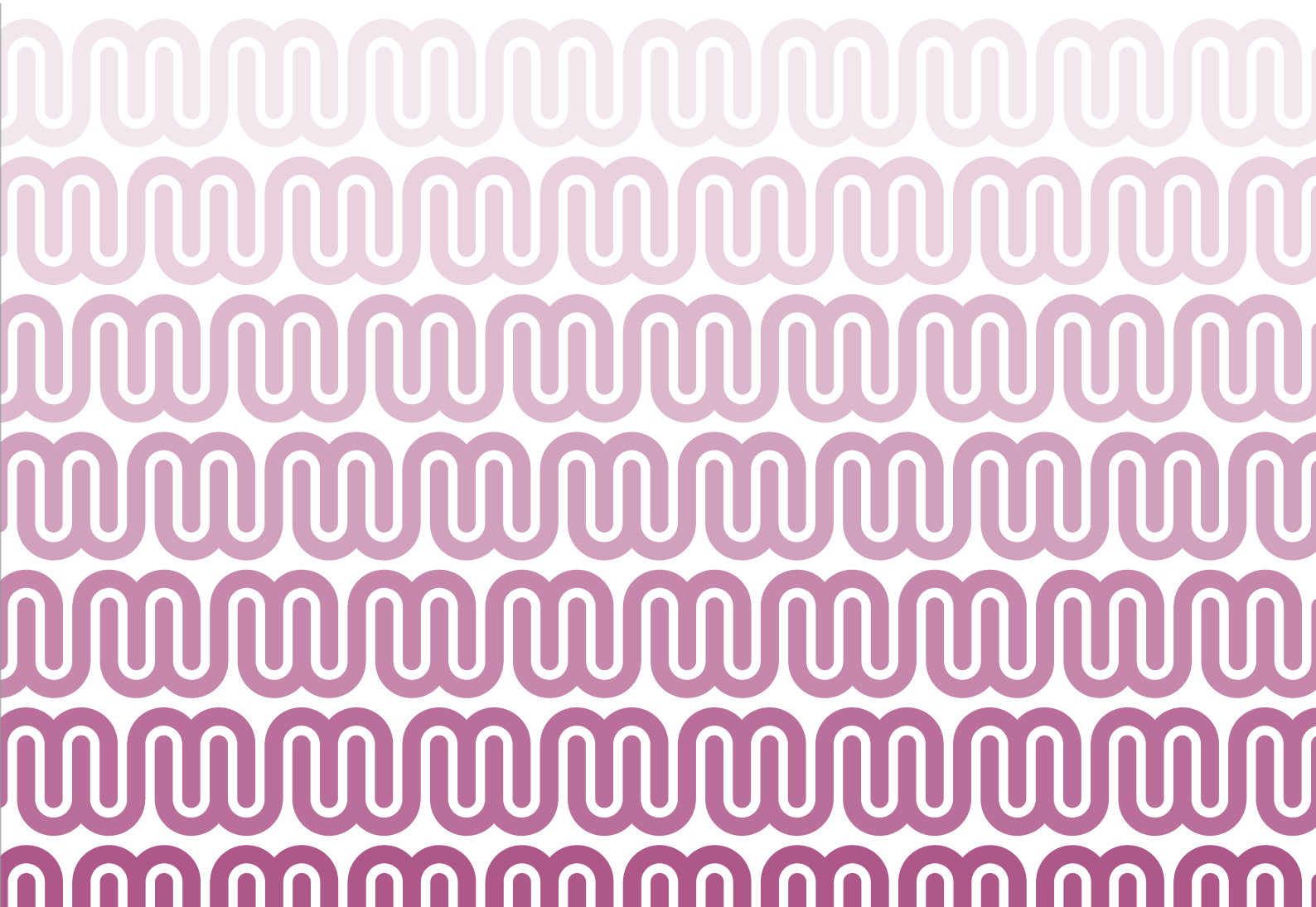

Our mission and purpose

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

Main changes in this update

The main changes are:

- New: **4.20** Proxy refusal of Covid vaccination
- New: **6.11** Mask exemption and car use for service user
- Updated: **9.11** Vaccination priority for unpaid carers – carers now invited to register for vaccine
- Updated: **11** Other useful information – links checked and updated

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 is 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 was passed by the UK and Scottish parliaments, but much of this has not been put into effect.

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 (updated 2 April 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 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.

The Scottish Human Rights Commission has issued a briefing on the human rights implications of coronavirus emergency legislation:
http://www.scottishhumanrights.com/news/commission-flags-human-rights-implications-of-coronavirus-emergency-laws/

2.2. Human rights of care home residents (updated 29 January 2021)

A high proportion of deaths in Scotland due to coronavirus have happened in care homes. Early in the pandemic we heard through calls to our Advice Line of some situations where generalised advance decisions appear to have been taken about what care and treatment individuals living in care homes would be offered should they develop symptoms of Covid-19. It remains important that any such decision is taken as part of person-centred assessment that considers the risk and benefits of any particular treatment or intervention for an individual, based on, where possible, the views of the individual and their family or any proxy decision maker such as a welfare attorney or guardian.

The Commission has made it clear that people living in care settings who may be unable to state their views and wishes have the same human rights as every other person. See section 2.1, Human rights-based approach and section 9.2, Medical intervention and cardiopulmonary resuscitation (CPR) for people with dementia or learning disability and people in care homes.

The Royal College of General Practitioners has created covid-19 guidance for GP decision-making in primary care, which may be helpful to those working in care homes. The College also produced an ethical framework for covid-19 and related Q&A.

In December 2020 the Equality and Human Rights Commission published a briefing on equality issues in care homes during the pandemic, to support care homes and public authorities to comply with human rights and equality obligations.

2.3. International advice on maintaining human rights of people deprived of their liberty during the pandemic (2 April 2020)

The UN Subcommittee on the Prevention of Torture issued advice on 25 March 2020 in relation to the pandemic and measures taken to reduce the risk to detained people and to staff. This is broad advice relating to anyone detained, including prisoners and those detained under mental health legislation.

Some key points are:

- [People detained] should enjoy the same standards of care available in the community […] without discrimination on the grounds of their legal status
- Any restrictions on existing regimes should be minimised, proportionate to the nature of the health emergency, and in accordance with law
- Respect the minimum requirements for daily outdoor exercise, whilst also taking account of the measures necessary to tackle the current pandemic
- Where visiting regimes are restricted for health-related reasons, provide sufficient compensatory alternative methods for detainees to maintain contact with families and the outside world, for example, by telephone, internet/e mail, video communication and other appropriate electronic means. Such contacts should be both facilitated and encouraged, be frequent and free.
- Make available appropriate psychological support to all detainees and staff who are affected by these measures;

https://icva.org.uk/advice-of-the-subcommittee-on-prevention-of-torture-to-states-parties-and-national-preventive-mechanisms-relating-to-the-coronavirus-pandemic-adopted-on-25th-march-2020/

On 20 March 2020, the European Committee on the Prevention of Torture (CPT) published a "statement of principles" relating to the treatment of persons deprived of their liberty in the pandemic (also available in French and Russian). The CPT's advice includes:

- WHO and clinical guidance must be implemented in all places of detention;
- Staff availability should be reinforced;
- Persons deprived of their liberty should receive information;
- People should be tested for coronavirus;

- Any necessary restrictions on contact with the outside world, including visits, should be compensated for by increased access to alternative means of communication such as telephone or web-based communications;
- If a person is isolated, meaningful human contact should be provided every day;
- Monitoring bodies should maintain access; and monitoring bodies must promote the "do no harm" principle by taking precautions.

2.4. Scottish Government Covid-19 Ethical Advice and Support Framework (updated 7 August 2020)

The Scottish Government has published an updated ethical advice and support framework, which aims to support clinicians with decision making during the COVID-19 pandemic.

2.5. Access to advocacy (updated 2 July 2020)

Advocacy continues to be a right, and local independent advocacy services continue to operate using alternatives to face-to-face contact. As lockdown measures are eased, some advocacy services will start to be offered face-to-face, using PPE as appropriate.

It is important that patients are helped to access advocacy by whatever means this can be provided, including by telephone or video conference.

Although the emergency legislation has not been brought into use, and it currently looks unlikely that it will be needed, note that the right to advocacy would continue to apply in situations where patients are subject to reduced safeguards under the emergency legislation.

Information on local advocacy services is available at: https://www.siaa.org.uk/find-advocate/.

2.6. Scottish Government Mental Health Service Principles (7 May 2020)

The Minister for Mental Health has written to NHS boards, IJBs, local authorities and local mental health services leads setting out principles for mental health service during the pandemic.

The Minister's covering letter states the purpose of the document:

> 'This guidance is designed to support active local decision making and promote consistency to provide safe, person-centred and effective service responses for people using NHS and local authority social care services during Covid-19 mobilisation. I would ask that the Principles are used to guide considerations of any changes to care and/or treatment for all patients under the care of the NHS or who may be accessing local authority directly provided, or externally commissioned mental health services. For the most part however this is operational advice which will be relevant for those managing waiting lists and referrals.'

https://www.gov.scot/publications/coronavirus-covid-19-principles-for-mental-health-services---letter-from-minister-for-mental-health/

2.7. The Mental Welfare Commission's Position Statement on Section 13ZA, Social Work (Scotland) Act 1968 in relation to Coronavirus (9 October 2020)

1.0 The Mental Welfare Commission's role

1.1 The Mental Welfare Commission for Scotland (the Commission) is an independent organisation set up by statute, working to safeguard the rights and promote the welfare of anyone with a mental illness, learning disability and related conditions.

1.2 The Commission has specific legal duties in relation to safeguarding the rights of people who are subject to the welfare provisions of the Adults with Incapacity (Scotland) Act 2000 (AWI Act).

1.3 Section 9 of the AWI Act details the Commission's safeguarding role in respect of adults whose capacity to make decisions or take actions to promote or safeguard their welfare is impaired due to a mental disorder. These duties are carried out by monitoring the use of the legislation, visiting adults subject to welfare guardianship, investigating where someone's welfare may be at risk or may have been at risk due to their incapacity and giving information and advice in respect of the use of the Act.

2.0 The Impact of the Coronavirus (Scotland) Act 2020

2.1 The Coronavirus (Scotland) Act received Royal Assent on 6 April 2020 and the Commission noted the significant changes to how s.13ZA might operate under emergency powers in this Act. The Scottish Government agreed that the Commission would be key to the transparent, scrutiny process if these emergency powers were introduced (also known as the easements to s.13ZA) to prevent any abuse of these emergency powers.

2.2 The Scottish Government subsequently confirmed that even at the height of the pandemic 'the fine balance between the right to life and the right to be consulted was not such that the provisions should be brought into force'.

2.3 Easement of s.13ZA has therefore not been introduced to date and on 29 September 2020 the provisions expired through The Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020.

2.4 We do not anticipate that such provisions will be enacted in any future wave of this pandemic.

3.0 Existing Statutory Framework: Lawful authority

3.1 The easement of s.13ZA was not introduced as part of the response to coronavirus and it has now expired. Services therefore continue to need to operate within the existing statutory framework. If services are satisfied that a person who cannot consent will be deprived of their liberty, it is necessary to consider what lawful authority justifies that deprivation including the application of s.13ZA.

3.2 The principles of the 2000 Act must inform consideration in each case of the action to be followed. As well as applying to decisions under the AWI Act, it is explicit in s.13ZA of the 1968 Act that the general principles of the 2000 Act apply to whatever steps are taken by the local authority under the 1968 Act, in relation to the provision of community care services to an adult with incapacity.

3.3 Due legal process ensures the adherence of the European Convention of Human Rights (ECHR) and the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD)

3.4 The Commission has previously advised that it is essential to record the decisions about which power to use to provide services (supported by a holistic professional social work assessment) and the reason for taking this decision based on the unique circumstances of the individual.

https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf

3.5 The Commission intends to work with Health and Social Care Partnerships to independently review the practice in recent months with specific reference to moves from hospital to care homes and to make further inquiries as to the rights based practice and legal authority supporting the moves.

3. Emergency legislation

3.1. Emergency powers allowing temporary changes to mental health legislation not so far required (updated 11 June 2020)

The Coronavirus Act 2020 was put in place early in the pandemic to provide measures to reduce the pressure on services if necessary. It includes emergency provisions relating to the Mental Health (Care and Treatment) Scotland Act 2003 and Criminal Procedure (Scotland) Act 1995 (CPSA).

These provisions have not so far been required, and have not been put into effect.

If the situation were to change for the worse, the provisions can to be put into effect by the Scottish Government, which may also suspend them or put them into effect again as required. At present there are no changes to the major provisions of the Mental Health Act or the CPSA: https://www.gov.scot/publications/coronavirus-act-2020---impact-on-mental-health-legislation-update/

Schedule 9 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 a Transfer for Treatment Direction to be made with the written report of an AMP, rather than both an AMP and another medical practitioner, where complying with two reports is impractical or would cause unnecessary delay.

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 DMPs 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.

Act:
http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted/data.htm

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

3.2. Potentially infectious person (3 April 2020)

The Coronavirus Act now extends public health powers that were available for England across the UK. These powers allow for a public health officer to detain someone, and to require them to stay at a suitable place, return them to that place, and keep them in isolation or quarantine as they deem necessary. They can inform a constable as needed to enforce. The Act 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 protection team. Where the individual is managed is for public health to determine, with input from mental health services. The legislation used will be the Coronavirus Act 2020 (Schedule 21).

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.

Contact details for Health Protection Teams in each Board are given on the last page (p10) of the guidance on management of patients with possible/confirmed COVID-19 in secondary care, at this link:

https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2936/documents/1_covid-19-guidance-for-secondary-care.pdf

3.3. Changes to Scottish emergency legislation relating to the Adults with Incapacity Act (updated 2 March 2021)

The Coronavirus (Scotland) Act was passed by the Scottish Parliament on 1 April 2020 and most of its measures came into force on 7 April. It contains emergency measures relating to the Adults with Incapacity (Scotland) Act 2000. The Act allows these measures to be put into effect by the Scottish Government, which may also suspend them or put them into effect again as required.

From 30th September 2020 the measures which would have allowed local authorities to use s13ZA of the Social Work (Scotland) Act 1968 to move an adult into residential accommodation without taking into account the views of the adult and interested parties, including where a guardianship or power of attorney with relevant powers had been granted, have been removed. These measures were never introduced. The Commission had had concerns about human rights in relation to these measures, and welcomes their expiry.

The new Act also 'stopped the clock' on guardianship orders and section 47 certificates, because of concerns about the capacity of the Office of the Public Guardian and the courts, and the availability of doctors, mental health officers and solicitors.

In February 2021 the Cabinet Secretary, following consultation, extended these provisions and sus[ended them for a further six months. If the situation changes they therefore remain available and could be brought into effect again.

The clock was stopped from the point when the Act came into force on 7 April until 29 September inclusive, which is 176 days. This means that new expiry dates for guardianship order and for s47 certificates should be calculated by adding 176 days to the original date of expiry. For example:

> Original guardianship/s47 certificate expiry date – 20 April
>
> *Add on 176 days*
>
> New guardianship/s47 certificate expiry date – 13 October

Any guardianship orders granted or s47 certificates issued between 7 April and 29 September would have the number of days between the date granted and 29 September added to the expiry date.

The clock was stopped on **all** guardianship and s47 certificates that were in existence when the provisions came in to force, not only those which would have expired during that period. For example a longer guardianship that expired in 2025 would still have 176 days added on to the expiry date. For example:

> Original guardianship expiry date – 23 May 2025
>
> *Add on 176 days*
>
> New guardianship expiry date – 15 November 2025

These measures may be extended by regulations for one further period of six months, giving a maximum duration of 18 months.

The Scottish Government has published updated guidance regarding the emergency provisions:

https://www.gov.scot/publications/coronavirus-covid-19-adults-with-incapacity-guidance/

4. Safeguards

4.1. Does the recent High Court decision in England that a MHA medical examination needs to be face-to-face mean that this is also the case in Scotland? (29 January 2021)

We are aware of the High Court's recent decision in England: *Devon Partnership NHS Trust v Secretary of State for Health and Social Care* [2021] EWHC 101 (Admin).

The Court determined that a Mental Health Act (MHA) medical examination in England and Wales requires the doctor to be physically present with the patient.

This resulted from the Court's interpretation of wording in the Mental Health Act (1983): "personally seen" and "personally examined". This statutory wording is different, and more restricted, than the wording in the Scottish MHA (the 2003 Act). The 2003 Act includes "carries out a medical examination".

The Commission's view is that this High Court judgment in England does not alter the position in Scotland regarding whether a MHA medical examination requires to be face-to-face, or whether it could be done via telephone on video-technology. Our guidance on this at section 4.6 of this advice note remains unchanged.

Please note the Commission's view is not a definitive legal opinion. Ultimately, if the examination forms part of an application to the Tribunal, or a determination that is reviewed by a tribunal, or is reviewed in court, it is up to the tribunal or court to decide if an appropriate assessment has taken place and criteria are met. Each tribunal reaches its own view, and a question such as whether there has been a medical examination which complies with the legislation will be answered on a case by case basis.

4.2. Second report for CTO application (updated 29 January 2021)

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. (See section 4.6, MHA and AWI assessments and examinations by video technology or telephone; and section 4.1 about recent English case law on face to face examinations.)

4.3. Moving someone without 13ZA process being completed (updated 15 October 2020)

The Commission was consulted early in lockdown 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 lack of alternatives for care provision, and given the consultation which had already happened, we advised that they could consider the move taking place in the best interests of the individual, and that if this was the decision and rationale for the move should be clearly documented along with the consideration given to the principles of AWI.

Now that things have moved on in relation to the pandemic response we would always expect an alternative social worker to be identified to complete the assessment.

We have issued a position statement on the use of 13ZA in relation to coronavirus, which highlights that emergency legislation in relation to 13ZA was never introduced and has now expired, and that services must operate within the existing statutory framework (see section 2.7): https://www.mwcscot.org.uk/news/commission-updates-position-statement-section-13za-social-work-scotland-act-1968-relation

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. Deleted (2 March 2021)

This section dealt with an emergency measure which 'stopped the clock' on s47 certificates, which ceased to have effect on 30 September 2020.

4.5. Moving an individual to a care home without family agreement (updated 15 October 2020)

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 early in lockdown 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).

We advised that unless emergency measures under the Coronavirus (Scotland) Act 2020 were put 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. Note that these emergency measures were never introduced and have now expired.

We advised that 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.

In October 2020 we issued a position statement on the use of 13ZA in relation to coronavirus, which highlights that services must operate within the existing statutory framework (see section 2.7): https://www.mwcscot.org.uk/news/commission-updates-position-statement-section-13za-social-work-scotland-act-1968-relation

4.6. MHA and AWI assessments and examinations by video technology or telephone (updated 29 January 2021)

During the pandemic there have been questions about using technology to undertake MHA assessments. There is little literature or policy on this. The Act is silent on the mechanism but the Code of Practice envisages that these are done face-to-face. Of course, the pandemic brought new challenges due to social distancing and shielding affecting patients and service users, those important to them, and professionals working with them.

The Commission's position was that only in exceptional circumstances might it be appropriate for MHA assessments to be done by technology. However during the early phases of the pandemic we recognised that these exceptional circumstances might occur more commonly. We are now finding our way in the 'new normal' and keen to ensure that patient rights are safeguarded but also that the innovation that has been helpful to patients and those important to them can continue. This forms the basis of the revised position on the use of technology recognising that in some cases, the use of technology for MHA assessments, rather than a second choice may actually be preferable.

See section 4.1 about recent English case law on face to face examinations.

It should go without saying that the criteria for detention must have been fully assessed through whatever mechanism is used for the assessment.

The Commission's view is that for assessments for Mental Health Act detentions for EDCs and STDCs and for the 'first report' for a new CTO this should normally continue to be done face-to-face.

However, the Commission recognises that for certain assessments, e.g. a second CTO report by a GP or an extension of a CTO or CO, it might be preferable for the patient to have someone who knows them undertaking the assessment via technology or by telephone rather than defaulting to a 'face-to-face' assessment with someone who does not have an ongoing working relationship. Indeed, the purpose of the second report from a GP is to ensure that more longitudinal knowledge of a person is available to aid decision making about applying for a CTO. A determinant in pursuing a non-face-to-face MHA assessment for the above situations should be patient participation and consent that the assessment can be completed using video technology or by telephone to allow an assessment by a professional with whom they have a more long-standing working relationship.

The same principle would apply to assessments for AWI measures.

Please note the Commission's view is not a definitive legal opinion. Ultimately, if the examination forms part of an application to the Tribunal, or a determination that is reviewed

by a tribunal, or is reviewed in court, it is up to the tribunal or court to decide if an appropriate assessment has taken place and criteria are met. Each tribunal reaches its own view, and a question such as whether there has been a medical examination which complies with the legislation will be answered on a case by case basis.

We understand that the RMO narrating reference to the MWC's guidance and the taking of advice from the MWC, plus the surrounding circumstances making the telephone or video assessment adequate, will maximise the chances of the tribunal accepting the position. If the local COVID situation has been part of the reason for the decision to proceed with a telephone or video assessment, details of this should be given.

The Commission has compiled a list of factors that might be helpful to consider as to whether an assessment can be conducted by tech e.g., considerations of connectivity, privacy, support from a professional with them etc., and if in doubt please contact the Commission to discuss further.

4.7. MHO consent to STDC where they cannot access the patient and the patient refuses to speak by telephone (2 April 2020)

The Commission was asked to advise on the position if an MHO was unable to attend a ward due to health reasons in relation to coronavirus risk, it was not possible to arrange for another MHO to attend, and the patient refused phone interview.

The Commission's view is that if no other approach were possible, the MHO should document the situation. It would be for the Tribunal to decide if this was sufficient if the STDC was appealed.

If the MHO is not able to fill in the MHO DET2 page and sign it, the notes on page 4 of the DET2 form are clear that the AMP can complete that page. It is not a requirement that MHO does so.

Section 45 of the Mental Health Act requires that if it has been impractical for the MHO to interview the patient, that they record the reasons and send this to the AMP within 7 days.

4.8. Can a hospital-based colleague complete the second medical report for a CTO application? (updated 2 July 2020)

The question is whether it might be preferable to ask a hospital-based colleague to assess and complete the second report for a CTO application rather than the GP, during the lockdown. The Commission agrees that, given the current circumstances of social distancing, in some situations this would be a better option.

It is difficult to be exhaustive on each situation and ultimately the position may be challenged at a tribunal. However, the Commission can see scenarios where it would be preferable; for example:

- if the GP can only commit to a phone based assessment but a colleague based at the hospital and without a conflict (eg not in supervisory relationship) is able to undertake a face-to-face assessment

- or in the situation where the GP has little past knowledge of the patient, and given social distancing, a judgement is made that there is little longitudinal knowledge here and it would be better to seek a local second assessment.

The Act specifies that a GP may undertake a report; it's the code of practice that emphasises the GP role more clearly. A counter-situation might be if the patient is particularly keen on their GP being involved, in which case, the possibility of this ought to be considered first before going to a local colleague.

In summary, it's a judgement call in each situation with considerations of public health, patient preference, and past knowledge of the patient; and the Commission can see that seeking a local second report might be a better first option in some situations. Letting your patient know is vital for transparency. (See section 4.6.)

4.9. Can RMO send T2 consent form to patient to sign? (30 April 2020)

If an RMO is interviewing patients remotely for a T2 consent to treatment form, it is acceptable in the current situation to send the patient consent form out to the patient to sign.

4.10. Authority for Covid-19 testing of individuals unable to consent (updated 2 July 2010)

Part 5 of the Adults with Incapacity Act provides the general authority to treat an adult with incapacity provided a section 47 certificate has been completed (there are some exceptions to this). Where a resident at a care home who is lacking capacity and is unable to consent requires testing for Covid-19, the authority to provide this test to safeguard their physical health is covered by the section 47 certificate - that is: a new certificate that has testing for Covid-19 specifically authorised; or an existing certificate written to cover "fundamental healthcare procedures".

Any intervention under the Act must satisfy the principle of providing benefit to the adult.

Fundamental healthcare procedures are defined in the code of practice associated with the Act, but in the current situation of a pandemic it is the Commission's view that testing for Covid-19 for care home residents (a sector in which there is known to be a higher risk) would constitute a fundamental healthcare procedure. The Commission therefore believes that such a section 47 certificate provides authority for testing for care home residents who are incapacitous.

Please note however, that where an asymptomatic, incapacitous resident objects to the test, Public Health Scotland has advised the Commission that their view is that a test should not be forced. (See section 4.11 Person without capacity resisting Covid test in a care home). Further advice on associated scenarios is contained in that section of this advice note.

Please note that following the Coronavirus Scotland Act coming into force, section 47 time periods are extended so that certificates remain valid and do not run out during the period whilst these powers are in force.

4.11. Person without capacity resisting Covid test in a care home (30 April 2020)

We had an enquiry about whether an individual in a care home lacking capacity might be tested despite resisting/objecting to the test.

We have been advised by a health protection team that hundreds of people are currently being tested in care homes but it is not the practice to test anyone who resists or does not want the test, nor to restrain anyone for COVID testing.

Their advice was that if a care home resident is symptomatic of COVID and refuses a test, staff should treat that person as if they are COVID positive, in accordance with guidelines.

A COVID test may be relevant to an individual's healthcare to rule out other causes of symptoms. When an individual refuses the COVID test, the usual other investigations for other causes of their symptoms should still be considered, e.g. a stool sample to investigate diarrhoea.

Health Protection Scotland have issued new COVID-19 information and guidance for care home settings:
https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/information-and-guidance-for-other-settings/#title-container

4.12. Testing people in hospital for Covid-19 who are lacking capacity and are objecting/refusing the test (updated 2 July 2020)

There is now a recommendation for testing anyone over 70 in a hospital setting on admission and regularly after admission, regardless of the cause of their admission:
https://www.gov.scot/publications/coronavirus-covid-19-update-first-ministers-speech-27-april-2020-1/

This has led to questions about how and whether to test a patient for Covid-19 who is lacking capacity and who is objecting to the test.

The Commission's view is that where the patient is asymptomatic, and lacks capacity but objects to the test, the test should not be forced using the authority of a section 47 certificate.

However, for a symptomatic, objecting, patient lacking capacity, our view is that it might be appropriate to test using authority under a section 47 certificate for testing. This will help to determine the optimum treatment for them, and may prevent a move to a setting that might expose them to greater risks of Covid-19 (i.e. if they were actually negative for Covid-19, but treated as if positive due to a test refusal and the need to manage them as if they were positive).

Any intervention under the AWI Act must satisfy the principle of providing benefit to the adult.

4.13. Decisions about shielding for patients with reduced capacity

Some people have been asked by the Scottish Government to shield due to underlying conditions which put them at risk if they were to be infected with Covid-19; and some of this

group may have conditions, such as dementia or learning disability, which impact on their decision-making abilities.

As the Scottish Government implements its route map out of lockdown measures, further decisions will need to be taken on when and how people come out of shielding. These decisions will be based on clinical advice but should fully involve the patient.

The Commission's view is that the decision on whether to come out of shielding for vulnerable groups is not an easy one, but in many ways is similar to other difficult decisions that come up for people with reduced or lacking capacity. While some people will lack capacity for this decision, for many there may be a reduction in capacity rather than either full capacity or a lack of capacity.

We recommend a supported decision making framework for this situation, involving the person as much as possible, ascertaining views of significant others and attorneys, and having regard for the person's current wishes and past wishes.

See the Commission's good practice guide on Supported Decision-Making, particularly the diagram on page 15, the power of attorney section on page 30 and the appendix with a list of questions.

4.14. Is a test essential for admission to a care home? (Updated 26 November 2020)

We were contacted about a situation where a patient lacking capacity was due to be discharged to a care home, but was resisting a test. The care home manager refused to admit the individual without the test being undertaken.

We raised this and the issue of testing patients moving from the community to care homes who were asymptomatic, lacking capacity and refusing the test with the Care Home Rapid Action Group (CHRAG).

The advice from CHRAG was the adult could have been admitted without the test being done prior to admission. Health Protection Scotland (HPS) advised that 'lack of testing shouldn't preclude admission'. They noted that the test is only valid for the day completed, and that there are false negatives. All admissions should be isolated for 14 days. Advice from HPS is that the consultant communicates with their local Health Protection team and discusses such a situation in their partnership.

HPS's COVID-19: Information and guidance for care home settings v1.9 (13 October 2020) states:

> The presumption should be that residents being admitted to a care home should have a consented PCR test before or on admission unless it is in the clinical interests of the person to be moved and a risk assessment can support this; local HPTs can advise in more complex situations. Even if a COVID-19 test result is negative, a 14 day period of isolation must be completed.
>
> For adults without the capacity to consent to a test, see COVID-19: clinical guidance for nursing home and residential care residents for further information.

The clinical guidance states in relation to COVID-19 recovered patients being discharged from hospital that deciding whether the test is in the best interest of the patient is an individual clinical decision, and that, 'Where a test would be too painful or distressing and not in the interest of a patient it would be reasonable to return to the care home after discussion with the Home manager/senior staff. The individual would have to continue the 14 days of isolation in the care home.'

4.15. Legal authority for Protect Scotland Covid smartphone app for people with incapacity (15 October 2020)

The Commission was asked about installing the Protect Scotland smartphone app for individuals with learning disability who have difficulty doing it without support.

The Commission's view is that it is fine to help someone download the app provided they can be supported to understand and consent to this, for example by using easy read guidance about Test and Protect and on testing and contact tracing.

If the individual is deemed to lack capacity to agree, it could be argued that the app could be seen as a fundamental healthcare procedure during a pandemic and so a guardianship or power of attorney with the relevant powers might be seen as sufficient authority to install it for an individual where it could be of benefit, after consideration of the principles of the Act.

For those without a proxy and unable to give informed consent use of the app may not be possible, as seeking a new specific power or an intervention order is unlikely to be reasonable.

4.16. Covid vaccination and section 47 certificates (updated 23 December 2020)

The Commission has been asked about legal authority for Covid vaccination for people who lack capacity to give informed consent.

There is a legal argument that a Section 47 certificate containing general wording to cover all medical treatment would be able to cover the Covid vaccine. The Mental Welfare Commission position is that a valid section 47 certificate that notes this, or the term "fundamental healthcare procedures", would cover Covid vaccine. Although the code of practice description of fundamental healthcare procedures does not include vaccinations, it is the Commission's view that, in the context of a pandemic, vaccination can be viewed as fundamental. Best practice would be for the certificate to be written in line with the code of practice and specify Covid vaccination, but this is not required in the current pandemic situation.

Section 47 certificates written with general wording to cover all medical treatment are not best practice. For adults requiring multiple or complex healthcare interventions, the code of practice recommends the use of treatment plans attached to s47 certificates and gives guidance on what treatments can be covered by an entry for "fundamental healthcare procedures". Treatments for all other conditions should be authorised by a single entry for that individual condition.

The Commission has been made aware of some cases where those administering vaccines under s47 certificate have not consulted a proxy (guardian, attorney or intervener). It remains the case that if an individual is treated under a s47 certificate has a proxy with relevant powers,

the proxy must be consulted on treatment under a s47 certificate, wherever this is reasonable and practicable. Nearest relatives and primary carers should also be consulted.

Our view is that it would be sufficient for care home staff to contact proxies and relatives in advance, to let them know that the individual is to be vaccinated unless they object or would like to discuss the treatment further with the medical professional. Public Health Scotland has provided materials for use with residents or their proxies for this purpose, and advises that consent conversations and decisions must be documented.

See:

- guidance and resources for care homes from Public Health Scotland, including guidance on obtaining vaccine consent from individuals or their proxies
- Scottish Government guidance on the use of section 47 certificates relating to Covid 19 vaccination
- the Commission's good practice guidance on AWI section 47 certificates
- the AWI code of practice for medical practitioners.

4.17. MHO access to interview a resident in a care home in a level 4 area (29 January 2021)

We were asked by an MHO about whether a visit to interview a care home resident for an AWI report is an essential visit and so always allowed. Scottish government guidance for level 4 says, 'Visits by professionals should be restricted to essential visits by healthcare workers, inspectors, faith visitors and social care staff.".

It is a statutory requirement for the MHO to complete the report based on an interview and assessment (section 57(3) b i and ii). In some situations, for example where the MHO knows the resident well and where a virtual interview appears possible, this could be tried.

However, it is likely that for most adults lacking capacity virtual interviews will not be appropriate. In our view this is an essential visit and should be facilitated by the care home, with appropriate planning and discussion with the care home, risk assessment and precautions such as testing, PPE and physical distancing.

4.18. Covid vaccination and use of force (2 March 2021)

The Commission has been asked about practice (generally) around giving Covid vaccines to people who are incapable of consenting and who resist, e.g. some elderly people in care homes.

We appreciate the wish to ensure that patients benefit from Covid vaccinations, and concerns that some people may not receive vaccines due to their incapacitous refusal and physical resistance to the injection procedure.

There is no Scottish Government guidance that we are aware of that specifically addresses the matter of whether a Covid vaccine might appropriately be given with force. Where a clinician has contacted us to ask about whether and how much force might be appropriate to

administer a Covid vaccine, we have provided them with advice about matters that we think they should consider in their assessment in order for them to reach a balanced decision about how to proceed in the individual case.

Section 47 can provide authority for Covid vaccination for a patient who lacks capacity to consent or to refuse consent, but does not authorise use of force or detention unless it is immediately necessary, and only for so long as is necessary in the circumstances.

Our view is that whether it is justified to give a Covid vaccine where this would involve overcoming physical resistance by the patient, and what legislative authority would be required for that, needs to be carefully considered on an individual basis for each patient.

The question is not only whether force is immediately necessary but also the degree of force, and whether that would be proportionate.

The doctor's assessment should include:

- Careful assessment of the patient's capacity in respect of making a decision to consent to or refuse the vaccine. Where there is any uncertainty, we suggest a second opinion on the capacity to consent or refuse the vaccine.
- Consideration of the Principles of the Adults with Incapacity Act (AWI), ie:
    - **Benefit**
    - **Minimum intervention**
    - **Take account of the adult's wishes and feelings** e.g. what has the person's view been about vaccinations generally?
    - **Consult others** - consultation with relevant others, including relatives, to determine their views and also what information they can provide about any past wishes of the patient. Welfare proxies with relevant powers (intervention order, welfare guardian or welfare attorney) should be consulted and can consent. However, unless there is a specific intervention order or welfare guardianship power authorising restraint for medical treatment, there is no authority for restraint beyond the s47 authority for this (or not).
    - **Encourage exercise of residual capacity**.

Further matters to consider as to what the consequences would be for the individual:

- How distressed the patient may be by being given the vaccine (particularly if they have firm beliefs that there will be positive or negative consequences for them if they refuse it or are given it).
- Consideration of the level of risk to the patient if they do not have the vaccine. Their physical risk factors if they contract Covid, how likely they are to contract it.
- Consideration of what measures would, or might, be required and would be fair and proportionate if the patient does not have the vaccine. For example, isolation for their own protection if other people in their environment have Covid, or to protect others if the patient develops Covid, impact on treatment and support options (e.g. chances of securing supported accommodation). Discussion with the patient re these matters – how would they feel about this, might this information influence their decision?

- What are the practicalities of giving the injection? Is the vaccine available in the ward or would the patient need taken to another setting while resisting?
- Also consider environmental factors in balancing the risks, including Covid prevalence levels in current setting; factors that increase or decrease the risk of the patient contracting Covid; whether they might choose to revisit the decision given more time, etc.
- After these discussions with the patient, and if they are still resisting, what level of force or restraint would be required to give a vaccine to this patient? The least restrictive measures should be identified.

It is necessary to take this information and these factors into account, and balance the risks to decide whether the intervention that would be required would be proportionate and justifiable use of force in the individual case.

The authority, if under s47 alone, would be dependent on the treating doctor being of the view that force was immediately necessary.

The doctor or Board could seek legal advice from the Central Legal Office, and/or the doctor could ask their defence union for advice.

Finally, if it is felt that a Covid vaccination should be given with force, but that s47 alone does not authorise this for the individual patient, an application could be made for an intervention order or a welfare guardianship with powers to authorise this. If there is a welfare guardianship already in place, an application for a (AWI) section 70 compliance order could be considered.

Each particular case will be different but we hope this summary of the sort of considerations that we've been discussing with colleagues is helpful.

4.19. Extending a community compulsory treatment order (CCTO) by phone or video if care home is in 'lockdown' (2 March 2021)

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 or video 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.

Please note the Commission's view is not a definitive legal opinion. Ultimately, if the determination was subject to review by a tribunal or the court, it would be up to the tribunal or court to decide if an appropriate assessment had taken place and criteria were met. Each tribunal reaches its own view, and a question such as whether there has been a medical examination which complies with the legislation will be answered on a case by case basis.

We understand that the RMO narrating reference to the Commission's guidance and the taking of advice from the Commission, plus the surrounding circumstances making the telephone or

video assessment adequate in whatever the local COVID situation is, will maximise the chances of the tribunal accepting the position.

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.

See section 4.1 about recent English case law on face to face examinations.

4.20. Refusal of Covid vaccination by welfare proxy (19 March 2021)

We have been contacted about situations where a welfare proxy (guardian or attorney) has refused consent for Covid vaccination.

Section 50 of the Adults with Incapacity (Scotland) Act 2000 provides a process for dispute resolution where a proxy (or other interested party) disagrees with a proposed treatment (see Code of Practice).

The Commission's view is that a multidisciplinary meeting should be arranged, including the guardian or attorney and advocacy, to discuss the benefits and risks of vaccinating or not vaccinating the adult, taking into account their circumstances and past and present wishes, and the reasons the proxy has for objecting. It might be helpful to refer to section 4.18 on Covid vaccination and the use of force; not because of the issue of the use of force but because the risk balancing considerations about vaccinating vs not vaccinating may be relevant and should be discussed with the proxy to inform decision making.

If after this meeting the proxy still refuses, and the consensus is that in the individual's specific circumstances the vaccine is warranted, the medical practitioner should request an AWI section 50 dispute resolution by contacting the Mental Welfare Commission to request that the Commission nominates a medical practitioner to give an opinion as to the medical treatment proposed.

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. DMP assessments under level 4 lockdown (updated 23 December 2020)

The Mental Welfare Commission has been mindful of the safety of patients, staff and carers throughout the pandemic. As all mainland areas of Scotland are entering level 4 lockdown on Boxing Day, with restrictions on travel, all designated medical practitioner (DMP) assessments will be carried out using remote video or telephone assessment wherever this is possible, until restrictions ease. The Commission and/or the DMP reserves the right to visit individual patients in those cases where that is considered necessary.

5.3. Clozapine monitoring when patient self-isolating (updated 25 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, self-isolating in the community, and cannot be accessed for blood sampling. In the majority of cases this is likely to be a very short term issue – maximum 2 weeks, and any local procedures should be followed with agreement with local pharmacy services and a clinical risk assessment.

Where there are significant concerns about breaks in monitoring of under 2 weeks, or for any more extended breaks, decisions on whether or not to do this would need to be taken by the RMO on an individual basis. The RMO should consult with the relevant clozapine monitoring service. The RMO should fully take into account the patient's circumstances and health, and the risks vs benefits of continuing clozapine without full monitoring. They should provide the patient with information and discuss with them the benefits and risks as far as possible, determine their views, and take these into account.

The RMO should fully consider whether, based on the above risk assessment, it would actually be possible to undertake monitoring. This would include determining availability of Personal Protective Equipment (PPE) that would enable staff to take blood from the patient.

If clozapine is continued outwith regulatory monitoring requirements, there should be a clear documented rationale and care plan for this. We would advise the RMO to seek the opinion of a colleague such as a pharmacist, another consultant psychiatrist, or their medical manager.

For patients on a T3, the Mental Welfare Commission should be informed in writing regarding the circumstances and necessity for any break in monitoring, including mitigating arrangements. For minor breaks or extensions of under 2 weeks we would not ordinarily request a further DMP visit. If there is likelihood of more extensive breaks, a DMP opinion should be sought.

5.4. New electronic request form for DMP assessments (SOP1) (2 July 2020)

The Commission has now introduced an online form for Responsible Medical Officers (RMOs) to request designated medical practitioner (DMP) assessments under the Mental Health (Care and Treatment)(Scotland Act 2003 and Criminal Procedure (Scotland) Act 1995. The form (SOP1) and instructions are available on the Commission website at the following addresses:

https://www.mwcscot.org.uk/sites/default/files/2020-06/SOP1_final.pdf

https://www.mwcscot.org.uk/sites/default/files/2020-06/SOP1_Form-Instructions.docx

Please note that from 1 August 2020, the Commission will only accept DMP assessment requests via the completed electronic request form (SOP1). The form includes the Appendix E. **Telephone requests for Mental Health Act DMP assessments will not be accepted after 1 August 2020.**

Requests for second opinions under s.48 and s.50 of the Adults with Incapacity (Scotland) Act 2000 can still be made via the Commission's advice line or emailed to mwc.2ndopinionrequests@nhs.net

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 and from care homes and enhancing wellbeing guidance (2 March 2021)

On 24 February 2021 the Scottish Government issued its new guidance on care home visiting, Open with Care: Supporting Meaningful Contact in Care Homes. The full guidance, together with related materials including Frequently Asked Questions, a quick guide on essential visits, a checklist for care homes, and posters, is here: https://www.gov.scot/publications/coronavirus-covid-19-adult-care-homes-visiting-guidance/

Information for residents, family and friends is at: www.nhsinform.scot/openwithcare.

The guidance sets out that indoor visiting, initially by two visits once a week from up to two designated visitors (over the age of 16), can now be put in place. It recognises that visits are vital to residents' well-being, and that the vaccination and enhanced testing programmes, alongside other protective measures, can allow safe indoor visiting from early March, or earlier where care homes are ready. Care homes are asked to begin to put measures in place immediately. The intention is that care homes will further increase visiting opportunities will from this level. Only essential visits can take place if there is a Covid outbreak in a home.

The guidance allows local flexibility to accommodate care homes' different circumstances , and care homes facing challenges in delivery should work with Local Oversight partners, led by the NHS Director of Public Health, Executive Nurse lead, Medical Director, Chief Social Work Officer, and Health and Social Care Partnership Chief Officer.

The guidance set out principles to be followed when considering approaches to visiting, including respect for human rights, and in particular the right to private and family life.

The starting point of up to two designated visitors weekly, visiting one at a time "should be seen as the minimum starting point with consideration given to increasing the number of

visitors and frequency of visiting, as and when the care home judges it is safe to do so, with expert advice and support from oversight arrangements where appropriate." Time limits are not defined and should be agreed between the home, residents and visitors. Visits should normally be in residents' own rooms.

Safety measures must be in place, "This includes hand hygiene, PPE as appropriate, ensuring good airflow (as far as reasonably comfortable), and rigorous cleaning of surfaces before and after visits." Visitors should be provided with a fluid resistant surgical mask and be allowed to touch the residents. Including "brief hugs or embraces". Further PPE is needed if the visitor is involved in personal care.

Outdoor visits can also take place, including walks or outings using a wheelchair (in line with indoor visitor levels) and outdoor meetings for designated visitors and other family members including children and young people, with the group size in line with the wider Covid restrictions. Trips by car are also possible: "with one designated visitor in the car and avoiding public indoor spaces, adopting IPC and safety measures with advice from local health protection in more complex scenarios."

The designated visitors should be agreed between the care home and the resident or their proxy decision maker such as a welfare attorney or guardian.

Essential visits

These are unaffected and "should always be compassionately and generously enabled", with children and young people included if appropriate.

An essential visit is one where it is imperative that a friend or relative is supported to see their loved one and not subject to the same time limits as routine indoor visits. This may be in circumstances of the resident's distress, deterioration or end of life care. Essential visits are:

- Not just at imminent end of life
- Not the same as routine indoor, garden or window visits
- Not socially distant
- Not supervised or observed
- Not generally limited by wider COVID-19 restrictions
- Not time limited
- Not limited to one visitor

Enhancing wellbeing visits and activities guidance

The Scottish Government is currently reviewing its October 2020 guidance on enhancing wellbeing activities and visits in care homes, which will be available soon.

6.3. Guidance on restricted patients (updated 11 June 2020)

The Scottish Government restricted patient team circulated specific guidance for practitioners on restricted patients and COVID-19 on 25 March 2020. 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 in the emergency legislation, which has not so far been brought into force.

https://www.forensicnetwork.scot.nhs.uk/restricted-patients-and-covid-19-guidance-legislative-25-march-2020-2/

If you have any queries about the guidance, email forensicmentalhealthpolicy@gov.scot

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

6.4. Hospital visiting (updated 26 November 2020)

From 2 November, there is new hospital visiting guidance for the Scottish Government's five tiers of COVID-19: https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/

- For hospitals in Tier Zero local authority areas, essential visits and two designated visitors observing physical distancing will apply
- For hospitals in Tier One local authority areas, essential visits and two designated visitors observing physical distancing will apply
- For hospitals in Tier Two local authority areas, essential visits and one designated visitor observing physical distancing will apply
- For hospitals in Tier Three local authority areas, essential visits only will apply. However, in Tier Three areas clinicians at hospital level will be empowered to move to one designated visitor if they judge that this is safe and appropriate
- For hospitals in Tier Four local authority areas, essential visits only will apply.

Although current travel restrictions prohibit travel into and out of areas at level 3 and level 4, travel to visit someone resident in a hospital, care home or hospice is listed as an exception.

In the event of an outbreak locally hospitals may have to impose restrictions, but will not necessarily revert to essential visits only. Boards are asked to give patients, staff and visitors as much notice as is reasonably possible of any changes.

In a letter on 17 November 2020 the Cabinet Secretary said that access and funding should not be a barrier to someone receiving social care support from paid or unpaid carers in hospital and that carers providing care do not count as visitors:

> "[…] revised hospital visiting guidance aligned to the strategic framework is now in place across the country. At all times and in all local authorities, essential visitors continue to be welcomed – and in many places also one or two designated visitors. However, you will want to remember that carers are not to be counted as "visitors" whether they are paid carers or unpaid carers. . Those who are providing care to a supported person should be supported to continue providing care if that person is admitted to hospital. This includes paid and unpaid carers as they are both essential to safe effective care."

A person-centred, flexible and compassionate approach is encouraged. “The individual views and needs of each patient and, in the case of someone with incapacity, the views of the Power of Attorney or Guardian, should be central to the decision. If an individual lacks capacity, the principles of the Adults with Incapacity (AWI) Act make it clear that attempts should be made to involve the person in whatever way possible, considering past and present views.”

Visitors must arrange the visit with staff in advance to allow physical distancing and should go straight to the ward. Boards must make sure they adhere to appropriate infection control measures, including face coverings and hand hygiene, and physical distancing where possible.

For patients in Covid wards, only essential visits are allowed.

Essential visits are allowed at every tier. These include visits to support someone with mental health issues, dementia, autism or learning disabilities, where not being present would cause stress or distress and for those receiving end of life care.

In the case of essential visits, the Commission’s view is that each situation should be individually assessed, and the need for the visit balanced against the risks. The rationale for a decision to allow or disallow a visit potentially deemed essential should be recorded and explained to the patient and the visitor.

Every effort should be made through provision of phone calls or other technology to assist patients to remain in frequent contact with family and friends.

Anyone who is unwell and/or exhibiting symptoms of COVID-19, who lives with someone showing symptoms or who is self-isolating following contact with someone with COVID-19 should NOT visit any patients in a hospital.

6.5. Can guardian take adult with incapacity home temporarily from their current accommodation? (2 April 2020)

The Commission was consulted about a situation where a welfare guardian of an adult living in a supported tenancy wished to take them to the family home for a few days.

The adult receives personal care from a support provider, which was concerned about the risk this could pose in relation to coronavirus.

It is understandable that families are facing a tough time currently with self-isolating households, and lack of contact with loved ones. This will be exacerbated at occasions such as the Easter holiday weekend.

There is no concern about the quality of the care the family would provide, and their own view is that the adults are at greater risk from Covid-19 from interactions with care staff coming and going than they would be at home.

In normal circumstances guardians with relevant powers could take any action that was reasonable, proportionate, and meeting the principles of AWI. Earlier in the pandemic the Commission’s view would have been that the guardians could not be prevented from bringing the adults to their own home. We would encourage the local authority guardianship supervisor to be informed and discuss with the family. However, the provider might consider that the

adult could have been exposed to Covid, and pose a greater risk to staff, and ask them to self-isolate for two weeks, before resuming care provision.

However, the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020, laid before Parliament on 27 March 2020, state that no person may leave the place where they are living other than for a limited range of reasons such as to shop, for medical reasons and for daily exercise. This proposed visit does not come under any of the reasons listed and unfortunately should therefore not take place.

6.6. Use of seclusion (9 April 2020)

The Covid-19 pandemic has had a significant impact across the range of mental health, learning disability and older adult services. Services may face additional challenges in working to keep people safe from the virus. Services should consider on a case by case basis whether restrictive measures for this purpose may amount to seclusion.

The Commission has recently updated our guidance on seclusion, which is relevant across a range of settings. The basic principles set out in the guidance apply whether in a hospital, care home, other community setting or a person's own home.

Seclusion refers to a situation where an individual is kept apart from others and is prevented from leaving the area, either by a locked door or by staff. The person is not there by agreement. Seclusion is used to attempt to contain severe behavioural disturbance which is likely to cause harm to others. Essentially, it is a form of restraint and should be used in the context of an overall policy on the prevention and management of aggression and violence. It should only be used as a last resort where all other interventions have failed or where it may be safer than prolonged periods of physical restraint.

We are concerned that many instances of the use of seclusion does not respect the individuals' human rights due to being misidentified and often referred to by another name (time out, room based care etc). In these situations, however, there is usually some form of coercion involved, whether explicit or implicit.

In practice, we found that there are commonly two distinct levels of seclusion to which an individual may be subject, depending on whether the person is restricted by explicit means or by implication via instructions from staff. We have called these level 1 and level 2 respectively:

> Level 1 – usually involves a locked door or the exit blocked by a member of staff.
>
> Level 2 – may involve verbal coercion and/or restrictions on access to the physical environment.

All services which use restrictive practices of this kind should have a policy in place and a protocol to follow so that staff are clear about their role. Only by acknowledging that the restrictions placed on individuals amount to seclusion can staff ensure they can minimise the need for its use and learn from their practice. Part of the learning, moreover, is gained through regular review of individual episodes. Therefore, we expect that services will keep clear records of use of seclusion and the Commission may ask to see these, together with a copy of the local policy, when we visit or by request.

The full guidance can be found here:

https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

6.7. Using physical restraint for patients with confirmed or suspected Covid-19 (updated 10 December 2020)

The Scottish Government has updated its clinical guidance for NHS Scotland on using physical restraint for mental health and learning disability patients with confirmed or suspected COVID-19.

This guidance is aimed at staff who are already familiar with the underlying principles, guidelines and techniques around physical restraint and who are working with mental health and learning disability patients within inpatient mental health / learning disability settings. It should provide these staff with further guidance on using physical restraint practices for patients with confirmed or suspected Covid-19, where physical restraint is deemed to be required after all other attempts of de-escalation have been exhausted, whilst ensuring safe practice and effective infection prevention and control management is in place.

Staff must be clear on the legal authority under which they would be administering restraint or medication. See the Commission's Good Practice Guide: Rights, risks and limits to freedom. Each individual service will have locally agreed protocols and guidance for the use of physical restraint and all staff should ensure that they are up to date with these.

COVID-19 can vary in severity, generally causing more severe symptoms in people with weakened immune systems, older people and those with long term conditions such as diabetes, cancer and chronic lung disease. In what is anticipated to be exceptional circumstances, where physical restraint is deemed necessary, it should be recognised that this is intrusive in nature, reduces the ability of those involved to practise social distancing for the duration of the interaction and, increases the risk of transmission of COVID-19. It is therefore imperative that good infection prevention and control measures are implemented; in particular, appropriate personal protective equipment (PPE) is utilised. This will ensure the safe delivery of care and protection of both patients and staff whilst preventing the transmission of COVID-19.

Principles

Restraint should be:

- Minimised through the avoidance of triggers
- Used only as a last resort
- Used for the shortest time possible.

Clinical practice should continue to be underpinned by:

- The principles of human rights
- Respect
- Accordance with known wishes
- The use of de-escalation when possible
- The minimisation of psychological harm wherever possible
- The provision of least restrictive care
- The provision of trauma informed care.

Minimum use of restraint

It is critical that physical restraint is kept to the minimum necessary and is a last resort, where there is no viable alternative. There must be a genuine belief that it is necessary to prevent serious harm including the risk of injury to the person or others. Managing acute disturbance in the context of COVID-19 infection risk is underpinned by ensuring it is the least restrictive, that it is trauma informed, and does not create difficulties and or flashpoints that could otherwise have been avoided (NAPICU, 2020, UK Restraint Reduction Network, 2020).

Preventative approaches such as:

- Tools to support the early prevention of deterioration of mental ill health/challenging behaviour
- Robust communication with clinical teams through safety briefs
- Physical health monitoring utilising NEWS (with particular attention to respiratory care)
- Preventing boredom and the build-up of frustration as a result of shielding or social distancing measures in place to prevent the transmission of COVID-19.
- Avoidance of flashpoints
- Access to meaningful activity
- Maintaining communication with the outside world through digital technology or agreed plan of contact with a named person in line with NHS COVID-19 visiting policy.

Risk assessment & risk management

It is recognised that COVID-19 can result in severe respiratory symptomatology. Therefore, before a decision to implement physical restraint is made, a full risk assessment should have been carried out on the patient, ideally at point of admission to the service and updated as necessary. Factors such as: Covid-19 status, existing physical injuries, cardiac / respiratory problems, obesity, pregnancy, alcohol / drug use, epilepsy and psychological trauma should be considered; however this list in not exhaustive.

Certain restraint positions carry less associated risk. Seated restraint position is the recommended position to be used whenever possible, provided the patient is maintained in an upright seated position, as any compression of the patient's torso against or towards their thighs can restrict the diaphragm and ribcage, further compromising respiration. If utilising the seated or indeed the supine (face up) restraint positions, there may be a risk to staff from exposure to body fluids (spitting) from the patient so the agreed PPE should be used. Additionally an extra member of staff will always be required to observe the patient's airway throughout these restraints.

Prone (face down) restraint should be avoided as far as possible and must only ever be used as a last resort in extremely high risk situations, for the shortest length of time possible and only when all other restraint positions are deemed unsuitable / unsafe. When utilising a prone restraint position, it is imperative that even minimal pressure is not placed on any part of the patient's torso as this could restrict diaphragmatic movement, lung function, affect the ability to breathe and further compromise the patient's airway. Staff must ensure that the patient's airway is maintained at all times. The possible risk of death due to positional asphyxia can result from any restraint position and long and protracted restraint should be avoided. This is especially pertinent if restraining a patient who has or is suspected to have Covid-19.

Regardless of what restraint position is being used, the patient should be constantly monitored for any signs of distress and these must be acted upon immediately.

Following any restraint with patients who have or are suspected to have Covid-19, local infection prevention and control procedures must be adhered to.

Medication use for acute behavioural disturbance

The choice of medication should be directed by local protocols but requires some additional consideration of the specific contra-indications and side effects associated with COVID-19.

- Where possible, oral medication should be offered as the first choice.
- Physical health monitoring utilising NEWS (or local equivalent), especially respiratory rate and level of consciousness, should be carried out when either oral or parenteral rapid tranquillisation is administered.
- If a patient with suspected (awaiting testing/results) or diagnosed COVID-19 is acutely disturbed and there are no signs of respiratory compromise (decreased or increased respiratory rate), cardiovascular disease or decreased level of consciousness; then medication should be used with caution as the full effects of COVID-19 are still unknown.
- Consider short acting medication, as a patient's physical health condition may rapidly deteriorate.
- Ensure the medication for acute disturbance is an effective dose as an ineffective dose may lead to the increased need for additional injections.

Restraint personal protective equipment (PPE)

The Chief Nursing Officer and Chief Medical Officer for Scotland have reviewed and continue to review guidance on PPE, in conjunction with Health Protection Scotland and the UK nations. The most recent updated guidance on the use of PPE can be accessed via the following link:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe.

Staff should be supported by their employer to familiarise themselves with PPE equipment.

Isolation

For individuals who are COVID-19 positive or are suspected to be COVID-19 positive and require to isolate the following action should be implemented (NAPICU):

- Ensure adequate and ongoing mental health assessment, planning, care and review providing one-to-one therapeutic interventions to meet the needs of individuals.
- Provide current information regarding Covid-19 in an accessible format.
- Ensure items are available to the person which could improve their experience of isolation, reducing the potential for disturbance/flashpoints.
- Items helpful in meaningfully occupying time should be for the person's individual use, and not re-introduced to the general unit/ward area use until cleaning or disposal consistent with infection prevention and control recommendations.

- Items that can be disposed of following use should be disposed of in line with infection prevention and control guidance.

Post incident debrief

As soon as practicably possible following a physical restraint, the staff involved should meet in order to discuss, reflect and consider any issues anyone may have as well as reviewing the details of the incident itself, the infection prevention and control practices and any revised risk assessment and care planning opportunities. Any significant points raised must be documented and discussed. It is essential to identify what went well and what improvements should be made to ensure practise remains person centred, safe, effective and underpinned by the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 . All persons involved in the restraint must be offered post-incident support by the appropriate line manager and be involved in any support or feedback process. Additionally managers should ensure staff and patients are signposted to available local and national wellbeing resources.

Further information

If staff have any concerns regarding any aspect of restraining a patient with suspected or confirmed Covid-19, they should discuss these with their line manager in the first instance. Additional information can be obtained from your local Occupational Health service, Infection Prevention and Control Team, Violence Reduction Service and the Scottish Government website.

See also the Commission's Good Practice Guide: Rights, risks and limits to freedom.

6.8. NHS Trust in England changes coronavirus visits policy following legal challenge (16 April 2020)

In an English case, the parents of a young man detained in hospital under the Mental Health Act challenged the NHS Trust over arrangements for communicating with their son. The young man has autism, learning disabilities and anxiety. His parents have visited him twice a week for two years but this was stopped due to the pandemic and replaced with telephone calls. However, this was not suitable for him and the lack of face-to-face contact was distressing him and affecting his behaviour.

The Trust refused to arrange other means of communication. The parents cannot afford to buy smart phones or tablets.

On behalf of the young man, his parents instructed lawyers to challenge the Trust's policy. They wrote to say they would seek judicial review unless the Trust either provided the means to have virtual contact or allowed visits with a two meter distance. This was on the basis that the Trust's policy of telephone-only communication breached human rights and indirectly discriminated against people with disabilities.

The Trust amended its policy to reflect their duty to facilitate the use of online communication between patients and their relatives, and provided the young man with an iPad.

See https://www.doughtystreet.co.uk/news/nhs-trust-changes-its-coronavirus-visits-policy-following-legal-challenge

6.9. Visiting to and from residential settings other than care homes (updated 29 January 2021)

The Commission has received a number of queries about whether people living in residential settings, other than care homes, should be able to make and receive visits. Our view is that the minimum possible restrictions should be applied, based on balancing the right to a private and family life with the necessary restrictions that are required to protect the individual and other residents from the risk of Covid infection, and the current Covid restriction level in operation in the area.

Health Protection Scotland (HPS) updated their guidance, COVID-19: Information and Guidance for Social, Community and Residential Care Settings (excluding Care Home settings) to version 1.7 on 31 December 2020. We have included the relevant extract below.

Note that this guidance is subject to current Scottish Government restriction levels and advice on staying safe must be followed.

Individuals going out during the day

Individuals who are able to go out during the day, for example to attend a hospital appointment or simply to socialise or go shopping, do not require the same measures as a new patient or resident. The guidance outlined on NHS inform on physical distancing, hand and respiratory hygiene and when to self-isolate must be followed. Any concerns about potential exposure to COVID-19 when going out into the community may require a risk assessment to determine whether additional measures should be considered.

Individuals staying away from the facility overnight

Individuals who are able to visit family or friends overnight can do so, as long as Scottish Government advice on staying safe and protecting others is followed. Note this must comply with any other restrictions on the person's movements, e.g. for those living in a prison and detention centre.

A risk assessment and consideration on current travel guidance for the area may be required for those wishing or requesting to stay overnight. If an overnight stay is decided, then it is important to ensure the individual will not be staying overnight in a household where a household member has COVID-19 symptoms or diagnosed with COVID-19 (whether they have symptoms or not).

Restriction of Visitors

Visiting which adheres to Scottish Government advice regarding meeting people indoors and outdoors is permitted. Residents who have been advised to shield, should continue to follow current shielding guidance. Settings should undertake a local risk assessment and document this taking into account a range of factors, including the nature of the setting (e.g. ranging from sheltered housing with no shared facilities to communal living), the clinical vulnerability of others in the setting and the capacity to maintain physical distancing. If there are particular concerns or difficulties e.g. large proportions of highly vulnerable individuals, then the local HPT can be contacted for advice.

All visitors must be informed of and adhere to IPC measures at all times. Visitors should wear face coverings in line with current Scottish Government guidance and not attend with COVID-19 symptoms or before a period of self-isolation has ended, whether identified as a case of COVID-19 or as a contact. Visitors must not visit any other rooms or shared areas and should stay within the resident's own room/accommodation, or designated area, for the duration of the visit. A log of all visitors should be kept which may be used for Test and Protect purposes. Visiting may be suspended if considered appropriate by the facility, or on the advice of the local HPT. Consider alternative measures of communication including telephone or video call where visiting is not possible.

6.10. Patients preparing for discharge accessing community services across Covid restriction levels (26 November 2020)

Some patients preparing for discharge from hospital may need to access services across local authority boundaries. Current Scottish Government travel restrictions prohibit travel in and out of areas which are in levels 3 and 4, other than for a specific list of exceptions. Even where an exception applies, the guidance is that travel should be minimised as much as possible.

The list of exceptions does not explicitly address this situation. However, it is the Commission's view that the individual circumstances should be reviewed and risk assessed with regard to Covid on a case by case basis, guided by local health protection advice, and with care plans in place detailing travel and contact arrangements. However, 'travel for health care', and 'travel for essential services, including social care' and 'services of a charitable or voluntary nature' are listed. Where a suitable alternative plan is not possible, it is our view that accessing services as part of a care plan facilitating discharge should be considered essential travel for these purposes.

6.11. Mask exemption and car use for service user (19 March 2021)

We were contacted by the family of a person with complex learning difficulties and reduced mobility, who is unable to wear a face mask. Previously during the pandemic he had been supported by care staff to go out in his mobility vehicle, but the provider changed its policy and told the family that based on public health advice this could no longer be allowed. The provider's understanding was now that mask-exempt people must observe 2m social distancing at all times and this was not possible in the vehicle. Even with masks and a larger vehicle and open windows, journeys should be kept to the shortest possible.

The family were concerned because the car trips were the only activity currently possible for the individual, and essential for their wellbeing.

We discussed the issue with Health Protection Scotland. After discussion by their public health consultants, their advice was:

> *This [is] a matter for risk assessment, including the risk of real harm to the individual should the activity not go ahead. Balancing mitigating measures should be taken into account, and some risk reduction measures that could be considered [are]:*

- *Ensure hand hygiene performed by all individuals entering the car and again on leaving the car*
- *Ensure the car is cleaned after use paying attention to touch surfaces*
- *Ensure carers are wearing masks*
- *Keep windows open for ventilation*
- *Wherever possible, try to ensure it is the same staff accompanying the patient each time rather than lots of different staff.*

Mitigating measures will need to stay in place during the ongoing vaccination programme, until such time that reduced Covid case numbers in the wider population allow the government to relax them.

7. Mental Health Tribunals and courts

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 for support for 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.

7.2. Tribunal applications by email (updated 5 November 2020)

An MHTS update on 31 March said:

> Routine applications including requests for the appointment of a curator *ad litem* may be sent to MHTS by email, although we will still require enough information to determine that a patient lacks capacity to instruct a solicitor. The same applies to applications to withhold intimation of certain paperwork, including CTO applications, from patients where the risks to the patient or to others as a consequence of disclosure are significant. We will also accept motions made in the course of a case by email. As you may already be aware, a CTO1 form does not require to be signed by the MHO if it comes from a secure email address. We will extend this practice to allow other statutory forms to be sent from professional staff using a secure email address, without a signature.

Note that the Act requires that detention paperwork is signed, and therefore forms sent to the Commission must be signed. Any copies of any of those forms that are sent to the Tribunal should also be copies of the signed form e.g. STDC, CTO3a. There is no such requirement in the Act for most other documents sent to the MHTS to be signed. The MHTS does not require this for forms making an application to the MHTS (e.g. a CTO1 form to apply for a CTO). The MHTS must be satisfied that they come from the RMO or MHO and while a signature is the usual method, alternatives are possible. (see section 8.1 Can I send an unsigned form to the Commission by email?)

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

7.3. Late Tribunal documents guidance (23 April 2020)

MHTS issued guidance on 16 April 2020 that any reports sent less than three days before a hearing should be copied by the sender to the patient and named person (or any other relevant person) and MHTS advised of this.

If a document must be submitted less than 24 hours before a hearing, it should be provided to the patient and named person by any appropriate means, such as personal delivery to home or ward. Copies should be emailed to any parties with secure email addresses and those with non-secure email should be notified that the document exists. If a way cannot be found to provide them with it, Tribunal members will do their best to communicate its content, but

depending on its significance, there may be no option but to continue the hearing to another date.

Full guidance is here: https://www.mhtscotland.gov.uk/mhts/News/News

7.4. Patients whose court date is postponed (30 April 2020)

The Commission has been asked about situations where a patient on a treatment order (TO) on a general adult IPCU has had their court date postponed, and the treatment order is no longer felt to be necessary. The pandemic situation may mean more court dates are postponed.

The usual practice would be to phone the procurator fiscal office for the area, explain the situation and request them to organise for the date to be brought forward.

If there is a problem, the RMO could consult the Scottish Government restricted patients team or their local forensic colleagues. The restricted patient team must also approve any suspension of detention for a patient on a TO.

7.5. Guidance on civil court cases during the pandemic (11 June 2020)

The Scottish Courts and Tribunals Service has issued updated guidance and a summary on the processing of civil cases during the pandemic. Included in the list of business considered urgent and/or necessary are urgent applications/motions:

- for interim orders under the Adults with Incapacity Scotland (Act) 2000
- under the Mental Health (Care and Treatment) (Scotland) Act 2003
- under the Adult Support and Protection (Scotland) Act 2007.

There is also a process that can be followed to restart cases which are stuck in the system having been sisted or adjourned at the start of the lockdown, where:

- the court is satisfied there is good reason for doing so;
- the action can be progressed remotely; and
- a hearing requiring the leading of evidence is not required.

On 1 June they issued information on a phased approach to reopening courts, in line with the Scottish Government's route map for moving out of lockdown:
https://scotcourts.gov.uk/about-the-scottish-court-service/scs-news/2020/06/01/sheriff-courts-business-update

8. Administrative practicalities

8.1. Can I send an unsigned form to the Commission by email? (updated 5 November 2020)

Early in the lockdown we said that in situations where it was not possible for a form to be signed and scanned during the pandemic situation, the Commission would accept an emailed form without a signature, provided the email was coming from a recognised, secure email address.

We reviewed the position in June, and assessed that this is not necessary now that the situation has moved on and there has, fortunately, not been widespread workforce shortage. This remains the case.

The Act requires that detention paperwork is signed, and therefore forms sent to the Commission must be signed. Any copies of any of those forms that are sent to the Tribunal should also be copies of the signed form e.g. STDC, CTO3a. There is no such requirement in the Act for most other documents sent to the MHTS to be signed. The MHTS does not require this for forms making an application to the MHTS (e.g. a CTO1 form to apply for a CTO). The MHTS must be satisfied that they come from the RMO or MHO and while a signature is the usual method, alternatives are possible. (See section 7.2 Tribunal applications by email)

We therefore continue to require forms to be signed as normal where there is a legal requirement for these to be signed.

8.2. Witnessing formal named person and advance statements documents (updated 5 November 2020)

The Coronavirus (Scotland) (No 2) Act came into force on 27 May 2020. Among its provisions, it temporarily removes the requirement for witnessing the signature of a person nominated to be a named person. The Act was in force initially until 30 September 2020, has been extended to 31 March 2021 and thereafter could be extended to 30 September 2021.

The patient's signature still requires to be witnessed for both named person nominations and advance statements. This should not be a difficulty where an individual is an inpatient. However, there may be difficulties in the community in witnessing these documents in person due to Covid-19 issues. It is important that patients are not disadvantaged and are able to appoint a named person and make an advance statement.

The law is that the original document must be signed by the witness. However, section 3 of the Requirements of Writing (Scotland) Act 1995 allows that a person may witness a signature if they see the granter sign it, or if the granter acknowledges to the witness that they have signed it.

Our view is that this could be achieved by a conversation between the witness and the granter with an e-mail exchange of copies of the document, or looking at it by video. The granter could confirm that it is their signature, and the witness confirm by email that they are happy to witness it. The original document would be posted to the witness and a copy kept. The witness should speak again to the granter at the point of signing and add a signed and dated annotation to say that the granter confirmed before them that this is their signature. If this is

done, the validity of the document could be considered robust, which could be more important if the patient's capacity were to change. The witness would then return the signed original.

There would necessarily be a time lag before the witnessed document was available. The Commission's view is that during this period the document should be treated as though it were operational, on the basis of the confirmatory email from the witness. This could be challengeable, but in our view is a proportionate response in the current circumstances.

The Scottish Government has produced guidance.

8.3. Can an MHO ask a colleague to sign and submit documents to the Commission? (7 May 2020)

An MHO contacted the Commission seeking clarification about whether it is acceptable for another MHO to sign then scan documents, so that they can be submitted to the Commission within the statutory timescales.

We can confirm that in the current circumstances the Commission will accept documents pp'd by a colleague MHO.

9. Other issues

9.1. Depot for patient with COVID-19 symptoms (26 March 2020)

We are aware that some patients are concerned about what might happen if they are unwell with virus symptoms when they are due to receive their depot.

Guidance from the Royal College of Psychiatrists sets out consideration of short term alternatives such as deferring treatment for 2 weeks or switching to oral medication. However, depot should be administered if it is essential, by staff using personal protective equipment (PPE) and following Infection Protection and Control (IPC) procedures.

For detailed guidance see https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services-covid-19-guidance-for-clinicians

9.2. Medical intervention and cardiopulmonary resuscitation (CPR) for people with dementia or learning disability and people in care homes (updated 2 October 2020)

We have heard through our advice line and other contacts that many people are worried about coronavirus and whether someone having dementia, a learning disability or similar condition that may affect their capacity to make medical decisions will negatively influence medical decision making.

This is a big worry for family, friends and other carers, particularly about medical decisions to resuscitate someone in the event of a cardiac arrest (CPR) and some other health care interventions such as access to ventilators.

Clinical decisions about whether or not to attempt CPR are complex and rates of survival and recovery following CPR are much poorer for those with increased levels of frailty or other conditions.

However, dementia or a learning disability should not in themselves be a reason not to provide CPR or other medical treatments. They should be considered as part of person-centred assessment that considers the risk and benefits of any particular treatment or intervention.

The assessment should include, where possible, the views of family or any proxy decision maker such as a welfare attorney or guardian. This will help inform the doctor when making a decision. However, family and proxy decision makers cannot insist that a doctor initiates any treatment or an intervention the doctor believes will not benefit the patient.

In relation to care homes, the most recent Scottish Government guidance states that Anticipatory Care Plans (ACP) should be in place for as many residents as possible, so that residents' and families' wishes can be taken into account. See also section 9.10 of this guidance, on ACPs.

https://www.gov.scot/publications/coronavirus-covid-19-clinical-and-practice-guidance-for-adult-care-homes/

Up to date advice in relation to CPR can be found at:

https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/

Note that the current guidance from the BMA, Resuscitation Council and RCN still stands, as supplemented by Covid-19 specific guidance; see: https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation

To be clear, CPR is a specific medical intervention aimed at restarting the heart in the event of a cardiac arrest. A DNA CPR notice relates only to that specific intervention. It does not replace the need for wider conversations and the recording of individual wishes regarding end of life care.

9.3. Scottish Clinical Advice on Covid-19 (updated 7 August 2020)

Revised clinical advice from the CMO's office was published on 13 July and provides a protocol and templates for the approach, assessment, care and treatment of people with or suspected to have Covid-19. The guidance has been revised in line with comments from the Commission and other organisations about the limitation around the use of Clinical Frailty Scale for people with disabilities.

The Commission had also raised the issue of non-discrimination in making decisions regarding admission to hospital and decisions such as DNACPR for people with conditions such as learning disabilities and/or autism. The guidance makes clear that no clinical decisions should be made "on the basis of any characteristic(s) of a patient, such as age, disability or the presence of existing health conditions or impairments that are not clinically relevant to the potential benefits of a course of treatment. The healthcare response is crucial to ensuring that the rights to life and to health continue to be respected, without discrimination, and that resources reach those who are most likely to clinically benefit."

https://www.gov.scot/publications/coronavirus-covid-19-clinical-advice/

9.4. Mental health support services (updated 16 April 2020)

Information and support is available via the NHS 24 Mental Health Hub. They are expanding their service to include Psychological Wellbeing Practitioners (PWPs) - registered mental health nurses including senior charge nurses.

The current approach is largely to provide psychological support including Distress Brief Intervention model (DBI) triage and signposting to appropriate services.

Should an individual calling into the MH Hub require additional support or mental health assessment a referral can be discussed with CPN, psychiatrist, emergency department or home visit. A joint pathway has been created between Police Scotland and Scottish Ambulance Service in an effort to ensure the public can access appropriate services when needed.

Services currently providing input into the MH Hub are CAMHS, LD, Older People and Addiction services.

To access:

1. Call NHS 24 on 111, message will offer menu options e.g. press x for mental health (Mental Health Hub currently available 6pm to 2am, but this is likely to increase)
2. www.nhsinform.scot Coronavirus (Covid19) page for specific advice on mental wellbeing during the pandemic
3. www.nhsinform.scot Mental Health Self-Help Guides (under 'Symptoms and self help' menu) offer a wide range of information and guidance for conditions including managing symptoms of stress, anxiety, low mood etc.

Breathing Space and 3rd Sector partners

Breathing Space (0800 83 85 87) has expanded capacity with additional funding and staff from third sector organisations.

Times will remain the same for now: Mon – Thurs 6pm to 2am and Fri – Mon 6pm to 6am.

9.5. Detained patients receiving palliative care for Covid-19 (16 April 2020)

We have been asked for advice about revocation of detention in these circumstances. If an individual subject to a STDC or CTO has Covid-19 and is receiving end of life care, the RMO may decide that detention under the Mental Health Act is no longer appropriate. In these circumstances, a revocation form must be completed. It is important that the reason for revocation is stated eg patient is receiving palliative care for Covid-19.

This is in keeping with previous advice given for patients who are in receipt of end of life care when clinical needs have changed significantly.

9.6. Place of safety orders (section 297) (16 April 2020)

We are aware that mental health assessment centres are being set up around the country to divert unnecessary attendance at A and E departments and to limit the number of home assessment visits.

This will involve review of the local NHS mental health service current psychiatric emergency plan (PEP).

We have been made aware of concerns that this could result in the inappropriate use of police custody cells as a "place of safety".

Our view is that police stations should only be used as the Place of Safety in exceptional circumstances, where it is the best option for the individual.

Place of safety orders are not included in modifications of the Mental Health (Care and Treatment) (Scotland) Act 2003 emergency provisions.

Background

Place of safety orders can be used by the police under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 when they find someone in a public place who they believe may have a mental disorder and be in immediate need of care and treatment. The

individual can be taken to, and detained in, a Place of Safety for up to 24 hours in order to be assessed by a medical practitioner, and for any necessary arrangements to be made for that person's care and treatment.

The police are required to notify the Commission within 14 days of any person held under this power and provide details of the date and time of the removal from a public place, the circumstances giving rise to this, the address of the Place of Safety and, if the removal was to a police station, why this was done. They also have a duty to inform the local authority and nearest relative, if possible.

Further details on section 297 can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf

9.7. Person with learning disability living in shared accommodation attending a family funeral – no requirement for self isolation afterwards (7 May 2020)

The Commission was contacted by family about an individual with learning disability attending the funeral of a close family member. The funeral director had advised that this was possible: funerals can be attended by immediate family only, but a carer could attend to support the individual. This was in line with Scottish Government guidance on funerals: https://www.gov.scot/publications/coronavirus-covid-19-guidance-for-funeral-services/

However, the individual lives in shared accommodation with other residents, and the family were advised that if he did attend the funeral he would then need to self-isolate in his room for 14 days. This advice was based on Health Protection Scotland's advice on new admissions, section 2.5, which states that 'admissions to care homes regardless of origin should be tested and isolated for 14 days.'

We discussed this with Health Protection Scotland, who agreed that this was an over-interpretation of their guidance. The same guidance on Page 9 states that patients discharged from hospital should be isolated for 14 days, but that 'an attendance at A&E that didn't result in an admission would not constitute an admission'.

The attendance at a funeral (which will have stringent measures in terms of attendance to reduce risk of infection) would be commensurate with a care home resident being transferred to, and attending at, an A&E department. Isolation of an individual with learning disabilities who is likely to need more support and human contact after a family funeral would be very distressing and should only occur if a risk assessment locally identified that there was a significant unexpected COVID-19 exposure in the process of travelling to or attendance at the funeral.

Attendance at the funeral should be in line with the guidance; which sets out that attenders must observe social distancing guidance, can be supported by a carer, and should not attend if they are in a high risk group or if any member of their household has symptoms.

However, it is possible that there are particular circumstances which might require risk assessment, such as another resident being in a high risk group. For some individuals,

alternatives to physical attendance, such as live-streaming, might be considered, where this would benefit the individual and be acceptable to them.

9.8. Visiting and end of life care (27 May 2020)

The Royal College of Physicians of Edinburgh, with the Academy of Medical Royal Colleges, Marie Curie and Scottish Care, have published new guiding principles on Covid-19 end of life care, designed to ensure that dying patients in Scotland are treated humanely, compassionately and with dignity. The principles say that all patients in Scotland who are judged to be dying from COVID-19 or other terminal conditions - within hours or days - must receive equal access to visits from family or friends. The document sets out an ethical framework and practical principles to minimise risk.

9.9. Reopening adult day services (11 September 2020)

The Scottish Government published guidance on re-opening building-based day services for adults on 31 August.

Adult day services can reopen using the guidance. They should carry out a risk assessment, involving the local authority, health protection team and Care Inspectorate, if required.

Services are likely to need to operate differently and at lower capacity in order to ensure physical distancing between supported people, and may need to prioritise, fully involving supported people and their unpaid carers. Alternative support must be considered for anyone not given a place. Day services are not bound to the current Scottish Government guidance for the general public in relation to maximum numbers of households that can meet indoors.

Care Inspectorate and Shared Care Scotland have developed an operational guide, Back to Business, to help with practicalities.

Shared Care Scotland has also produced a decision-making guide to help providers determine how and when services can be safely restarted.

9.10. Anticipatory care planning guidance (2 October 2020)

The Chief Medical Officer has issued guidance on anticipatory care planning for Covid-19: https://ihub.scot/improvement-programmes/living-well-in-communities/anticipatory-care-planning/covid-19-anticipatory-care-planning/

and Guidance for GP practices on anticipatory care planning conversations with people with dementia living in the community:

https://www.sehd.scot.nhs.uk/cmo/CMO(2020)24.pdf

9.11. Vaccination priority for unpaid carers (updated 19 March 2021)

In December the Scottish Government announced that unpaid carers aged 18 and over would be included in priority group 6 of the JCVI Green Book - details can be found in the table on pages 9 and 10. All four UK nations have agreed to take this recommended prioritisation approach.

On 15 March 2021 the Scottish Government invited unpaid carers aged 16-64 who are providing regular face-to-face care to self-register to be prioritised for a vaccine, at nhsinform.scot/carersregister.

9.12. Face coverings, communication and exemptions (29 January 2021)

The issue of the impact of supporters wearing face masks on people with communication difficulties has been raised with the Commission.

Scottish Government guidance includes a list of exemptions. The Commission would expect these to be applied and the situation assessed individually for each person where the individual or a supporter wearing a face covering may be problematic for them.

Exemptions include:

- a person who is communicating with someone else who relies on lip reading and facial expressions to communicate; such people should remove the face covering only temporarily whilst communicating and replace it immediately afterwards
- a person who is providing care or assistance to a vulnerable person and where wearing a face covering would make this more difficult.

In some situations the use of a transparent face covering may be helpful.

There are also other exemptions, including:

- when a person may have a certain health condition, disability (including hidden disabilities, for example, autism, dementia or a learning disability) or severe anxiety, which prevents them wearing a face covering safely.
- where it would cause difficulty, pain or severe distress or anxiety to the wearer or the person in the care of the wearer

Those exempt do not have to prove their exemption, but a face covering exemption card can be requested from 0800 121 6240 or through the exemption card website.

10. Information governance

10.1. 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/

10.2. Information Commissioner guidance on data protection and COVID-19 (25 March 2020)

Data Protection and Coronavirus- what you need to know - for organisations.

Coronavirus and personal data 18 March 2020 – for the public.

Data Protection and Coronavirus - statement for health and care practitioners.

10.3. Changes to Freedom of Information arrangements (11 June 2020)

The Coronavirus (Scotland) Act 2020 includes measures to address the current pressures on public bodies in responding to Freedom of Information requests. The measures included extending the time limit for responding to requests and reviews under FOISA from 20 to 60 working days. However, The Coronavirus (Scotland) (No 2) Act on 27 May revised the time limit back to 20 days.

Measures still in place:

- enable the Information Commissioner to take into account the effect of coronavirus on authorities when deciding appeals where authorities have failed to comply with timescales
- enable authorities and the Commissioner to issue formal notices by electronic means.

See the Scottish Information Commissioner's Covid-19 and FOI Information Hub for more information.

11. Other useful information (links checked and updated 19 March 2021)

11.1. Guidance for clinicians (updated 19 March 2021)

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

Guidance for clinicians on a range of topics including workforce, digital, patient engagement and ethical considerations is here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians

Their advice re care on inpatient wards and in community services 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

NHS Education for Scotland Coronavirus (COVID-19) Learning materials for professionals: https://www.nes.scot.nhs.uk/news/coronavirus-covid-19-learning-materials-for-professionals/

Royal College of Psychiatrists in Scotland webinar (24 April 2020) – The impact of COVID-19 emergency measures: https://www.youtube.com/watch?v=kDLRNITEYpM&feature=youtu.be

The Faculty of Public Health has issued a briefing on the implications of Covid-19 law and regulation for health professionals in Scotland: https://www.fph.org.uk/media/2994/scotland.pdf

11.2. Social work and social care (updated 19 March 2021)

The Scottish Government has published guidance for managers and field social workers regarding home visits and other face-to-face direct contact with service users. Coronavirus (COVID-19): safe and ethical social work practice: https://www.gov.scot/publications/coronavirus-covid-19-social-worker-guidance-on-safe-contact/

Health Protection Scotland issue COVID-19 information and guidance for care home and other settings: https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/information-and-guidance-for-other-settings/#title-container

Scottish Government additional national adult support and protection guidance for chief officers and adult protection committees relating to the COVID-19 pandemic: https://www.gov.scot/publications/coronavirus-covid-19-adult-support-and-protection-guidance/

Guidance on self-directed support from the Scottish Government, Social Work Scotland and COSLA: COVID guidance on Self-directed support Options 1 & 2 and Frequently Asked Questions publication

11.3. Learning disability (updated 19 March 2021)

Accessible easy-read guidance for people with learning disabilities on the Coronavirus outbreak and how people can protect themselves, from the Scottish Commission for Learning Disability (SCLD): https://www.scld.org.uk/information-on-coronavirus/ This site also includes a collation of materials relevant to people with learning disability during the pandemic from a wide range of organisations.

A series of guided self-help booklets developed with four universities to support people with mild to moderate learning/intellectual disabilities during the COVID-19 outbreak: https://www.scld.org.uk/covid-19-guided-self-help-booklet-series/.

Scottish Commission for Learning Disability Statement on Human Rights and COVID-19: https://www.scld.org.uk/a-statement-on-human-rights-and-covid-19/

SCLD also have easy read guidance for people who have been shielding, on moving out of lockdown.

Easy read guidance on Test and Protect by People First:
http://peoplefirstscotland.org/test-and-protect/

COVID vaccination information for people with learning disability and their family carers: https://www.enable.org.uk/vaccine/

11.4. Dementia

Coronavirus Coming into Hospital Guide, for people living with dementia, their families and carers:
https://www.alzscot.org/sites/default/files/2020-04/Coronavirus%20-%20Coming%20Into%20Hospital.pdf

11.5. Children and young people

Advice on supporting children and young people:

https://www.cosla.gov.uk/__data/assets/pdf_file/0018/15570/covid19adviceforsupportingchildrenandyoungpeople.pdf

11.6. Sensory loss

Communication for people with sensory loss during the COVID-19 pandemic: advice for health and social care staff in Scotland – produced by a group of organisations:
https://www.pmhn.scot.nhs.uk/wp-content/uploads/2020/04/COVID-19-Communication-for-people-with-Sensory-Loss.pdf

11.7. Support for frontline staff (updated 24 July 2020)

The Scottish Government have launched a new wellbeing line for the health and social care workforce based within NHS 24's Mental Health Hub:

0800 111 4191 (24 hours)

National Wellbeing Hub provides self-care and wellbeing resources designed to support the workforce:

www.promis.scot

A group of mental health charities have launched 'Our Frontline' to support the mental health and wellbeing of key workers by offering round the clock emotional support, practical advice and resources: www.mentalhealthatwork.org.uk/ourfrontline/

11.8. Accessible Covid-19 guidance (7 August 2020)

General guidance on the current Scottish rules including shielding, social distancing and stay at home advice, in 12 languages including BSL, plus easy read and audio formats:

https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19

11.9. Scottish Government mental health transition and recovery plan (26 November 2020)

The Scottish Government has published the Coronavirus (COVID-19) Mental Health - Transition and Recovery Plan:

https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/pages/1/

11.10. Care Inspectorate Covid compendium (10 December 2020)

The Care Inspectorate publishes a compendium of guidance and information in relation to Covid-19:

https://www.careinspectorate.com/index.php/coronavirus-professionals#:~:text=The%20Care%20Inspectorate%20has%20developed%20a%20compendium%20of,primarily%20to%20support%20our%20staff%20in%20advising%20services

12. 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
TO	Treatment Order
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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