

Submitted to **1. Summary survey**

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## **1. What Scotland needs to do**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

#### **Why do you think that?:**

Why do you think that?

The British Psychological Society welcomes the Review's

- aspirational focus on the human rights of people with autism and / or learning disability, in line with Scottish Parliament commitment

- far reaching and extensive evidence gathering

- focus on the reports of experts by experience. We acknowledge many people with autism and / or a learning disability will find it difficult to express their lived

experience so consultations can be at risk of only taking into account part of that disability group

- looking to other models within this country and in others.

We agree it is optimal to aspire to high standards of human rights but we are mindful that while disability rights are extremely important, there should not be

discrimination between disabilities. It is important to acknowledge that professions currently work within organisations who are required to make a statement

about any implications for protected groups and in terms of equality, and organisations have policies developed to govern safety, best practice and users' rights.

That aside, the Society believes it timely to review mental health law for people with a learning disability and/or autism.

Within the Review documentation, we believe that there is a lack of clarity and a lack of consistency around wording, definitions and concepts. We also believe

the easy read documents do not accurately reflect the issues involved, which can lead to a concern that a misinterpretation of ideas can occur. For example, the

case studies within the easy read consultation document miss information in them which could mislead towards a response bias (see comments below). We have

concerns as to whether the easy read documentation describes a change in legislation as being the only possible solution which will result in positive outcomes

within existing legislation. It is to be highlighted, within clinical practice, there are a number of current examples where insufficient resourcing is the reason why certain outcomes don't happen for individuals, not the absence of appropriate legislation.

Utilising a disability based model is thought to be of value, although it may be difficult to implement in practice.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

How could these ideas be made better?

While undoubtedly this is a worthy framework, we have concerns that a sole reliance on human rights factors is felt to need further consideration, for example, in

cases where capacity issues are of concern or there are concerns about harm to self and others (to be discussed in later sections).

We believe that the review could consider each of the examples that they give within the easy read documentation and consider whether resource limits could

also have been an impacting issue. Otherwise, there is a risk time and effort is spent amending parts of the legislation which, on a practical level, will make no difference for care and support of clients.

Inconsistencies within the report should be addressed and we believe that examples and flow diagrams of a person's journey through the proposed legalisation

would promote clearer understanding of the proposals/decision making processes and impacting considerations.

The Society believes that separating legislation into Disability Rights legislation and Mental Health Act legislation could be an effective way forward.

## **2. How we understand autism, learning disability and mental health**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

#### **Why do you think that?:**

An understanding of learning disability and autism as disabilities is required but also recognition of the biopsychosocial model related to, and impacting upon,

these disabilities is important. The biopsychosocial model, first introduced by Engel (1977), states that health and illness are determined by a dynamic interaction

between biological, psychological, and social factors and that it is the interplay between these factors that determine the course of health-related outcomes.

We welcome the vision to support decision making regarding rights in law. However, it is unclear how this will work in practice in such occasions where a person

is unable to make decisions even with support for decision making (for example, people who have learning disability and / or autism who also have severe dementia or severe psychosis). We are concerned about the assumption that everyone has legal capacity. This fails to recognise the complexity of decision making often involved in care and treatment decisions and the complexity of presentations.

There seems to be a tone throughout the document that decisions made by independent advocates are likely to be viewed as 'better' than by specialist professionals, which we don't believe to be the case. We are also concerned by the idea that decision making by professionals should be (quite rightly) subject to a level of scrutiny but that decisions made by independent advocates do not appear to be subject to similar scrutiny.

We also have concerns about the proposal around legal capacity, especially in regard to tribunals respecting non-instructed advocacy professionals' best interpretation of a person's will and preference. This is contrary to the person themselves having capacity and is potentially making a non-instructed advocate the person who determines decisions about treatments which they do not have relevant competencies to do so.

As mentioned earlier, we welcome the disability model as sensible but we have some reservations that this may lead to rules for some groups of people which do not apply to others. It is an unfortunate fact of life that anybody can lose capacity and need support.

Many learning disability services and MDTs invest a great deal of time and energy to deliver person centred services consistent with a person's wishes and preferences. Positive effective outcomes are dependent upon effective MDT working. Effective MDT working requires well-resourced teams informed by a multimodal approach directly linked to person centred care by teams which are tied to governance requirements, trained, competent and subject to professional standards.

Regarding terminology changes, the current definition of learning disability refers to a specific group of people who have the highest level of need (about 2% of the population) and by such identification they then receive appropriate specialist services. We are concerned any change in terminology towards a term which is

currently believed to refer to a wider population may lead to less shared language and understanding, less consistency and less association with diagnosis documents.

The statement, "Autism and learning disability are diagnosed by psychiatrists or clinical psychologists." We recommend that it is best practice for an MDT

approach to be taken in regard to Autism diagnosis, with specialist input also sought from Speech and Language colleagues. Equally there are other domains of

psychology such as counselling or educational who may have the competencies to complete a full and formal diagnosis of learning disability.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

How could these ideas be made better?

An illustrative case example of the concepts discussed would be useful.

Standards for advocacy services are required. We are aware that The Scottish Independent Advocacy Alliance published recently principles, standards and the code for best practice for independent advocacy practice (2019).

There are inconsistencies which require addressing throughout the document when referring to impairment or referring to disability. These inconsistencies lead to difficulties in comprehending the frameworks and arguments presented.

A disability model is already the model we use for people with a learning disability and / or autism. Sometimes they, like anybody, can also develop mental health

difficulties or behavioural difficulties and there will be times when a person with a learning disability or autism will be considered to lack capacity to take certain

decisions and the law should remain the same in that respect. They should be equal in the law to others. They should have a right to support for decision making

when their mental health or intellectual impairment impairs their capacity.

We recommend you reconsider tribunals respecting non-instructed advocacy professionals' best interpretation of a person's will and preference. It may be that we

have misinterpreted the strength of the wording 'respecting' within the document and that the approach to be followed would be a more balanced and view of

harm versus human rights. Clarity is required.

It should be noted that it is almost exclusively the role of applied psychologists to undertake the individualised psychometric assessments which produce the IQ

scores considered valid for the purpose of establishing a diagnosis of intellectual disability This has been a longstanding role for psychologists, who receive specific training in the administration, scoring and interpretation of intelligence tests.

### **3. Support for decision making**

#### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

#### **Why do you think that?:**

We welcome the vision for each person to have a statement of rights, will and preferences and that these should not be disregarded by professionals. The

Society believes having a statement of rights, will and preferences will have an extremely valuable role in empowering individuals, families and professionals.

There are also psychological and practical benefits in terms of the clarity they can provide.

The Society welcomes increased support for decision making should be in place. However, we have concerns regarding the view that its validity would not be

dependent on whether the person was believed to have enough mental capacity to make a statement” (page 23). We acknowledge this is a radical way of

thinking but consider the role of supported decision making, the possibility of undue influence from others, whether this would apply to all situations and if there is

change over time. If this process is never reviewed then it cannot be regarded as valid. Again, we wonder why this would be a different approach in law to those

who do not have a learning disability and / or autism and have other disabilities.

We refer you to the BPS submission made to the Scottish Government ‘Adults with Incapacity Reform’ consultation in April 2018. In it we expressed concern that

“equating a “wish” with “valid consent” is problematic. “A person may be compliant with the placement/ care/ treatment however not have the cognitive capacity to

understand the implications of the placement/ care/ treatment.” (BPS, 2018)

The Society welcomes the role of independent advocacy and the proposed opt out system of independent advocacy, for those able to make that informed

decision. Advocates should be skilled in communication but also familiar with the Mental Health Act. Positive discharge outcomes in England and Wales have

been linked to the Mental Health Act recommendation that the same advocate be in place as long as possible, and that the person’s right to advocacy remains

after discharge. We would welcome similar approaches to consistent and long term advocacy be in place in Scotland. We are aware that The Scottish

Independent Advocacy Alliance published (October 2019) principles, standards and the code for best practice for independent advocacy practice.

We are concerned that on page 27 it states in the instance where a person may not wish to receive treatment that a tribunal will respect the preferences as

interpreted by an independent advocate – we have concerns about the role of non-instructed advocacy in this situation and would request that all involved parties'

views also be sought and respected.

We are also concerned there seems to be a perception that greater weight for decision making is placed on the opinions of independent advocates when

compared to that of those working within a MDT specialist team. There is no indication within the documentation of the level of training or expertise that the

independent advocate would require to have, nor of governance arrangements or of any means of appealing against their opinion.

We welcome that all professionals have to be open and transparent about their decisions and why they may not follow someone's previously stated will and preference.

We also welcome explicit authorisation for psychological therapies. We believe that it is a good idea to have a written and authorised record why any treatment is

happening and the associated evidence base.

The Society welcomes the premise that all professionals should be able to demonstrate that they have taken all reasonable steps to support a person's decision making about support, care and treatment.

We are concerned about the section on decisions about psychological interventions (pp.37-39). When comparing this to section 6 it is unclear whether this would

apply to all psychological interventions proposed or only those for who are detained and/or unable to give consent. It is also unclear what the document means by

psychological intervention – there are differing levels of psychological interventions and it is unclear which level/s or proposed input would need to be taken to a

tribunal for authority to progress. It is unclear what is defined as serious harm.

Although we agree professionals need to outline the possibility of harm to those undergoing treatment, the Society believes that the language used in pages

37-39 gives the impression that psychological therapies are being used extensively without consent and not in collaboration with patient, which is not the case.

We wish to emphasise robust ethical approaches and clinical governance systems are in place concerning the delivery of psychological interventions.

The Society is happy to provide advice regarding psychological interventions.

We welcome the recognition of the role of PBS (an ethical, evidenced based, proactive and person centred approach designed to help staff support and manage

an individual's challenging behaviours) in the prevention of psychotropic over medication. PBS is a highly recommended as an intervention for challenging

behaviour (The Matrix, 2014) and is an approach in line with the NHS Scotland Healthcare Quality Strategy's (2010) themes of delivering safe, effective and

person centred care for people with learning disabilities and complex care needs. It is accepted internationally as best practice and it is well-established as an

effective framework for supporting people with learning disabilities and challenging behaviour.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

We believe the statement of rights, will and preferences will need to be detailed, and that there should be evidence that the person has thought through options

and alternative scenarios. We note also that provisions should be put in place for situations where the wishes and preferences of the individual may later change,

potentially placing them in apparent conflict with a previous statement, which they no longer have the capacity to withdraw. We are aware the Essex Autonomy

Project <https://autonomy.essex.ac.uk/> has been thinking through these ethical dilemmas and that the Review are aware of their work.

Regarding supporting decision making, we recommend that every effort to support the adult to understand a proposal and to express their view should be made.

The Society believes psychology has a key role in facilitating informed supported decision making and request their skills be incorporated into your

considerations.

Psychologists possess relevant knowledge and skills in relation to assessment processes. They are aware of issues of validity, reliability and standardisation

methodology. When working with specific patient population groups they have experience of using adapted communication to adjust their interview style to the

situational demands, such as breaking-up information into smaller 'chunks', using simpler language, pictorial aids and using non-verbal measures. Psychologists

are aware of the presentation of mental health difficulties and how to assess effectively for them. They are aware of the impact difficulties such as low mood or anxiety can have on information processing, memory abilities and decision making. They are also aware of the impact emotion can have on decision making

processes in addition to the effects of substance misuse. Psychologists are aware of how decisions are made (the individual steps that lead to effective decision

making) and are aware if any steps have been missed, or have not been executed correctly, when a decision is made. They have experience of interviewing

people about internal processes. They assess attentional and attributional biases in patients' perceptions of situations. They are aware of potential acquiescence,

suggestibility and the fear of negative evaluation affecting decision making abilities. They are aware of impulsivity issues, assess for motivational issues and for

levels of insight and readiness to change. They are practiced in the assessment of a person's beliefs and attitudes and how they may be impacting on that

person's decision making ability. They are also aware of potential lack of assertiveness or a lack of social skills impacting on a person's ability to communicate

decision making.

Re the role of decision supporters. We are aware that this is not being addressed within the Review. For your information, the BPS made a submission in April

2018 to the Scottish Government consultation regarding the Adults with Incapacity Act in which we discussed our position re Decision Supporters. (BPS, 2018)

We would be happy to provide you with a copy of that response, on request. In short, we agreed that an official supporter for decision making should facilitate

decision making but that there would need to be safeguards in place for this process. Impairment of cognitive functioning can make people vulnerable and the

position of official supporter will be a position of trust and influence. The Society believes that the decision for someone to be appointed as official supporter

should primarily be that of the person requiring support, however opinion on this should be sought from others that know the person well including family

members, carers and professionals working with the person, to ensure that the person assigned is suitable. The Society feels this procedure needs to be clarified

in guidance. There would need to be guidelines in place about the characteristics required of an official supporter, the safeguards in place and there should be

training opportunities/website support available for official supporters. The Society recommends that provisions be made to take into account the possibility of

relationship break down after an official supporter has been put in place.

We recommend the review considers the need for consistent and long term advocacy to be in place. We believe that all involved parties' views be sought and respected when non-instructed advocacy is in place and that appropriate weight be placed on the views of MDT specialist teams when discussions are made.

We believe that the review should clarify the detail around requesting authorisation of psychological interventions, such as whether this would apply to all

psychological interventions proposed or only those for who are detained and/or unable to give consent. It is also unclear what the document means by

psychological intervention – there are differing levels of psychological interventions and it is unclear which level/s or proposed input would need to be taken to a

Tribunal for authority to progress.

We recommend the review gives clarity of what they define as serious harm.

#### **4. Support, care and treatment**

##### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

##### **Why do you think that?:**

The Society endorses the need for increased access to services with knowledge and skills in autism.

However, we have concerns as to why Autism has been separated out for a right to diagnostic assessment (and other neurodevelopmental conditions such as

Foetal Alcohol Spectrum Disorder and Attention Deficit Hyperactivity Disorder are not considered also) and also why such a shift has been deemed necessary.

We are aware the review documentation states the national autism service would be available to give second opinions re support, care and treatment and we

wonder if a similar service would be available for learning disability.

If the national autism service becomes law this will require a significant resource allocation, which we are concerned may move resources away from other patient

population groups, however, we do acknowledge such duties on public authorities will provide services to areas less resourced but our concern is that resourcing

would only be for autism.

In relation to the national autism service the Society would like to draw your attention to the Autism Training Framework being implemented by NHS Education for

Scotland (NES) which is directly linked to the Scottish Government's Autism strategy. Additionally, NES has many other training avenues available to upskill the

workforce.

The Society welcomes the proposal for all autistic children and children with learning disability who need services for their mental health having a right to a

Co-ordinated Support Plan. However, as detailed above there are significant resource implications and, again, concerns around whether such supports should also be available to other children with other neurodevelopmental disorders.

As mentioned earlier, a key message is we believe rights should apply equally to all, not to one group rather than another group; the Society would welcome some clarification how this will be managed.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

We believe that clarification needs to be provided as to why Autism has been separated out for a right to diagnostic assessment and other neurodevelopmental disorders have not.

The Society would welcome more details how a proposed national autism service would plan to address fully, and sustainably, the work it is envisaged. Also

further details on how it is expected that this resource demand will be met effectively and efficiently without adverse knock on effects on resourcing for other population groups.

We would wish consideration be given for Co-ordinated Support Plans to also be developed for children with other neurodevelopmental disorders. Again, further details how it is expected this resource demand be met effectively and efficiently would be beneficial.

## **5. Where support, care and treatment happens**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

#### **Why do you think that?:**

The Society welcomes voluntary care over restriction and detention as the preferable option, however sometimes patients do not wish to seek or receive help. We

wish to emphasise that compulsory care in hospitals is based within whole system MDT working, and grounded in assessment and interventions linked to a biopsychosocial model.

There is strong empirical evidence that people with learning disabilities experience the same range of mental health difficulties as the general population

(International Association for the Scientific Study of Intellectual Disabilities 2001, Emerson 2003, Bouras and Holt 2007) but they present with higher rates of

these difficulties than people without a learning disability (Deb et al 2001, Cooper et al. 2007, Cooper et al. 2007b, Strydom, 2007). The prevalence rate of

schizophrenia in people with a learning disability is reported as being 3%, while for the general population it is between 0.4 and 1%. The prevalence rate of

depression in the general population is around 2%, whereas in adults with a learning disability it varies between 1.3 and 3.7%. Psychotic disorders are up to five

times higher and dementia three times higher than in the general population. Anxiety and affective disorders, including self-harm, are reported to be more.

Although these figures are confounded by definition and sampling differences it is agreed by clinicians that people with learning disability are more likely to

develop mental health problems than non-learning disabled peers

It is often the issue of comorbid mental illness which is the key component in decisions made to restrict or detain. We would encourage the Review to consider the impact of mental illness on the care suggestions provided.

Regarding the proposal of a safe place and a secure support centre, we encourage the concept of avoiding admission and the need to have a service staffed by

people specialist in learning disability and / or Autism. However, we believe such services would need to have a fully trained MDT approach to service delivery

with associated legal protections, clear clinical governance and standards, staff working to professional codes and associated training and supervision. This

would lead to service delivery by managers and staff who are trained to ensure that they had the necessary skills and expertise in delivering specialist

interventions or approaches to care. There would also need to be an adequate staff pool to call on. We wonder if there is a risk patient flow may not be as

anticipated through safe places and secure support centres, thus creating mini assessment and treatment centres and services therefore not available to those

that need it when they need it.

More specifically, regarding a safe place, there is concern about the lack of detail and how they would function to reduce risk. Often people referred to our

services are referred by others and not by themselves, and what would happen in this situation (would there be a proviso if it becomes discovered that person is

planning to harm others for others to be able to help the person to a safe place). Clarification is needed on whether other options will be available, such as web help, web resources for those who need help but do not wish the stigma of being seen to approach a safe place. Also whether practices such as restraint/seclusion will be monitored by the mental welfare commission.

More specifically regarding secure support centres and the proposal that they would need to be led by social work or social care professionals, nurses or

occupational therapists – we have concerns regarding this and it may be a misinterpretation we have made of the term ‘led by’ and what it is anticipated this

would actually look like in practice. Clarification is needed on whether practices such as restraint/seclusion will be monitored by the mental welfare commission as

well as whether or not secure support centres become stigmatising and isolating.

The Society is concerned that the document mentions detention considerations related to suicide but does not acknowledge detention considerations when there is severe self-harm/injury or the risk to others of severe harm.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

The Society would welcome more details how safe places and secure support centres would address fully, and sustainably, the work it is envisaged to deliver.

The Society asks that consideration be given to a fully trained MDT approach, grounded in the biopsychosocial model, for safe places and secure support centres.

Further details are required on how it is expected these resources will deliver effective and efficient care without adverse knock on effects on resourcing for other population groups, and how such an approach will ensure the necessary competencies and sustainability of the front line workforce.

It would be beneficial for the review to explain further how they anticipate that there will be adequate patient flow through safe places and secure support centres to prevent service blocking, service inaccessibility and lack of required responsiveness.

Although we are unsure how this can be written into legislation, the Society would have welcomed more consideration around the introduction and roll out of

preventative approaches, the promotion of mental health wellbeing, and early intervention to preclude further use of the mental health act legislation (maybe place

duties on authorities to develop co-ordinated and sustainable apps, web information, community resources, drop in groups, peer support services etc.)

## **6. How professionals make decisions**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

#### **Why do you think that?:**

We believe that there should be approaches to reduce the use of restraint and seclusion but as you state there needs to be recognition that this is a complex issue and Scotland is not at the point of ending all detention in a safe way. We agree it is important for peoples' human rights to be considered as part of any assessment.

We are concerned there seems to be a lack of clarity on what should be expected of health professionals when a person's will and preferences are clearly going to place them, or others, at risk.

It is mentioned within the document that "we think that professionals who are making decisions should not be the people to decide what the best interpretation of the person's will and preferences is. That could lead professionals to make decisions based on judgements about 'best interests', instead of decisions that aim to make the person's will and preferences a reality." (p.76). Although we understand the motivation behind this comment we feel this does not reflect our experiences of most professional decision making and clinical input. Our experiences are of involved professionals using assessment, the consideration of differential diagnosis and mental health and formulations to try to better understand why a person is feeling or behaving the way they are. The Society feels what is most appropriate is assessment from a highly skilled multi-disciplinary team, including robust input from advocacy (and most definitely in cases involving non unstructured advocacy). All members of the team are highly skilled and knowledgeable within their area of expertise, and hence as job remits vary widely input should constitute a MDT approach/decision rather than one profession feeling placed to speak for a team.

The Society welcomes the suggestion for support, care or treatment without consent to be considered and authorised separately by a tribunal, such as psychotropic medication, psychological interventions, and other forms of support, care or treatment. We feel it is a good idea to have a written and authorised

record why all treatment is happening and the associated evidence base for all treatment offered. We ask the Review clarify the detail around requesting authorisation of psychological interventions, such as whether this would apply to all psychological interventions proposed or only those for who are detained and/or unable to give consent. It is unclear what the document means by psychological intervention – there are differing levels of psychological interventions and it is unclear which level/s or proposed input would need to be taken to a tribunal for authority to progress.

Often there is a great deal of interplay between different forms of support, care and treatment.

We welcome the proposal to prevent over medication of those who are detained. However, we are mindful that, for some, medication is necessary to protect someone from harm and/or improve their mental health to a point where other MDT approaches could bring about more effective and positive outcomes.

There are 3 main areas within this section the Society wishes to comment on in turn – new professional roles, the role of psychology and risk assessment/human rights assessment.

- New professional roles

The Society believes that more clarification is required as to the duties and responsibilities of each role proposed. The lack of detail, and some inconsistencies through the document, has led to confusion around the roles suggested.

Regarding the proposed care manager role, The Society is not clear what the extent of the role of care manager is, and given the complexity of people who are likely to be detained, it is of concern that it is acknowledged they may, or may not, have experience in autism or learning disability. This role would have to be firmed up significantly, particularly in relation to situations where there were a range of opinions in the supporting clinical team. Throughout the document there are inconsistencies between whether this role will be to access and co-ordinate services or where the care manager will lead the overall approach to that person's care (in secure support centres) even when human rights are found to be impacted upon.

Regarding the proposed Responsible Officers role – The Society welcomes the idea of Chief Officers of Health and Social Care Partnerships, or Chief Social

Work Officers, having the final responsibility for orders made by the Mental Health Tribunal for Scotland. We also feel it appropriate that psychiatry or psychology

are proposed to be expert advisors, though we would advocate that this is not limited to clinical psychologists. We feel this approach places the responsibility and accountability for appropriate community discharge packages where it needs to lie; as it is often the lack of appropriate community discharge packages which causes longer hospital stays or out of area placements.

Regarding the Mental Health Officer role – The Society welcomes that they would need to be employed in a way which makes them independent of the Health and Social Care Partnership and the Social Work department to avoid a conflict of interest.

We believe that it is not clear within the document who will be responsible for ensuring that the care, support and treatment plan is in place and being applied to reduce restriction as quickly and safely as possible.

- The role of psychology (and the non-medical approved clinician model)

The Society's members have expressed concern that within the document there seems to be some confusion around the role of psychology within a MDT system and we would like to take this opportunity to clarify it.

Psychologists (utilising a scientist-practitioner approach) assess, formulate, treat and evaluate their input. They provide psychological therapies (using the available evidence base). They also, in addition to mental health are skilled in neuropsychological assessment. Additionally, psychologists are trained in audit and research methodology.

Psychological formulation is a core competency and key component of psychological involvement. Psychological formulation is powerful in identifying factors contributing to an individual's presentation and thus identifying appropriate treatment routes, be it for those presenting with challenging behaviour, forensic behaviours or mental health difficulties (or any combination thereof). Psychologists' ability to formulate across the lifespan, to understand disability, personality, relationships and mental health helps us to identify factors which disable people from maximising their human rights and to find routes out of difficult circumstances. Psychological formulation is the summation and integration of knowledge acquired by an assessment process which may involve psychological, biological and systemic factors and procedures. A formulation draws on psychological theory and research to provide a framework for describing a patient's problem or needs, how it developed and is being maintained. All psychological interventions are based upon a formulation.

Professor John Taylor has highlighted, when meeting with the Review staff, in his experience psychological formulation was essential to positive outcomes achieved by non-medical approved clinicians in England and Wales. Additionally, Taylor et al. (2017) describe the use of formulation in facilitating successful transitions from hospital to community services for detained offenders with learning disabilities.

Psychologists have extensive experience of clinical situations which involve having emotive conversations with others (patients and their personal and professional support systems) and often have a lead role in creating safe, reflective, therapeutic environments through training, supervision of non-psychology staff and the facilitation of reflective practices.

It is unfortunate that the example given for psychological treatments within the documentation is "behaviour modification methods" as readers may assume this refers to an aversive approach which in no way fits with current practice.

In direct regard to the review, we welcome the proposal that an opinion is required from a psychiatrist or psychologist on whether the person meets the criteria for compulsory care or treatment. The Society has concerns as to whether the use of the term 'unsound mind' is the most appropriate. We think there is more clarification required as to who will oversee the treatment, care and support of someone detained. The society is in agreement it would be beneficial for those who authorise initial detentions or continued detentions to not be therapeutically involved and vice versa. However, due to current workforce implications this may prove challenging for services.

At our meeting with the Review on 3rd October, our understanding is psychology and psychiatry are being viewed as the medical experts within the proposed model, such that when a responsible officer asks for a medical opinion to be discussed at a tribunal it will be either of these professions that give their opinion considering the test of proportion regarding the person's human right and whether detention, is needed, needs to be continued or can be discharged. We are aware that the process needs to be clarified regarding emergency detentions.

At the meeting with the Review team on 3rd October we were encouraged that, following the Review's visit to Northgate, they acknowledge the competencies that psychologists possess when working within a collaborative MDT. The Society thanks you for your positive comments regarding the competencies psychology contributes to the non-medical approved clinician model in England and Wales and your noting of the evidence of positive outcomes we already provided (Miles

France Associates. 2018, Oates et al. 2018). As you are aware, the Department of Health holds a positive view of the non-medical approved clinician role and is expanding the role nationally.

We are aware the Review is proposing there not be an approved clinician role but the skills and competencies psychologists possess are directly transferable not only to the review's proposed role for Psychology of recommending detention, the continuation of detention to the ceasing of detentions but also to overseeing the treatment, care and support of someone detained. We draw your attention to the Millan principle of reciprocity (2001) - where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services.

Your views on the increased role for psychology are timely, with respect to the current and foreseeable well documented significant workforce challenges for psychiatry throughout Scotland, which have been highlighted recently in the national media. E.g. <https://www.bbc.co.uk/news/uk-scotland-49951842>

Within the document you refer to the training for approved clinicians to have a strong focus on the medical model, not the disability model. The Society would like to take this opportunity to disagree with this view and to clarify that to become a non-medical approved clinician mandatory training is a two day course, focussing on the following issues in relation to the Mental Health Act:

- Legal;
- Mental health; and
- Human rights.

Prospective non-medical approved clinicians are also required to provide extensive, detailed and corroborated evidence that they possess the relevant

knowledge, clinical skills, competencies and ethical approaches before they are authorised to take on the role. Once qualified, non-medical approved clinicians

are required to refresh their knowledge every five years with a one day course and will continue to remain subject to their profession's clinical and professional

governance regulatory requirements. Professionals considering becoming approved clinicians are urged to submit a portfolio of competency evidence for peer

review – which provides a report on the suitability of the applicant. In addition to demonstrating they have the required competencies applicants are also required

to complete an accredited 'Initial Training' course for approved clinicians. This rigorous application and review process ensures the approved clinician approval is

extended only to competent non-medical professionals.

- Risk assessment/human rights assessment

The Society's members have asked us to specifically highlight inaccuracies within the Review's report (page 94) under the heading 'public safety'.

We agree that other people's rights have to be considered when there is an element of risk and strongly believes to do this effectively requires some form of risk

assessment/formulation to allow for the development of a positive risk management/treatment plan. The Society supports the proposal for a "proportionality" test

(a human rights assessment), and we strongly recommend consideration of the rights of others as part of that decision making process. We sense the Review

views the proportionality test to be examined in a 'balanced' way but fear this view is not clear within the documentation released.

We are concerned about the initial equation of risk with 'dangerousness' (p.86). The concept of risk is (incorrectly) often associated only with dangerousness

rather than with a more holistic approach to working with people's needs, vulnerabilities, and the risk to self and / or others. We are encouraged to see the Review

later discounts dangerousness as a concept, preferring to address risk to rights. However, we ask for more clarification how risk to self and / or others will be

included in a human rights assessment as described in the consultation.

We believe that risk assessment and management is crucial to the effective diagnosis of 'disability' as proposed, and is crucial to effective decision making within

the proportionality test framework. Risk assessment is also crucial to positive risk management in relation to ensuring that care, support and treatment are

optimised and reflect the will and preferences of the individual concerned. Positive risk management is about giving people the opportunities they desire without

compromising their or others' safety. To do so effectively requires good and open risk assessment processes. A good risk management plan with a clear

implementation plan is likely to be a key component in reducing levels of restriction required.

Although we welcome the human rights based approach, the Society believes that it is important to strongly address the Review's view that clinicians should not

be undertaking risk assessments as contrary to other best practice ongoing not just in the UK but worldwide. Indeed, the last 20 years has seen a move towards

ensuring that clinician decision making does not take place without reference to risk and that risk decisions are not made without reference to clinical issues. Of

course, non-clinicians often do complete violence risk assessments, social work being the most obvious example. However, where issues such as personality disorder, psychosis, learning disability, head injury (to name some) are implicated clinicians are often sought for their expertise in this area. The Risk

Management Authority in Scotland accredits Risk Assessors for the purposes of completing Risk Assessment Reports for those being considered for an Order of Lifelong Restriction. Although accreditation was open to psychiatrists, psychologists and social workers, only psychologists and psychiatrists have ever been

accredited. Having clinicians involved in risk assessments allows for consideration of the role of any illness/disability/deficits in the enactment of violence, i.e. in

some cases it will have a central role, in others it will be a peripheral role – the risk formulation helps you understand this – it then also means that risk

management strategies take into account, any illness/disability/deficits/as required. For example, a learning disability may not be the primary risk factor for

violence in a hypothetical case, it may be the use of drugs for example, but making sure the risk management strategies are responsive and relevant for someone

with a learning disability will be very important. Appropriate management of a case for someone with an offending history could not take place without an

appropriate risk assessment. Risk management should not be taking place without an appropriate risk assessment outlining potential risk scenarios that need to

be managed.

The Risk Management Authority <https://www.rma.scot/> recommends the use of Structured Professional Judgement (SPJ) risk assessments rather than actuarial

ones, advocating a formulation based narrative - of which Psychology is ideally qualified to do. An actuarial approach merely looks for the presence of absence of a factor.

SPJ tools such as the HCR 20 are recognised as being the appropriate methodology for assessing and managing risk, and are recommended by the Risk

Management Authority. The development cohort of the HCR 20 assessment included individuals with learning disability.

Psychology and/or Psychiatry are best-placed to complete, or at least play a central MDT role in, risk assessment and should not be excluded from completing

risk assessments. Within one NHS area, in relation to MAPPA although social workers and police do the majority of risk assessments on offenders, where

offenders have mental health or learning disability or autism issues, the use of a clinical service (SOLS), staffed by psychologists and psychiatrists, is utilised to

ensure risk assessments are relevant and appropriate.

The Society's members highlight that when involved in MAPPA there have been significant concerns/risks associated with some of the actuarial tools used by non-clinical professionals which require understanding of how the presence of a learning disability can impact on scoring. These often required a clinical opinion, in addition to the scoring, to ensure that people with learning disabilities were not categorised at a higher risk level than was appropriate. Not having learning disability or autism professionals involved in such processes could therefore disadvantage people.

The Society believes that it would be beneficial, where possible, for SPJ risk assessments to not be conducted by the practitioner whom is providing therapeutic input; someone external to the therapeutic team would be better able to carry out a more objective view. Not only would it negate any concerns around conflicts of interest or the creation of a conflictual therapeutic environment, it would protect the human rights of the person.

The Society wishes to draw your attention to studies that include people with learning disabilities in SPJ risk assessment tools. The ARMIDILO-S is specifically developed to be used in cases where a person has a learning disability. The ARMIDILO-S is an adapted tool for people with a learning disability who sexually offend, and there is initial research, some conducted in Scotland, that is supportive of its use. The FARAS has also been established for people with autism whom offend, although it's newer than the ARMIDILO-S so the evidence base is more sparse. The Risk Assessment Management Authority produces RATED (the risk assessment tools evaluation directory) which provides information / guidance on tools and their evidence base; the ARMIDILO-S is the only SPJ designed specifically for people with a learning disability and it is currently in the 'awaiting validation' section. The Society is aware it takes time to build up a robust evidence base, particularly when numbers are small and outcomes are determined on reoffending rates (which can take years to become clear). Writing into law a recommendation against clinically driven SPJ approaches because of these aforementioned reasons, when such reasons are being addressed, is of concern. You mention "We think that psychiatrists and clinical psychologists should not provide assessments of risk from autistic offenders or offenders with learning disability towards other people when this could lead to pre-emptive detention. Pre-emptive detention includes detention before an offence is committed, and detention after an offence which continues for longer than a typical detention. Pre-emptive detention of persons with disabilities on public safety grounds would be

contrary to some of Scotland's human rights duties." (Page 94). Clarification on who is best placed to undertake this assessment with the relevant and most appropriate competencies would be beneficial.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

The Society feels an illustrative example of a human rights assessment would have been helpful to consolidate understanding and prevent misinterpretations of terms used.

The Society requests more clarity on what should be expected of health professionals when a person's will and preferences are clearly going to place them, or

others, at risk.

The Society does not agree with the view that professionals who are making decisions should not be people to input into what the best interpretation of the person's will and preferences is. The Society feels what is most appropriate is assessment from a highly skilled multi-disciplinary team, including robust input from advocacy (and most definitely in cases involving non unstructured advocacy).

We ask the Review clarify the detail around requesting authorisation of psychological interventions, such as whether this would apply to all psychological

interventions proposed or only those for who are detained and/or unable to give consent. It is also unclear what the document means by psychological

intervention – there are differing levels of psychological interventions and it is unclear which level/s or proposed input would need to be taken to a given authority

to progress.

The Society believes that more clarification is required as to the duties and responsibilities of each professional role proposed. The lack of detail, and some inconsistencies through the document, has led to confusion around each role suggested.

The Society believes that acknowledgement is needed as to the many psychological treatments available (see the Matrix, 2014 and the British Psychological

Society, 2016) and believes that the outdated and inaccurate term "behaviour modification methods" should be removed.

The Society questions whether the use of the term 'unsound mind' is the most appropriate. The Society has done work previously, in relation to capacity, where

members had suggested “impairment of the mind or brain” as an alternative description.

Due to NHS workforce challenges, we would welcome clarification on how workforce implications will be addressed to prevent any professionals taking on dual and conflictual roles when working within small resourced areas.

The Society strongly urges the review to address their comment that clinicians should not be undertaking risk assessments as this is contrary to best practice ongoing not just in the UK but worldwide. However, it may be that the review had in their thoughts those specific clinicians engaged in a therapeutic relationship with a person rather than clinicians per se; if that is the case, we apologise for our misinterpretation and ask the reference to clinicians be made clearer within the documentation.

We believe that it should be considered who would be best placed to undertake pre-emptive detention assessment with the relevant and most appropriate competencies. We recommend SPJ assessments be conducted rather than actuarial assessments, as per best practice for people with a disability.

## **7. How decisions are monitored**

### **1 What do you think about the ideas in this section?**

I like the ideas

#### **Why do you think that?:**

We welcome the proposal to expand powers and the authority of the Mental Welfare Commission. Currently their role, though highly valued and relevant, is advisory and the granting of more authority would prove beneficial to protecting and meeting the human rights of people with learning disability or autism. We are aware that previously SHAS and then QIS for people with learning disabilities (with whom experts by experience were members of review teams) had a similar remit. The Society believes it is right and proper that professional decisions be monitored. If the Mental Welfare Commission is to carry out this new role they should involve a range of professionals as well as users and carers.

We welcome proposals to make clinicians more openly reportable for their decisions re treatment options. Tribunals could become more confident in upholding patient rights, or determining when detention is no longer legal or applicable if such information is readily available.

In principle the role of second opinion professionals could be helpful but the limited description of the role (p.104) requires more detail and thought. Psychologists should be included in this.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

The Society would welcome the idea that a person would need a right to notify the Mental Welfare Commission when any statement of rights, will and preferences was not complied with, in addition to duties on professionals to report this.

If the Tribunal is to explicitly consider psychological interventions, the Society recommends psychologists be considered as Tribunal members.

## **8.Offenders**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

### **Why do you think that?:**

We believe that any system for supporting communication within the legal system would be helpful.

Offenders detained in hospital are admitted or detained in order to receive help in coping better with problems in life, and in changing their thinking and behaviour to try to reduce the likelihood of getting involved in offending behaviour again.

We welcome the principle that individuals are not detained/incarcerated due to disability longer than sentences for individuals who have committed the same crime. There's a contrast to be drawn between individuals (who do not have learning disabilities) who have completed sentences and are released when they've completed their sentence, even when their risk of re-offending is determined to be high, and those people who have committed similar offences, but are not released from detention because their risk remains high – and they have a learning disability. There is a concern that seeking to continue to detain people just because they have a learning disability is paternalistic and discriminatory. We are aware there are some lessons to be learnt from the New Zealand experience, where they sought to do this but, we understand, did not progress because of a fear of re-offending. Looking to actual re-offending statistics would be helpful when considering public risk when making recommendations for legislative changes in forensic services for people with a learning disability and/or autism.

We would welcome the use of intermediaries although whether this will be sufficient to abandon an 'examination of facts' in all cases is questionable as some

individuals may still not be able to participate effectively in a trial even with an excellent intermediary in place. We are mindful at our meeting on 3rd October the

Review team discussed that some examination of facts would need to be conducted but we are unclear what the boundaries would be for this.

We note that the Review acknowledges that despite any supports and reasonable adjustments some people may still not be able to stand trial. The Society is

aware that previously in the document the Review stated all persons would be deemed to have legal capacity and feel these contradictory statements require some clarification.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

The Society recommends clarification around:

- If and when examination of facts would continue to be required
- A possible inconsistency in the document that some people may not be able to stand trial but that all people would be deemed to have legal capacity.

## **9. Where support, care and treatment happens for offenders**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

### **Why do you think that?:**

The Society agrees that people with a learning disability and / or autism should have the same rights to rehabilitation as others, as long as they are not putting

themselves or others at undue risk during this time. However, it wishes to highlight that many people are very upset or distressed or unwell immediately after

involvement in offending and not immediately ready to behave in safe ways, Thus a secure environment may initially be required on occasions.

The Society supports the idea of facilitating access to community based sentences, but it needs to be recognised that this will need appropriate adaptations and appropriately trained staff to be in place.

The Society has concerns about the ability of 'rehabilitation centres' to deal appropriately with the very complex needs of individuals currently detained in medium

and low secure forensic settings as, to ensure the safety of other service users and staff they would still need the same physical security as in current services set up.

The Society is concerned about the safety of many vulnerable people with a learning disability and / or autism who cannot always speak for themselves. Prison would not be safe for such people and the Society would welcome more detail about how specially designed or adapted prison accommodation would be used for people with a learning disability and / or autism.

## **2 Could these ideas be made better?**

Yes

### **How could these ideas be made better?:**

The Society notes that many people are very upset or distressed or unwell immediately after involvement in offending and not immediately ready to behave in safe ways, Therefore a secure environment may initially be required on occasions.

Facilitating access to community based sentences is recommended but it needs to be recognised that this will need appropriate adaptations and appropriately trained (and supervised) staff to be in place.

We have concerns about the ability of 'rehabilitation centres' to deal appropriately with the very complex needs of those individuals currently detained in medium and low secure forensic settings regarding the physical security in place for themselves and others.

We believe that more clarification is needed on how specially designed or adapted prison accommodation would be used for people with a learning disability and / or autism. There are also questions whether this would end up recreating hospital areas in prison or are all prisons to have a 'special area'. In Scotland the numbers are so low that there may be a special area in one prison (but that would then have offenders with learning disability and / or autism in a place far from families and friends).

## **10. What this means for the law**

### **1 What do you think about the ideas in this section?**

I have mixed feelings about the ideas

### **Why do you think that?:**

Please find all Society comments within the main body of this response.

## **2 Could these ideas be made better?**

Not Answered

### **How could these ideas be made better?:**

Please find all Society comments within the main body of this response.

## **About you**

### **1 What is your name?**

**Name:**

Joe Liardet

### **2 Are you taking part as an individual person, as a professional or as a group of people?**

A Group

### **3 Do any of these apply to you?**

None of the above

### **4 If you are taking part as a professional, what is your profession?**

**Profession:**

### **5 If you are taking part as a group, what is the name of your group?**

**name of group:**

British Psychological Society

### **6 Do you live in Scotland?**

Yes

### **7 Do you want us to publish your response?**

Yes please publish my response anonymously

### **If you want to say anything else at all please say it here:**

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a

registered charity with a total membership of just over 60,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and

applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are

committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

#### Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content NHS Scotland to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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#### About this Response

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