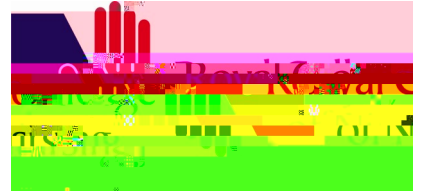


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Additional Comments

We deal with five matters not otherwise dealt with above: conflicting rights, an enhanced role for nursing; shifting care from hospital to the community; the introduction of a National Care Service and mental health care and treatment pathways.

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RCN's views on the proposed principles

RCN does not disagree with the opening propositions in this section, that 'the purpose of the law should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled and that it should 'seek to ensure that the wider needs of people with mental disorder are met' or with the four attendant principles:

- x Respect for dignity.
- x Respect for autonomy.
- x Non-discrimination and equality.
- x Inclusion

Nor do we disagree with the potential inclusion of a principle of respect for carers, a specific principle concerning the rights of children and a principle of reciprocity.

In pursuit of the realisation and accessibility of rights we understand the need to consider what duties should be placed on delivery bodies and we accept the review's 'current thinking' (p. 37) concerning core minimum obligations; reframing health and social care duties in terms of human rights standards; monitoring; and recasting the Scottish Mental Health Strategy.

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The consultation states (p. 44) that: 'we have heard from many, that individuals' views must compete with other principles, practices and cultures that might be more favourable to non-consensual intervention and that inadequate service provision has an impact as well.'

Whatever 'principles, practices and cultures' may have grown up organically in specific situations there are no 'principles, practices and cultures' inherent in, or proscribed for, the ethos and professional practice of nursing that are inimical to the

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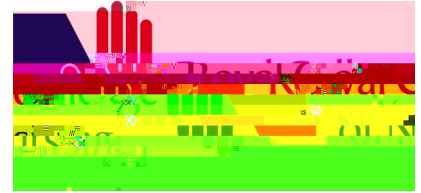
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In our original submission we stated that ‘a human rights-based approach to (the) review has been welcomed by our members’ and that the review could improve the law’s recognition of social, economic and cultural rights. We are pleased to see, from the consultation, that the review has proceeded very much along these lines.

That being the case, and given the nature of our response so far, we are broadly supportive of the ‘proposed recommendation’ (p. 66) for ‘the inclusion in law of a framework which enables respect for human rights; to ensure a focus on respect for the will and preferences of people with mental disorder, whilst at the same time ensuring appropriate support and protection. The framework applies irrespective of diagnosis and would be applied in situations currently covered by mental health, adults with incapacity and adult support legislation’.

We also broadly support the new concept of ‘human rights enablement (HRE)’ informing processes such as those outlined on p. 68 (community care assessments etc.). However, we note that the language of the consultation, despite talking about HRE as ‘not a one-off or discrete event but rather an underpinning process’ (p. 67) quickly turns HRE from a verb into a noun (human rights

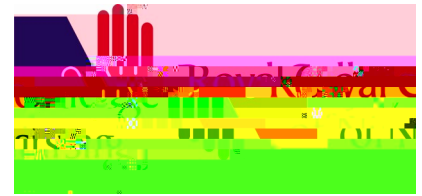


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This is not to argue against the introduction of an HRE per se. We understand the review's imperative (and that there is an obvious argument that if we waited for public sector digital provision to catch up with what we needed it to do we might never do anything at all) but we must ask whether, in this particular instance, it is sensible to make legal provision for something that is going to prove either undeliverable because of inadequate resources or, perhaps worse, end up being a half-hearted 'tick box' exercise because those who have to undertake it have no real appreciation of what it is supposed to be about or to achieve. The consultation paragraph that most obviously encapsulates the problem is the one on p. 69 under 'Things to consider as part of an HRE evaluation are', which reads: 'Have all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment? A record should be made of this consideration. This record should be easily accessible for ease of later review.'

Even if the HRE is limited to the list of European Convention on Human Rights (ECHR) and International Covenant on Economic, Social and Cultural Rights (ICESCR) and the derived rights contained in recommendations 1(a), 1(b) and 2 of the National Taskforce for Human Rights Leadership (NTHRL, <https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/pages/4/>) this still amounts to twenty-one rights. Will they all be listed on the form, with a requirement to explain how each has been assessed as being met or not being met, how and to what extent?

It is unfortunate that the review has not found itself in a position to set out in much greater detail at this stage how an HRE would or could work for those who would be required to undertake it and exactly which existing processes the HRE would 'build upon', rather than providing a few examples (on p. 68). We note that that the consultation asks a question about the 'triggers' for an HRE but the review is better placed than any respondent to take the overview of which processes the HRE would 'build upon' because only the review has the clear picture of what its own proposal (the HRE) is intended to achieve. Much more detail is required if any truly useful detailed comment is to be offered. As the proposal stands it is impossible to understand what an HRE form would look like to, for example, a nurse making a decision to detain pending medical examination under section 299 of the 2003 Act or a nurse seeking to safeguard or promote the physical or mental health of an adult under section 47 of the 2000 Act or for an approved medical practitioner conducting a medical examination of a patient for the purposes of an application for a compulsory treatment order under sections 57 and 58 of the 2003 Act. Delaying this detailed thinking until such time as a Code of Practice is written (as is implied by the proposal for a code on p. 76) is an inadequate approach in the circumstances.



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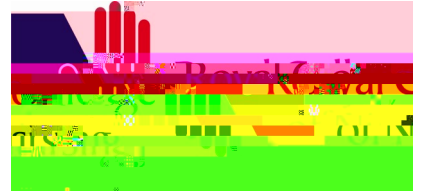
The proposals for a requirement for there to be action on the outcomes of the HRE (pp. 72-73) and rights of remedy and appeal (p. 74) only make the provision of greater detail all the more important. If an employing body has responsibility for the former and liability for the latter, that body will want to be sure that every HRE form is watertight by way of ensuring that everyone who has to complete it understands human, economic, social and cultural rights to the same extent. Under the NMC Code of Practice nurses must already 'respect and uphold people's human rights' (par. 1.5) but we wonder whether the review is guilty of understatement when it notes on p. 76 'that to develop a coordinated, formal HRE structure will require a strategy of training and awareness raising to realise the progressive change needed'. We suggest that a considerable programme of enhanced education, including adding to the content of university degrees, would be necessary to ensure the national consistency of practice across professions that will be required.

We have three other significant concerns with the HRE proposal:

1. The lack of detail provided on how responsibility and accountability for an HRE works as between its 'initiator', those 'additional practitioners' (both referenced on p. 70) who may 'review and revise' it (presumably this counts as 'formal updating' as per p. 73), those 'different practitioners (who) become involved and consider the person's needs from their specialist perspective' (also p. 70) and whoever is responsible for storing the HRE 'accessibly in the patient record' and ensuring that 'the record is placed in all relevant health and social care files' (p. 75, apparently this is to be done manually given the issues with IT cited and on which, see below). Which one of these people is or should be the 'identified professional responsible for ensuring that there is proper coordination, and that a coherent HRE plan is developed?' (p. 70). Might this person be the 'holder' of the HRE? Will this person be empowered to act if someone who has 'made or been involved with the assessment' fails to 'inform others', as per their proposed duty (p. 75)? The impression given throughout this section is that there is to be created a towering paper-based bureaucracy without any clear lines of accountability or governance (clinical governance and otherwise), to compensate for the fact that we cannot yet create a shared digital record to which a HRE could more straightforwardly be added. We cannot support this poorly expounded approach to implementing in practice what we otherwise support in principle. It is incumbent upon the review, not upon respondents to this consultation, to set out a far clearer process and set of relationships, responsibilities and accountabilities as between those who will have to operationalise the HRE in practice.
2. The lack of detail provided about how a person (or body) responsible for undertaking an HRE is expected to action its outcomes (p. 72-73) when to do so involves matters outwith the control (in whole or in part) of the person or body.

2. (cont). The risk and implications of creating a two-tier system associated with providing a greater level of support for the advancement of the human, economic, social and cultural rights of people with a 'mental disorder' than that available to others in general but more especially over other groups demonstrably subject to perceived vulnerability or unequal treatment. We appreciate that that the review may consider that the National Taskforce for Human Rights Leadership (NTHRL)'s recommendations <https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/pages/4/once-implemented>, will create a universal system to which the review's proposals will add a necessary extra support for an especially vulnerable group. However, aside from it being the review's remit to focus on a particular part of our society and group of people, it is not clear why this group is more or less vulnerable (and so should have support for it prioritised) than other vulnerable groups.

3. To make use of the same example from the consultation involving 'suitable accommodation', why should a housing related HRE issue be prioritised for a person with a mental disorder and with 'repeated chest infections', solely as a result of that person 'qualifying' for an HRE, when, for example, a person of colour without a mental disorder but also with 'repeated chest infections' may be equally in need of 'suitable accommodation' but cannot avail themselves of the benefits of having somebody responsible for actioning the outcomes of their HRE because they do not qualify for an HRE. This, if anything, is an argument for extending the concept of an HRE to all public services, not least because all public authorities are already required to operate their services under the current law in a way that is compliant with human rights at all points. If we need an HRE in mental health, it is arguably an indication that those services are somehow failing to comply with their current responsibilities via-a-vis human rights and if that is the case might there not be a similar problem across all public services that a 'universal HRE' would solve? The proposals for remedy and appeal also create a parallel structure whereby one group may be able to access a sympathetic, supportive and ultimately more effective process, perhaps run by the Mental Welfare Commission (p. 74), whereas other equally if differently vulnerable or discriminated against people may only have recourse to the 'main' system, whether this is an 'overarching framework for the protection of everyone's human rights' created in line with the NTHRL recommendations (p. 107), or the existing system. There is an argument that what we need is a universal system capable of accommodating all situations and of providing 'extra support' to a range of vulnerable groups, perhaps defined using on equalities law. Alternatively, we may need a range of extra supports outside the main system to accommodate those groups. The review's recommendations should set out



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We agree that it is not sensible to always require that 'the person who has completed the HRE (to) be the person completing the ADM test'. Until the matters of responsibility and accountability for the HRE discussed in our response to section 5 are clarified there can be no guarantee that there will even be a single identifiable individual with primary responsibility for the HRE who can be called upon to conduct the ADM (or for any other reason, for that matter).

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Under the Code of Practice nurses themselves 'must respect and uphold people's human rights' (as noted in our response to section 5) but they must also 'make sure that those receiving care are treated with respect, that their rights are upheld and

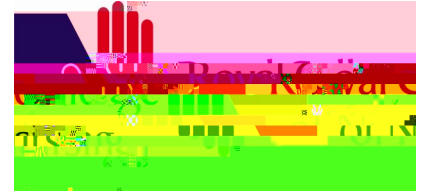
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The review says that it recognises that ‘

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Therefore, we must ask if the review's proposals at p. 95-98 can work and to what extent they can be established or promoted by changes to the law. It seems to us that the latter can only be achieved if certain types of services, including the stated the ethos of such services, are mandated at law and regulated (and inspected) on that basis, although we suspect that, at law (i.e., 'on paper'), most such systems would provide for such things already and it is in the breach that problems arise. Care services would be the obvious comparator. That said, much law (including the 2003 and 2000 Acts) now contains principles, which do assist in the interpretation and implementation of the law and so have value. The question remains, however: if we already have such law why do our services continue to operate in problematic ways? We would suggest that this is typically a question of under



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Despite purporting to seek to address ‘the use of coercion as a systemic issue’ (p. 89), the consultation does not make out that inappropriate coercion is a systemic issue or that current safeguards are inadequate (and in what way). We therefore cannot take a view on whether the Mental Welfare Commission needs stronger powers. As for the point on compulsory treatment orders (CTOs); if the data on rising rates of detention and increased use of CTOs is incapable of demonstrating whether these rises and increases are for ‘good’ or ‘bad’ reasons then, either the review has to recommend that the Scottish Government begins to collect such data on them as is capable of demonstrating that, and any changes to the law must wait for the results, or it must recommend that the Scottish Government accepts the principle that coercion in all but the most extreme case should be eliminated and that the law is changed to reflect that principle in all cases of coercion for which the law currently provides or may come to provide for. The problem with the latter approach is that there is almost certainly an argument that this is what the current law already does and so changing the law won’t solve the problem. The former approach is more precise in identifying the exact failings of the law but is obviously more laborious and time consuming. Nevertheless, it may ultimately prove to be the better alternative in terms of creating effective legislation.

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We agree that there must be a strong accountability framework enabling 'people (to) know what their rights are..what they can do and where they can go if they feel their human rights are being violated (with) clear and accessible ways for people to challenge this and seek a remedy or solution' (p. 106).

In keeping with our comments on section 5, on the risk of creating a two-tier system, we consider that the review must provide much greater clarity in its final recommendations than is present in this consultation on how the review's proposals should marry up with the recommendations of the National Taskforce for Human Rights Leadership.

The 'recommendations and ideas for strengthening the accountability framework for mental health and incapacity laws' (p. 110) contained in this section are quite specific to what would be elements of any future framework and, in fact, several of them could be introduced as additions to the current system even if the much greater surrounding change being proposed was not being proposed.

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We are supportive of the idea that powers of certain bodies to recommend actions (or to make statements that equate to recommendations for all practical purposes) are underpinned by enforcement powers and that resource allocation (including appropriate staffing both in terms of roles and levels of qualification and competency) accounts for the fact and the likelihood of services being required to change and adapt in response to such recommendations. Having said that, we agree with the review that any such powers should not 'be used to require professionals to deliver care which they do not believe can be clinically justified'.

We are supportive in the manner described above because we consider that it is the principled position to take but, given the prevalence of nursing in mental health services, and as an organisation that represents a group of people comprising both a profession and a workforce, we are bound to point out that those people have human, social, economic and cultural rights too, in that capacity, as well as in their capacity as citizens. In the context of accountability, the right to a fair trial (which is, of course, applicable to processes akin to court processes and not to those processes alone) is perhaps most obviously applicable but many other rights are potentially exercisable by an employee or worker with respect to an employer and a workplace. Whatever system eventually results from the review's recommendations it must account for the need to balance the rights of different parties to the same processes if the most effective person-centred care and treatment is to be widely promulgated. There should never be a situation where the rights of employees or workers are considered pl st

5.2.2.3.4. Proposed provisions

In terms of this consultation, the specifics of what is proposed under the headings of this section:

- x Principles
- x Rights to support
- x Crisis services
- x Age-appropriate services including 17

11.3.3.2 Proposed roles for the future

In terms of this consultation, the specifics of what is proposed under the headings of this section

- x Guardianship (including decision-making framework, decision-making supporter, co-decision maker, decision-making representative, support and supervision, application process, emergency provision, access to funds and management of residents' finances, codes of practice and guidance, transitional provisions)
- x Power of Attorney

do not conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make detailed comment other than what follows.

Any changes must be very clearly communicated to health and care staff. They must never be in any doubt as to who, of the individual themselves, the roles proposed to replace 'guardianship' and the existing role of the person who holds a Power of Attorney ('the attorney', a role which the review does not appear to propose to abolish, replace or fundamentally change), has final decision-making powers about the care and treatment of an individual as it will be those health and care staff who will have to provide that care and treatment.

Based on the consultation document and our understanding of the law (which we acknowledge is not that of an expert) there seems to be a considerable overlap between existing roles such as guardians, attorneys, advocates and named persons and proposed roles such as decision-making supporter and decision-making

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The consultation does not ask a question that relates to the information provided in this section, so we offer comment on the points made as we understand them:

It may be that it would be more effective to change the language of the above Code rather than of the law itself, but this is not a point on which we have a strong view. In any case, we do agree that, whether it is in the Code or in the law, there is merit in amending the language to make it clear that the authorised person is expected to have considered the will and preferences of the adult concerned as that will and preferences have been determined in whole or in part as a result of any supported decision making process / autonomous decision making test (whether taking place prior to or as a part of the circumstances giving rise to the need to certify) to the extent that it is reasonable and practical in the circumstances.

Otherwise, there may be merit in exploring whether or not treatment might be differentiated so that a requirement to account for the results of any supported decision-making process / autonomous decision-making test is dependent on the nature of the treatment and the circumstances, in a similar way to the way that Part 16 of the 2003 Act operates. That said, we have not given the matter of differentiation detailed consideration and we recognise that it may unnecessarily overcomplicate the law to no useful effect, which is why exploration of the matter is all that are prepared to advocate for at this point. Again, changes to the Code of Practice may be preferred to changes to the law.

We have no objection to the proposal to authorise other suitably trained and supervised practitioners, including psychologists, to issue a section 47 certificate relating to the treatment that they offer.

We suggest that introducing any audit or analysis of section 47 certificates is entirely reliant on 'technology making it possible to build in checks during completion to ensure that practitioners address themselves to the right issues, and for the certificates to be electronically recorded' (p. 165) and that no such audit or analysis should be introduced until such time as that technology can be made available to practitioners.

We also consider that if 'a huge number of (section 47) certificates' (p. 165) areP

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We agree that this restriction on treatment is too wide, particularly given the length of time many guardianship applications can take.

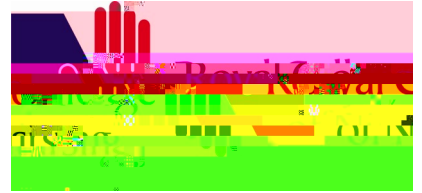
We agree that 'the procedure works reasonably well and does not require to be substantially amended'.

Given our comment above, with respect to the nine proposals on p 168-169 our position is as follows:

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Agree but it should only be introduced at such time as the enabling technology can be made available to practitioners.

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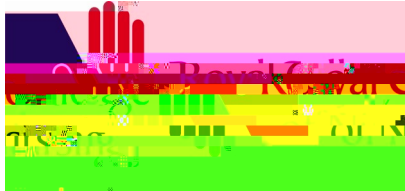
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Agree on the assumption that section 49(2) would still apply to any treatment that was the subject of dispute. We do not take this proposal to be seeking to sanction the withholding of treatment 'authorised by any other enactment or rule of law for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition'.



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The proposals in this section do not appear to us to conflict with the ethos and professional practice of nursing or appear likely to operate to the detriment of nursing as a workforce to the extent that we feel it necessary to make comment.

There will always be disagreement over the most sensitive language to use in areas such as mental health law, often most vociferously amongst the group of people being 'labelled'. For example, at the time of the closure of long stay hospitals for people with learning disabilities (in the late 1990s) the term 'learning difficulty' was seen by those subject to the term as far more progressive than the term 'learning disability', which those same people had fought hard to reject and yet which is now generally preferred. Within the disability movement at present there remains disagreement between activists over whether the term 'disabled people' or the term 'people with disabilities' is to be preferred.

It strikes us that whatever overall term is used in mental health law, there will have to be further differentiated definitions of that term (including diagnostic definitions) to do with the extent/profundity of a person's 'condition' and its effect on them, and which serve to identify the appropriate/possible care and treatment pathways for that person (including compulsory care and treatment, force and detention). Such differentiated definitions will inevitably, but not necessarily wrongly, affect the extent to which any given person may enjoy their rights.

The review's commendable aim to move to a system more focused on autonomous decision making will, if realised, still sit in the context of system where, as is clear from the consultation's discussion in section 7, some element of coercion will have to remain 'as a necessary and proportionate...part of promoting and protecting all of a person's relevant human rights' (p. 90). It is arguably those cases involving elements of coercion where the language applied is most stigmatising because it seeks to capture more extreme situations and therefore becomes more extreme, or at least emphatic, itself (as in 'significantly impaired decision-making ability').

That being the case, we hesitate to offer a view on the 'best' term to use, but we suggest that, for an overall term, 'mental health condition' might be the least stigmatising of those posited in the consultation. In any case nursing staff have adapted and will continue to adapt their language in order to most appropriately support those for whom they care and whom they treat in accordance with the wishes of those people and with the ethos of nursing as a profession of those

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Acknowledging the challenges to doing so we nevertheless support fused legislation. That is because it brings the opportunity for clarity as to core concepts, which are presently applicable across separate pieces of legislation, and the opportunity to bring a strong internal, intellectual logic and coherence to the law because a single Act, in terms of standard approaches to legislative interpretation, will be a mutually reinforcing guide to itself, at least in part.

From the point of view of nursing, whilst practitioners must, and do, familiarise themselves with the law applica- t, p ly

National Care Service

The consultation acknowledges the proposals for a National Care Services (NCS) but, because those proposals are at such an early stage, beyond noting some of the potential interconnections between the review's recommendations and whatever is ultimately proposed for an NCS, the review is understandably unable to be specific about how they may cohere or be interdependent. It also notes (on p.5) that 'by the time our final report is published we anticipate that legislation to create a National Care Service for Scotland will have been introduced in the Scottish Parliament. Our final report will reflect on this and its impact on the matters the Review is concerned with.' In RCN's response to the NCS consultation we acknowledged the review noting that 'any changes to delivery of mental health services must coincide with renewed urgency around reform of mental health legislation, with an emphasis on improving services and embedding the rights of people using them'. We also noted that '

