

Mental Health (Care and Treatment) (Scotland) Act 2003 Review

SCoD is putting together a response to the Mental Health Act Review. If you are deaf, care for a deaf person or support deaf people in the community/hospital and would like to have your comments included in this response, please look at the information from the Review Group below and email any comments to Mandy Reid, Policy & Research Officer at mandy@scod.org.uk or send them by post to Mandy Reid, Scottish Council on Deafness, Central Chambers Suite 62, 93 Hope Street, Glasgow G2 6LD.

Mandy does not need your name – if you want to remain anonymous – but she does need to know where in Scotland you live/work and if you are:

- Deaf yourself;
- A carer for a deaf person; or
- Support deaf people in the community or in hospital.

Mandy needs your comments by **5pm on Friday 3rd October 2008**.

MENTAL HEALTH ACT REVIEW

The Scottish Government has set up an independent Group to carry out a limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003, with the following terms of reference:

- To consider the operation of the processes in respect of the civil provisions of the Act in the context of the ten Millan Principles and advise on changes that should be made to improve the efficiency of the operation of the Act and the experience of patients; and
- To advise on other minor amendments to the Act to resolve technical or other issues as provided to the Review Group by the Scottish Government to consider; and
- To report to the Minister for Public Health with recommendations following appropriate engagement with those with an interest in the operation of the Act.

The Review Group is already aware of a number of issues about the operation of the Act from submissions made to the Government. Information from surveys and research activity will be, or already is, available to the Group.

The Review Group will also be arranging consultation events and meetings with people and professional organisations who have an interest in the operation of the Act.

This consultation paper sets out a number of the key areas where it has already been suggested that reform is necessary. It is not exclusive and the Group would welcome comments on any other area of the operation of the Act.

These are:

- Named Persons
- Advance Statements
- Second opinions - medical
- Mental Health Officer availability
- Mental health Tribunals
- Suspension of Detention

NAMED PERSONS

Background

Under the 1984 Act, which the 2003 Act replaced, the nearest relative of a patient had certain rights and responsibilities in relation to:

- Detention of the person in hospital
- Asking that the patient be discharged from hospital; and
- Receiving information.

What the Act provides

The 2003 Act allows a patient to nominate a Named Person, while recognising that many people will still wish their primary carer or nearest relative to act in that role.

The arrangements introduced by the 2003 Act have, generally, provided greater choice for patients but there have been some unintended consequences.

Issues for this Review

The Tribunal Rules state that a Named Person is a “Party” to the hearing. This means they receive all of the papers, including reports that contain medical and other sensitive information that a patient may not wish disclosed. This may be discouraging some patients from appointing a Named Person and not encouraging others to take up the role. Equally, Named Persons might find reading the whole record distressing.

Q1. Do you think Named Persons should be a full Party to Tribunal Hearings and receive all the papers, including confidential information about the patient?

If no, please give your reasons.

A person, over 16 years old, can nominate someone to be their Named Person.

But

- If no-one is nominated, the primary carer becomes the Named Person.
- If there is no primary carer, the nearest relative becomes the Named Person.
- Where no-one has been nominated, the main carer or nearest relative is the Named Person by default.

The patient can specify someone whom they do not wish to act as their Named Person. But there are no specific arrangements for the patient to say that they do not want to have anyone act as a Named Person.

Some people who have been patients in hospital for many years may wish to have a Named Person, but have no relatives or friends outside hospital to nominate.

Q 2. Do you think patients should be able to state that they do not wish to have a Named Person?

Q 3. Do you have any suggestions as to how a patient who wishes to have a Named Person but has no-one to act in that role could be provided with an appropriate person?

Q 4. When a patient has not made a nomination do you think that the present arrangements for a Named Person by default are appropriate? If no, please give your reasons.

The role of Named Person carries important responsibilities.

Q 5. Do you think Named Persons have sufficient preparation for their role?

Q 6. Do you have any suggestions for improving the support available to Named Persons?

Q 7. Do you have any other comments about the role of Named Persons?

ADVANCE STATEMENTS

Background

Advance Statements enable a person to set out how they would wish to be treated, or not be treated, for mental disorder if their ability to make decisions about their treatment becomes significantly impaired because of their mental illness.

What the Act provides

The principles of the 2003 Act require doctors and others carrying out functions under the Act to take account of the past and present wishes and feelings of a patient.

While not the only way to be sure of the patient's past and present wishes about treatment, an Advance Statement can be an important method of doing so and can also promote participation by a patient in care and treatment decisions.

Issues for this Review

The number of people making Advance Statements appears to have been lower than expected.

Q 8. Why do you think this is?

Q 9. How could the number be increased?

SECOND OPINIONS

CTO applications require a second medical opinion: from the patient's GP or, when the GP is unable to provide the report, from an independent Approved Medical Practitioner.

These arrangements allow for a medical report from a doctor who is a specialist (psychiatrist/psychologist) and a doctor (the GP) who has knowledge of the patient and direct responsibility for his or her primary care.

Where the GP is not available, an independent Approved Medical Practitioner can provide the second report. The Act says that the two Approved Medical Practitioners providing the medical reports cannot work in the same hospital. This is to ensure that there is no conflict of interest in the 2 reports and to make sure they are independent of each other. This is causing a problem in areas where there is only one hospital admitting detained patients, particularly the more rural areas.

One possible solution is to amend the legislation so only one medical report is required, which would come from the Responsible Medical Officer (a psychiatrist). The Tribunal would, as a matter of course, ask for an independent report from an Approved Medical Practitioner when it receives the papers. However, this solution would remove the requirement for GPs to provide the second report and potentially disconnect primary care from the process.

Q 10. Who do you think should provide medical reports?

Q 11. Do you have any suggestions to address the problem of perceived or actual conflicts of interest?

MENTAL HEALTH OFFICER (MHO) AVAILABILITY

What the Act provides

The Act requires the Approved Medical Practitioner to obtain MHO consent to an Emergency Detention or to provide an explanation of why this was not possible. In the case of Short Term Detentions, MHO consent must be in place.

Issues for this Review

The time spent awaiting MHO assessment for Emergency or Short Term Detentions varies throughout Scotland but can exceed several hours,

particularly in rural areas. There is a potential conflict between the need to obtain MHO consent and to minimise the time a patient is detained.

Questions have been raised about the status of a patient once a doctor has decided to detain them, but while the MHO assessment and decision is still awaited.

- On the one hand, urgent Emergency Detention is possible without MHO consent and the principle of least restriction means that the total time a patient is detained should be kept to a minimum.
- On the other hand, the provision of MHO consent provides additional safeguards for the patient.

A possible solution might be to create a period of time a patient can be compulsorily held after medical examination to allow an MHO to attend, though this does have implications for the least restrictive requirement.

Q 12. Do you think there should be a period of time when a patient can be detained in hospital to allow an MHO to attend?

Q 13. How else could this situation be improved?

TRIBUNALS

Mental Health Tribunals were introduced to Scotland in October 2005. Before then, hearings about compulsory detention under mental health law took place in sheriff courts.

Most people seem to approve of the new tribunal system, but there is a recognition that some areas of concern exist. The results of research being carried out by the Scottish Government and of a survey that has been commissioned by the Mental Welfare Commission, into how the Tribunal operates will feed into the debate about how these problem areas can best be addressed.

In addition, the general oversight of tribunals is a matter for the Administration, Justice and Tribunals Council (AJTC) and information gathered in these surveys and in the work of the AJTC will feed into this Review.

Some issues that have already been raised include:

The volume of interim orders

There have been a high number of Interim Compulsory Treatment Orders issued by tribunals. This has mainly been when there has been an application for a CTO for a patient already subject to short-term detention. In some cases there are several hearings before the tribunal is able to decide whether an order is appropriate.

There may be several possible causes for this:

- The timescales for CTO applications are very tight. For a patient subject to a short-term order (which lasts for 28 days) the hearing must be held before the end of the patient's short-term detention, although the detention can be extended by three days (in specific circumstances) and for a further five days to allow the hearing to be held.
- Delays while the patient's solicitor explores the options.
- Delays in getting an independent medical report(s) for the patient.
- Problems around the appointment of someone to act as a curator *ad litem* (The person who acts when a patient's mental capacity means he or she is unable to appoint a solicitor).
- Witnesses being unable to attend due to the short notice of the hearing.

Q 14. Are you aware of any other factors which may affect the number of hearings held?

The Review Group thinks that having several hearings is not generally in the best interests of service users, named persons or carers. It can cause distress and also involves considerable expense in terms of money and staff time.

We wish to explore ways of. There are two suggestions that might reduce the number of hearings for the patient. These are set out in **bold type** below:

Lengthen the timescales in the Act by which a first hearing must be held.

The Act could be changed to provide that once the mental health officer has made an application for a community treatment order, the short-term detention of a patient would be extended for up to 28 days.

There could then be a further renewal for 28 days, if it was felt that this was in the interests of the patient. This would enable all the necessary reports to be obtained. The law would also need to be changed to ensure that appeals against short-term detention are held promptly, within the 28 days.

Allow short preliminary hearings and interim orders without all the parties present.

Make provision (as in the sheriff court) for short preliminary hearings to hear and consider issues (such as requests for adjournment), from legal representatives and others, without the need for the service user and other witnesses to attend.

The tribunal rules (and if necessary the Act) could be clarified to state that where it appeared that the patient's representative would not have the information he or she needed by the date set for the hearing, the tribunal could grant an interim order, if there appeared to be grounds for doing this, without holding a formal hearing.

Q 15. What are your views on these suggestions?

Q 16. Do you have any alternative suggestions for reducing the number of hearings required, in a manner that benefits the service user?

Representatives at tribunals

This section looks at the roles of the different parties and representatives appearing before the tribunal.

It has been suggested that it may be difficult in some parts of the country for service users to find **solicitors** to represent them at hearings. To represent service users effectively solicitors need to have relevant qualifications and expertise.

Q 17. Do you have any comments on how easy or difficult it is to get appropriate legal representation?

Many service users who are involved in tribunal hearings have the support of independent advocates.

Q 18. Is the role of independent advocates clear to everyone at the tribunal?

Q 19. If no, have you any suggestions how this might be improved?

Q 20. In your experience, is independent advocacy generally available for people coming before the tribunals?

Q 21. Is independent advocacy effective in helping service users to participate in tribunal proceedings?

Confidentiality

The tribunal rules allow the tribunal to withhold part of a document from one of the parties, e.g. when the document is considered potentially harmful.

Q 22. Are the present provisions working satisfactorily? If no, please explain why.

The Tribunal and the provision of care plans

Q 23. In your experience, is sufficient regard given by the tribunal to the importance of the provision of care plans to people subject to compulsion?

Appeals and reviews

There has been some concern that appeals against orders are taking too long to be resolved. The Act does not set out any time limits for the hearing of appeals.

Q 24. Do you have any comments about this?

Q 25. If there is a problem, how might this be resolved?

If a tribunal makes a clear legal error in reaching a decision, the only way to amend this is if one of the parties appeals to the Sheriff Principal. This happens only rarely.

It has been suggested that it should be possible for the President to review decisions of individual tribunals and set aside decisions where there is a clear legal error.

Q 26. Do you have any comments on this suggestion?

SUSPENSION OF DETENTION

What the Act provides

If a detained patient has had his/her detention suspended and been out of hospital for a total of nine months within a 12 month period, no further discharges on suspension can be permitted. In these circumstances the order detaining the patient would normally be revoked.

Issues for this Review

In some circumstances, this rule, intended as a safeguard, can interfere with the principle of least restriction.

The following example may help to illustrate the problem:

- Jean, a detained patient, has been in and out of hospital as part of her rehabilitation programme. Towards the end of the year, Jean has a relapse requiring treatment in hospital. She recovers in hospital to the point where she would normally be discharged on suspension but, because she has already had periods of suspension totalling 9 months over the past year, suspension is not an option. Because of the 9 month in any 12 month restriction, her RMO is able only to *either* restrict Jean unnecessarily to hospital or to fully revoke the CTO to allow discharge. Neither option may be in Jean's best interests – a situation which runs counter to the Millan principles.

Q 27. Do you think the 9 month in any 12 month restriction to a suspension period is the best way of organising this?

Q 28. How else could a patient be protected from hospital based orders continuing longer than required without the drawback described above?

The 9 months rule requires hospitals to keep an accurate account of the periods of time a patient's detention is suspended.

Q 29. Does this lead to difficulties in practice?

Other questions for comment:

Q 30. Are there any matters relating to the tribunal which are not covered by the questions above and which you would like to bring to the attention of the Group?

Q 31. Are there any other matters relating to the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 which you would like to bring to the attention of the Group?