MENTAL WELFARE COMMISSION FOR SCOTLAND

RESPONSE TO CONSULTATION ON PROPOSALS FOR A MENTAL HEALTH AMENDMENT BILL

The Commission welcomes the opportunity to comment on the proposed amendments. We also submit some further suggestions for improvements to the legislation.

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions?

We support both these proposals. There is an additional issue about capacity to make an advance statement. We find that several advance statements are made by individuals who are, at the time, subject to compulsory measures. While this would not automatically prevent the individual from competently making an advance statement, it sheds some doubt on capacity. In this situation, we recommend that the capacity to properly intend the wishes in the advance statement is certified by an approved medical practitioner.

Question 2: Do you have any comments on the proposed amendments to the named person provisions.

We support most of these proposals. It is important to be consistent about named person provisions and we address this later in our reply.

In relation to the various applications to the Tribunal by the named person, we assume that the Tribunal will automatically grant leave if the named person has been nominated by the patient. In other cases, the Tribunal may have discretion as to whether or not to give leave to the named person. We think this needs to be clearer in primary legislation. We also think that someone with parental responsibilities should also have the automatic right to be granted leave by the Tribunal to appeal.

Not mentioned in the consultation document is the new S251(4A). As we read this new section, the primary carer will only be the “default” named person if he/she has consented in writing. Whose role is it to obtain this consent? And if the person does not consent, why does the nearest relative then become the named person with no requirement to consent? We cannot see the logic for this amendment.

Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions?

We would have some anxiety were there to be only one medical recommendation in support of a compulsory treatment order. We agree with the proposal to allow the general practitioner to comment on the report of the approved medical practitioner. We also agree that it is important that the patient can instruct his/her own report.

However, there is presently no requirement for this report to be produced at the Tribunal. And the Tribunal's discretion to instruct a report is an insufficient safeguard.

We consider it essential that the tribunal has more than one medical opinion at its disposal before it grants a compulsory treatment order. This could come from the GP, an independent medical practitioner instructed by the patient, or a medical practitioner instructed by the Tribunal.

We note that the consultation document does not include the recommendation from the McManus committee that the short-term detention period should be extended by ten working days, rather than the five working days at present. We would not have been in favour of the longer period. Effectively, the individual could be subjected to deprivation of liberty and compulsory treatment for up to 42 days before there is any external independent judicial review.

A further issue is that the proposed amendment places the responsibility for obtaining a report from the general practitioner on the MHO. As the Act stands at present, there is no specification as to the responsibility to obtain the medical reports. In practice, this is done by hospital managers. We have concerns about placing further burdens on MHOs and advise that either the responsibility should not be specified or that it should be placed on hospital managers.

We are assuming that the conflict of interest regulation in relation to medical practitioners working in independent hospitals will remain. In this case, we also recommend that the issue of conflict of interest in relation to extension of orders is resolved. The extension should be based on an examination by an AMP who is not contracted to the independent hospital.

Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions?

We advised that the 9 month in 12 provision was unworkable. However, there are potential problems with suspension of detention as opposed to community orders.

Section 127(6) allowed the responsible medical officer to attach potentially quite restrictive conditions to suspension of detention, including "such other conditions as may be specified by the responsible medical officer". In contrast, the Tribunal has a relatively limited number of measures it can apply to an order that does not authorise detention in hospital (section 66(1) c to h).

The danger is that individuals are maintained on suspension of detention for longer periods in order than more restrictive measures than Parliament intended can be used in the community. Parliament's initial intention was clearly to restrict the amount of time that detention could be suspended before the order was either revoked or varied.

Furthermore, the conditions attached to suspension of detention would be entirely at the discretion of the RMO and would not be judicially reviewed as the amendment

stands. There may be an opportunity to review them when the Tribunal reviews a determination to extend an order, but that may not happen for two years.

The Commission intends to visit individuals subject to suspension of detention in 2014-15 and will report to the Scottish Government on the present use of periods of suspension lasting up to six months. But we think that more safeguards would be needed if the nine month in 12 provision is repealed. Options include:

- Right of appeal to the Tribunal against the conditions imposed;
- Automatic review by the Tribunal if suspension exceeds a period of six months;
- Automatic visit by the Commission if a certificate is granted for up to six months (or if consecutive certificates amount to six months continuous suspension)

But even with these safeguards, there is potential misuse of suspension powers. This is a matter that could be helpfully addressed in the revised Code of Practice. Prior to the 2003 Act, we found a small number of cases where individuals were recalled from (what was then) leave of absence for one day after continuous leave for 12 months. The Commission would need to pay particular attention to certificates authorising suspension: another possible cost issue, including the issue of diverting Commission resources from other activity.

Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal

We understand the reason for this requirement but would advise against it at this time. MHO duties are considerable and are expanding due to the increasing use of welfare guardianship under the 2000 Act. We estimate that this would involve an additional 1800 reports a year from mental health officers. Bearing in mind the existing issue with non-provision of social circumstance reports, we do not support this extra pressure on MHOs.

We considered an alternative whereby the tribunal receives a report from the MHO when reviewing a determination to extend an order? This still carries a resource implication (about 500 extra reports per year).

There could be a requirement for the MHO to give reasons in writing for not agreeing to the RMO's decision to extend an order. This would seem appropriate and proportionate.

Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions?

We welcome the Scottish Government's response to the recommendations we made on these matters. The only issue is the proposal to send the STDC to various parties. We raised this initially but other proposals in this consultation document appear to be at odds with this.

The STDC should only be sent to a named person nominated by the patient. This would be consistent with the intentions of paragraphs 10 and 11 of the consultation

document. If our earlier recommendation is accepted, it would also be sent to a named person who has parental responsibility where the patient is under 16.

While we support, and indeed recommended, that the certificate is given to the patient, it may contain information that could be harmful, e.g. information from a third party. We recommend that hospital managers should have the same power as the Tribunal (under para 47 of the Tribunal rules) to withhold part of the document on application by the AMP or MHO involved in the granting of the certificate, for the same reasons as are specified in rule 47. The important point is that the patient must know the reasons for detention in order that he/she can challenge.

Question 7: Do you have any comments on the proposed changes to the suspension of certain orders etc. provisions?

We support these proposals

Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions?

We support these proposals with one suggested amendment (see para below). In particular, we welcome the proposed amendment to the nurse's power to detain. This may reduce the requirement for emergency detention without the consent of the MHO where a medical practitioner is in attendance but the patient insists on leaving. We welcome the use of the nurse's power to detain in this situation. We wonder if the same power could also be exercised by a medical practitioner in order that an examination can be completed.

Our only concern is extending the entire holding period to three hours. We think the amendment could continue the present provision of a two hour holding period, but if there is no medical practitioner available within the first hour, it is then extended for an hour from the attendance of a medical practitioner. Although we appreciate the intention of simplifying the Act, we see no justification for a longer statutory period of deprivation of liberty in this situation.

Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions?

We support the proposals. Article 5 of ECHR requires that an appeal against deprivation of liberty is determined speedily by a court or tribunal.

Question 10: Do you agree with the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why.

We support these proposals. In relation to mothers, we also recommend that there is a duty on local authorities to provide support for individuals with mental disorders who are parents.

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why.

We have no major concerns about most of these proposals.

In relation to patients who have absconded from other jurisdictions, the present situation is that they would need to be detained under the 2003 Act before treatment is given, except in emergencies. As criteria for compulsion vary among jurisdictions, we consider it may be better to retain this. An approved medical practitioner should determine whether or not the patient meets the criteria for treatment under the 2003 Act.

We remind the Scottish Government of two issues we raised in relation to cross border transfers, both of which are more important in terms of human rights.

Firstly, a patient transferred into from, e.g. England may lose a right of appeal because the Act specifies that no appeal can be made within three months of the order being granted. But in this case, the order is granted by reports from two medical practitioners and an approved social worker. There would be an immediate right of appeal to a Tribunal. The right of appeal; is lost if the patient is soon transferred to Scotland. The provision in the 2003 Act assumed that the order had been granted by a tribunal in Scotland. We recommend an amendment to the Act of the Cross-Border regulations to allow an earlier appeal to the Tribunal in this situation.

Secondly, the regulations in respect of removing a patient from Scotland give a right of appeal to the patient but not the named person. This is an anomaly as the named person can appeal a decision to transfer the patient between hospitals in Scotland. Again, this would apply to a nominated named person. It would also apply to a named person who has parental rights. In any other situation, the Tribunal would need to consider whether or not to give leave to appeal (as per question 2).

Criminal cases

Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?

The consultation document gives no justification for the proposal to authorise an extension to an assessment order for up to 21 days. The only problem quoted is that 28 days from the making of the order might result in expiry of the order if a further hearing is set for exactly four weeks time. As we understand the amendment, the assessment order effectively will now run for 29 days from the beginning of the day on which it is made. We support this. We see no justification for a further 21 day extension without further explanation as to why this is necessary.

We note that the proposed amendments apply the “day after the making of the order” provision to several criminal procedure orders, e.g. a compulsion order. This may cause confusion as this is different from the time period calculated for equivalent civil orders. We suggest that the extra day provision only applies to assessment orders as this is the only order that causes a problem.

Question 13: Do you have any comments on the proposed amendments to the "variation of certain orders" provisions?

We support these proposals. It would be helpful is hospital managers had the responsibility to notify the Commission of variations to orders so that the Commission knows which hospital the patient is in.

Question 14: Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be.

We support this proposal but only for compulsion orders with restriction orders. We had some anxieties that victims might receive multiple notifications because of the staged approach to rehabilitation within mental health services and we are pleased to see that the proposal addresses this and therefore does not disadvantage individuals treated in mental health settings.

We do not support the proposals for compulsion orders and we consider that they are unworkable without other amendments to the Act. There is no requirement to notify Scottish Ministers when the RMO suspends or revokes the order. How are Scottish Ministers then to notify the victim. And some of these orders are for minor offences. Are victims notified in a similar way for short sentences following relatively minor assaults? Scottish Ministers must give serious consideration to the risk of discrimination against individuals who receive mental health treatment following minor offences.

Question 15: Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer.

This is a problematic proposal and, as it stands, highly inconsistent. If we are reading this correctly, the RMO must have regard to the victim's views when suspending a compulsion order under section 179 but not when revoking it under S142. Also, this may apply to minor offences where no such provision would be required if the offender was in prison. Again, this raised the possibility of less favourable treatment.

Our previous advice was that both of the above provisions should only apply to individuals with restricted status and we have not changed our view. To extend the provisions to individuals subject to compulsion orders carries a serious risk of treating individuals with mental illness, learning disability or related conditions less favourably than others without those conditions. In our view, these proposals would breach the Equality Act 2010.

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics" listed above.

Some of the provisions for notifying victims and having regard to their views may result in individuals with mental illness, learning disability and related conditions being treated less favourably. See our answer to questions 14 and 15.

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible.

The proposed amendments will result in cost to the Commission. Any amendment that changes a form will result in two costs. The form itself may require a new licence. And the Commission's information system will require upgrading. There may also be changes to the Commission's system if rules and timescales change – e.g. different time limits for some of the CPSA orders. At present, we estimate the capital cost to be around £250,000. There would be around £50,000 revenue cost for depreciation for each of the subsequent five years.

We also anticipate that there will be extra finance needed for training medical practitioners, mental health officers and nurses.

Additions – we provided the Scottish Government with a number of minor amendments that would improve the working of the Act. Many of these have been included as proposed amendments. We have included other amendments for consideration.