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Mental Welfare Commission for Scotland response to a consultation for implementation of certain sections of the Mental Health Act (Scotland) 2015 and associated regulations (Part 1), (completed 30/05/2016)

July 2016

Response ID ANON-BWME-NP4N-B

A consultation for implementation of certain sections of the Mental Health Act (Scotland) 2015 and associated regulations (Part 1), Submitted on 2016-05-30 18:33:14

Introduction

Are you responding as an individual or an organisation?
Organisation

What is your name or your organisation's name?
Mental Welfare Commission for Scotland

What is your email address?
enquiries@mwcscot.org.uk

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:
Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?
Yes

New appeal right for listed persons in operation

1/ Do you agree with the proposal that listed persons should be given the status of 'relevant person' before the Tribunal?
Yes
Please state if you have any concerns or suggestions for changes to the proposal, including if there is a different or amended status that you think would be more suitable:
We are aware of arguments that 'relevant person' status goes too far in potentially giving the person a right of access to sensitive documents which the patient may not wish them to see (or would not, if capable); and the opposing view that it does not go far enough in allowing the listed person to participate in the process. We are conscious that the listed persons proposals were a late amendment to the Act, and these complex issues may require further consultation and debate.
On balance, we believe that 'relevant person' is probably a reasonable compromise, in that it does not appear to involve information being routinely shared with that person, but does allow the Tribunal, on request or at its own hand, to determine whether a document should be sent to the relevant person.

2/ Is there anything else that you think the Tribunal rules should set out in relation to the procedural requirements for the new appeal right for listed persons?
If the suggested approach is adopted, it may be necessary for guidance to be given to individual Tribunals on when it would or would not be appropriate to share documents with the listed person. That should include provision for when the Tribunal has concerns that the listed person may be acting inappropriately, or advancing their own interests rather than that of the patient. Conversely, guidance should provide clarity on when not sharing information may be detrimental to the transparency and fairness of the process and perhaps potentially lead to legal challenge.

3/ Do you agree that either the RMO or any AMP should be able to confirm whether or not the patient has capacity to appeal on their own behalf?
Yes, with qualifications. In principle, this seems reasonable, and we agree that an assessment of capacity should be undertaken by an appropriately qualified medical professional. However, we are concerned to reduce the risk of multiple assessments of capacity which may be distressing for the patient and add to complexity, cost and delay. In most situations, we anticipate that an opinion on capacity should be provided by the RMO, who should already have a detailed knowledge of the patient.

If the RMO believes (and the MHO agrees) that the patient does have capacity in relation to an application or appeal, and this is disputed by the listed person, we have some concerns if the listed person is able to insist, at their own hand, on another doctor undertaking an assessment of capacity (whether via legal aid or privately funded). It may be better in such cases for there to be a reasonably straightforward process allowing the Tribunal to appoint someone (whether formally a curator or in some similar capacity) who would satisfy themselves as to whether the patient was incapable of giving instructions).

4/ Do you agree with this overall approach?
Yes

Please state if you have any concerns or suggestions for changes to the proposal.
We have no major concerns about the proposal, but nor would we be unduly concerned by a more rapid handover, with the new provisions taking effect at a specified date for all patients, with the exception of cases where the named person is already a party to the proceedings.

5/ Do you agree with this proposal?
Yes

Please state if you have any concerns or suggestions for changes to the proposal.
See answer to 3 above. We have no major concerns, but this will mean that the regime will apply differently to different patients for some considerable time following implementation of the new system.

Supporting service users to choose the right representation

6 / What do you consider the key information required?
For professionals, particularly MHOS, guidance should be given on how they ensure consent from the nominated named person on the prescribed form. This should include issues that may arise with named persons living in England, Wales or Northern Ireland.
Through our role we come into contact with a number of carers, who have advised us that they are still unclear on the role of the named person and were often not aware that they were in this position. This seems to be the case for both those in the nominated and default position, and is borne out by research undertaken by the Commission on named persons published in 2013.
With this in mind we would suggest that consideration is given to how such changes should be communicated to the wider public. Information should be clear and differentiate clearly between the old and new roles. It may also be helpful to clarify what the role does NOT include. From discussion with carers on our advice line we find that family members can be confused on the roles of named person, nearest relative or next of kin.
We would also suggest that the process of nomination, witnessing and the role of professionals is clearly stated with an emphasis on embedding this in practice at a much earlier stage.

7/ How best should this information be provided to service users not currently in touch with specialist services, and should any agency or profession lead on this?
The Commission would be happy to host material on its website, and to use its networks to promote awareness of the issue.
However it will also be important for professionals, advocacy groups and others directly in touch with service users to have accessible information in electronic and hard copy form.
Information on the named person role could be held alongside material which is published to increase awareness of advance statements, under the new s26 duties - since making an advance statement and nominating a named person are both issues of planning in the event of a future episode of compulsory care.
We would also encourage the wider development and co-ordination of information about anticipatory care planning, including not just advance statements and nomination of named persons, but appointment of powers of attorney, personal statements and so on. Making it easy to find the right information in one place and make the necessary choices to plan for the future would be a significant advance.

8/ Is there any guidance or support needed beyond the Code of Practice and service user guidance?
The Code of Practice is unlikely to be particularly accessible to service users. Some form of portal which is designed and promoted to be accessible to service users may be helpful. Also, it is important that services are made aware of their responsibilities under the UN Convention on the Rights of Disabled Persons to provide appropriate support for disabled persons in the exercise of their legal capacity, which would include nominating a named person.

Named Person Secondary Legislation

9/ Do you agree with the proposals concerning the list of prescribed persons?
Yes
Please state if you have any concerns or suggestions for changes to the proposal.
None

Conflict of interest regulations

10/ Do you agree with this proposal?
Yes
Please state if you have any concerns or suggestions for changes to the proposal, including if there is a particular level of management structure, or unit of organisation that should be reflected in the regulations.
We agree with the general approach, but it may prove hard to define in practice as, for example, AMPs may be part of the same management structure but in different directorates. It may be cleaner to say that where one AMP has a direct management relationship with another, this would be a conflict.
Our response to question 17 is predicated on this approach. If that definition of conflict is adopted there would be little impact in rural areas. If not it would make the Act very hard to work in rural areas, for example in a rural health board such as Dumfries and Galloway or Highland all available AMPs will be part of the same management structure in the local NHS Board thus potentially having a conflict of interest. To get an AMP from out with the same management structure would be difficult and might compromise patient care.

11/ Do you agree with this proposal?
Yes
Please state if you have any concerns or suggestions for changes to the proposal.
We continue to believe that an AMP independent of a private hospital should provide the medical report recommending a patient's continued detention in that hospital, but recognise some merit in the argument that this potentially deprives the Tribunal of detailed information from the RMO, who will have had extensive knowledge of the patient for months and possibly years. This may be a matter to be covered in guidance to AMPs providing these reports, to ensure that the perspective of the RMO is properly put before the tribunal.
We also recognise a possible risk that, should the AMP not agree that the order continues to be necessary (possibly on the basis of a relatively limited knowledge of the patient); the order may fall without having been considered by the Tribunal. In such a situation, we wonder if it would be desirable to allow the RMO to bring such a case to the Tribunal, who could consider the opinion of the RMO and the AMP.
We agree below that, given the extra built in scrutiny of the first CO extension and CORO extensions, a requirement for an independent AMP does not seem to offer enough additional safeguards to the patient to outweigh the possible removal of the RMO from the review process. However, in relation to s182, we do believe that the second AMP opinion should be from someone who is not associated with an independent hospital.

12/ Do you think it is necessary for the regulations to set out conflicts of interest for medical examinations under section 139 (first mandatory review of CO) or section 182 (review of CORO), given that there is additional scrutiny in the process for reviews under these sections and that the decision for COROs is not a decision to extend the order?
No

13/ Taken together, are the proposals in Chapter 3 suitable for rural areas where hospitals and second doctors may be located further apart than in urban areas?
Yes

Safeguards for certain informal patients regulations

14/ Do you agree with this proposal? Yes

Please state if you have any concerns or suggestions for changes to the proposal and whether you agree that there should be an exemption allow for treatment in all the circumstances set out in section 243 of the 2003 Act?

We agree broadly with this proposal, if additional safeguards are put in place to ensure that there is no undue delay in providing treatment in those awaiting a DMP visit.

The provision of artificial nutrition is an invasive procedure that can be an essential form of medical treatment for young people under the age of 16 with certain types of mental disorder as part of a comprehensive treatment plan.

At present we do not know the precise numbers of young people who are treated informally on the basis of parental authority for mental disorder which involves the provision of artificial nutrition.

As far as the Commission's records demonstrate there have been no instances of young people under the age of 16 being provided with any treatment under section 244 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This situation would change therefore as a consequence of these proposals.

If the proposal to include Artificial Nutrition as a treatment regulated under Section 244 of the Mental Health Act then the safeguards for this treatments could be:

- where the patient is capable of consenting and does consent, either the RMO or a Designated Medical Practitioner (DMP) must certify that the child is capable of consenting, has consented in writing and that the treatment is in the child's best interests. Any such certificate must be given by a child specialist and the RMO or DMP completes a T5 form and sends it to the Commission.
- where the patient is capable of consenting and does not consent to these types of treatment but the patient does not meet criteria for detention under the Mental Health Act, then their right to refuse treatment cannot be overridden.
- where the patient is incapable of consenting, consent must be obtained from a person with parental rights and responsibilities for the child. A DMP, who is not the medical practitioner primarily responsible for the child's treatment must certify that the patient is incapable of consenting, a person having parental rights and parental responsibilities has consented in writing and that the treatment is in the patient's best interests having regard to the likelihood or its alleviating or preventing a deterioration in the patient' condition. If the incapable patient resists the treatment, it can only be given if the DMP certifies that the patient is incapable of making a decision, that consent has been given by a person with parental rights and responsibilities for the child, that the patient resists or objects and the treatment is necessary in line with the urgent medical treatment provisions of section 243(3) of the 2003 Act.

The purposes in section 243(3) are saving the patient's life; preventing serious deterioration in the patient's condition; alleviating serious suffering on the part of the patient; and preventing the patient from behaving violently or being a danger to themselves or others.

For treatment that is for the purpose of preventing serious deterioration in the patient's condition or for alleviating serious suffering on the part of patient then medical treatment can only be given if it is not likely to entail unfavourable and irreversible physical or psychological consequences.

For treatment that is for the purposes of alleviating serious suffering on the part of the patient the medical treatment can only be given if it does not entail significant physical hazard to the patient.

- The Commissions' guidance has been that in a child whose capacity to consent to treatment is either absent or uncertain due to developmental immaturity and the child or young person is being treated informally but under the authority of parental consent and that child is resisting or objecting to artificial nutrition then consideration should be given to whether the young person meets criteria for detention under the Mental Health Act which provides the young person with a number of safeguards not available to them when treated under the authority of parental consent.

We have been told by clinicians involved in the provision of artificial nutrition to children with mental health disorder that a child who is objecting to the treatment might require a five person restraint on occasion in order to provide the treatment with appropriate safety. The level of invasion of the child's physical integrity that this treatment entails suggests that safeguards might be beneficial to ensure the rights of the child are not overlooked when treated with artificial nutrition.

- DMP consent for medical treatment for artificial nutrition in a child can usually take between 2-5 days to be completed from time of RMO contacting the Commission to the assessment and authorising paperwork being completed.

Artificial Nutrition is a treatment that can be required in life threatening circumstances. As a consequence the inclusion of artificial nutrition in the regulated treatments under Section 244 must not delay the appropriate treatment for the patient. In the case of patients detained under the Mental Health Act treatment may be given without consent of the DMP where circumstances comply with the urgent medical treatment provisions of section 243 (3). In these circumstances the RMO is required to notify the Commission of the treatment and completes a T4 form for this purpose. Importantly the T4 completion does not authorise the treatment provided but provides a mechanism whereby treatment out-with the Act can be scrutinised and monitored by the Commission when further enquiries may be made as appropriate. In the case of an incapable informal child who requires treatment with artificial nutrition for mental disorder there would need to be a mechanism similar to a T4 notification to the Commission completed by the RMO in circumstances where the treatment is required prior to DMP review. T4 forms are non-statutory and therefore modification of the form could provide this mechanism and alteration of the form should not provide too great a challenge.

- As mentioned above the numbers of young people this would affect in any year is uncertain but estimates are that it would not affect significantly large numbers of (>50) young people. The changes would constitute an increase in demand for DMPs with specialist Child experience and training.
- It would still be the Commission's position that any informal child who is deemed incapable of consenting to treatment with artificial nutrition due to developmental immaturity and who is resisting or opposing treatment that consideration should be given as to whether the young person's rights would better be safeguarded with the authority of the Mental Health Act.

Advance Statements

15/ What suggestions do you have about the most effective best practice for Health Boards to promote support available for making an advance statement?

The MWC has developed resources, both in print, and on line, to promote advance statements and aid in their completion. See **http://www.mwcscot.org.uk/get-help/getting-treatment/advance-statements.**

This should be highlighted in the Code of Practice.

16/ Do you have any other views or suggestions on how the implementation of the 2015 Act could encourage the uptake of advance statements?

We will be undertaking further work on advance statements this year, in anticipation of the implementation of new duties on Boards to publicise support for advance statements. We will liaise with Scottish Government as this work develops.

Impact Assessments

17/ Do you think any of the proposals set out in this consultation will have an impact, positive and negative, on equalities as set out above? Positive

Please explain your answer:

Given that all the reforms affect a subset of the equality category of disabled persons, and they broadly promote the autonomy of these persons (particularly the named person provisions) or provide additional safeguards and entitlements, we generally believe there will be a modest but positive impact on equalities.

18/ What implications (including potential costs) will there be for business and public sector delivery organisations from these proposals?

Some costs to local authorities and NHS may be involved in the new Named Persons/listed persons procedures. The extension of conflict of interest regulations may create additional costs for independent hospitals. Requirements for additional DMP opinions for informal patients will impose additional costs on the MWC. The promotion of advance statements by Health Boards and their monitoring by the MWC will impose additional costs on the NHS and the MWC.

19/ Do you think any of these proposals will have an impact, positive and negative, on children's rights?

Positive

Please explain your answer:

The Chapter 4 safeguards for informal patients will provide more effective safeguards for vulnerable children.

Although Chapter 2 (Named Persons) does not apply to children, it may highlight concerns that children do not have the power to dislodge their parents from the Named Person role.

20/ Do you think any of these proposals will have an impact, positive and negative, on privacy?

Positive

Please explain your answer:

Named person provisions will give greater control to patients about the transmission of confidential information concerning them.

Other aspects of implementation

21/ Do you have any other suggestions, comments or views about the implementation of the 2015 Act that were not covered by other chapters of this consultation and which may not be covered by the second consultation?

N o n e

Evaluation

Please help us improve our consultations by answering the questions below.
(Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?

Slightly satisfied

Please enter comments here.

None

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?

Slightly satisfied

Please enter comments here.

None