

Limited Review of the Mental Health  
(Care and Treatment) (Scotland) Act  
2003: Report

As Presented to Scottish Ministers March 2009

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## CHAPTER ONE INTRODUCTION

### Membership and terms of reference

The Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter, “the Act”) was passed by the Scottish Parliament on 20 March 2003, received the Royal Assent on 25 April and came into force in October 2005. While there appeared to be general agreement that the Act was a significant advance on the Act of 1984, which it replaced, it was clear from the ongoing monitoring to which the Act was subject that there were some areas in which problems were being experienced. Accordingly, the Scottish Government decided to institute a limited review of the Act.

The Review Group appointed consisted of:

Professor Jim McManus, Chair  
Ms Shaben Begum  
Mr Iain Boddy  
Ms Carolyn Little  
Mr Jamie Malcolm  
Dr John Mitchell  
Ms Isabel Montgomery  
Mr Graham Morgan  
Ms Annie McGeeney  
Ms Hilary Patrick

A brief biography of each of the members is included in Appendix A. Each of us was appointed, and acted throughout, in our personal capacities. Our Report represents a consensus of all the members of the Group.

The Group’s Terms of Reference were:

*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.*

### Brief history of the 2003 Act

The Act resulted from the report of the Millan Committee in 2001 (*New Directions: Report on the Review of the Mental Health (Scotland) Act 1984, SE/2001/56*). A central feature of the Millan report was that both the law and

practice relating to mental health should be driven by a set of ten principles (see Appendix B), especially minimum interference in peoples' liberty and maximum involvement of service users in any treatment. The new Act, as most consultees still call it, introduced a different mechanism for deciding on compulsory treatment, making use of a tribunal system rather than the sheriff court; it also allowed compulsory treatment in the community, which had not previously been allowed. A new legal entity, called a named person, was created, to attempt to overcome problems experienced with next of kin having automatic rights when a person became mentally ill. The possibility of making advance statements, detailing treatment wanted or not wanted in the event of a person becoming mentally ill, was created.

These were among the most radical of the changes introduced and they had some two years to bed down before the review commenced. Throughout that period, there were many bodies monitoring the situation, from user and carer groups, service providers, the Tribunal Service and the Mental Welfare Commission. Each had kept the Government informed of areas which did not appear to be functioning as well as had been anticipated. There was, however, no strong feeling that there was anything fundamentally wrong with the Act, but the Government felt there was enough concern to justify a "light touch" review. As a starting point to our review, the Government provided the Review Group with a table of issues identified through this process.

It is interesting to note that no-one raised any issue with the ten Millan principles throughout this process. Indeed, all during our consultation process, we heard nothing but praise for the principles, and it was clear that they are constantly in use for assessing whether the system is delivering what was intended. Several persons with whom we spoke suggested that the principles should be given more force in law. While it was accepted that this would pose great difficulties for the courts in interpretation, and thus for the operation of the system, it was agreed that **there should be a clearer statement of the need for the principles to be observed in all matters relating to mental health, and not only in those areas governed by the Act.**

### **The Review Group's approach**

The principles governed our approach to the Review. Starting from the table of issues provided to us, and conscious that it was a limited review, we chose to concentrate initially on five main areas of the Act's operation about which concerns had been raised: named persons, advance statements, medical examinations for compulsory treatment orders, tribunals and suspension of detention. To be sure that these were the important areas, and in order fully to understand the issues involved, the Review Group initiated a series of meetings with individuals and groups with an interest in the Act. These meetings were with service users, individually and collectively; relatives of people with mental disorder, carers; professional staff in the NHS; social work staff, both at a senior level and those who work on the front line; advocacy, and local voluntary groups. In addition, individual members attended a number of tribunal hearings in different parts of the country to obtain insight into the patient experience in this forum.

Our formal consultation had three main strands to it. The first of these was a consultation document which was placed on the Review Group's website at the beginning of August 2008, and which was also made available in paper form and by email. The closing date for completed consultation documents was 31 October, though documents received late were accepted. In total, around 150 responses were received, from a variety of sources. Unfortunately, many respondents did not indicate what their background was, so it was not possible in our analysis to accord opinions expressed with the experience of the respondent.

Our second form of formal consultation involved holding separate meetings with a number of stakeholder groups identified by the Review Group. These meetings were mainly held in August and involved: Alzheimer Scotland, Enable, Heads of Psychological Services, Mental Welfare Commission for Scotland, Mental Health Tribunal for Scotland, NHS managers, NSF (Scotland), People First, Royal College of General Practitioners, Royal College of Nursing, Royal College of Psychiatrists, SAMH, Scottish Consortium for Learning Disability, The Law Society of Scotland, the Mental Health Nursing Forum, The Mental Health Sub-group of the Association of Directors of Social Work, Saheliya, Scottish Legal Aid Board, Administrative Justice and Tribunals Council and Voices of Experience. In addition, the Review Group met with researchers who had carried out research into named persons and advance statements to obtain, first hand, information on the main outcomes of this important work. The reports of these research projects only became available as we finished our work. We have attempted to take into account their major findings and recommendations, and it was encouraging to note that there is much overlap between our conclusions and those of the researchers.

The final strand of the consultation involved the arrangement of events in Glasgow, Edinburgh, Dundee, Inverness and Aberdeen during October. Details of these consultation events were publicised as widely as possible across Scotland and the Review Group was pleased with the attendance at each of these events, and the participants' contributions were greatly valued. Facilitation at these events was provided by members of the Review Group and by others who are working, or have an interest, in the field of mental health and the quality of their input was a contributory factor in the, mainly, positive feedback which these events generated. The number of facilitators available meant that the groups could be kept small and afforded everyone who attended the opportunity to have their say in a forum where respect for each others' views was paramount. Our facilitators also ensured that views expressed in a variety of media were captured. Copies of this report may be obtained from the Scottish Government.

The Review Group is enormously grateful to all those who have contributed their experience, knowledge and views to this Review. As far as we could tell, there were no marked differences in opinions among those with different roles in the mental health system, and substantial agreement on many of the issues we raised.

Many of the changes we now recommend can be achieved without legislative action. Indeed, the Mental Health Tribunal for Scotland, which has co-operated fully with this review, is already undertaking organisational changes to address some of the issues we have raised. But some of our recommendations will require changes to the Act or the Rules. All recommendations are made in order to bolster delivery of the ten Millan principles.

The Review Group gratefully acknowledges the assistance provided by Charlie Burns of the Mental Welfare Commission, who organised our meetings and general administration and gave us access to his many contacts in the field.



## **CHAPTER TWO      ADVANCE STATEMENTS**

### **Background**

An advance statement sets out the way a person wishes to be treated, or not treated, for mental disorder in the event of becoming mentally unwell and unable to make decisions about treatment. The purpose behind introducing advance statements was to improve patient participation, in accordance with the Millan principles. The Act obliges tribunals and those providing treatment to take account of the past and present wishes and feelings of the patient and the advance statement is one potentially important way of recording these wishes. It must be made in writing and signed by the person making it. A witness, from among a list of possible persons contained within the Act, must sign to confirm that the person has the capacity to intend the wishes expressed in the statement. Any treatment provided which overrides a valid advance statement must be reported to the Mental Welfare Commission.

There is no central register of advance statements, but it would appear from our consultees that the take-up of them has not been as high as expected. They have received about the same publicity as named persons, and many service providers have provided advice to service users about making one. Nonetheless, few people have taken the opportunity to make one.

### **Problems identified**

In our consultation, the commonest reasons for the low up-take suggested to us were:

- Most persons have never heard of advance statements and, even if they have, they do not think they would ever be relevant to them.
- People do not know how to go about making one, who they can have as a witness and what to do with the document once they have drawn it up.
- Service users recognise that when they are unwell they need medical treatment and trust those who may provide this treatment to provide only appropriate treatment.
- When in recovery, many service users find it hard to contemplate being unwell again and are not ready to prepare for that eventuality.
- People do not believe that any regard will be had to their statement if the time comes when it may be needed. They stress that it can be overridden and feel it is therefore useless. In practice, however, figures from the Mental Welfare Commission show that the vast majority of advance statements are adhered to and very few overridden. (The Commission's Annual Report for 2007-08 recorded 13 actual overrides in the whole year).

- There is some confusion about the difference and similarity among advance statements, living wills and personal statements. This results in people entering irrelevant matters in their advance statements, which should only deal with treatments for mental disorder.

## **Recommendations**

Encouraging and maximising service users' participation in their own care and treatment is a dominant feature of the Act, and any steps which can be taken to increase the take-up of advance statements can only improve the realisation of this goal. We believe the following recommendations would address these issues:

2.1 Clarify what can be in an advance statement, taking an holistic approach to treatment.

2.2 Provide much greater publicity, addressed to everyone, and place responsibility on designated members of staff to facilitate the making of advance statements.

2.3 Make it easier to make a valid advance statement, perhaps by combining them with living wills and personal statements.

2.4 Extend the range of persons who can witness advance statements to include independent advocates and all staff. It is important to stress that the witness's function is simply to certify that the person is competent to intend the wishes expressed. It does not indicate that the witness endorses the wishes expressed by the person making the statement.

2.5 Encourage all staff involved during the recovery stage to discuss advance statements with service users and to record reasons for decisions not to make one.

2.6 Give much greater publicity to the low number of advance statements being over-ridden reported upon by the Mental Welfare Commission.

2.7 Require responsible medical officers to review regularly any treatment in conflict with an advance statement and provide a written record of efforts made to address the person's stated wishes.

2.8 Introduce a central register of advance statements, with copies also retained in medical records. The Mental Welfare Commission has indicated that it would be prepared to hold the central register.

## **CHAPTER THREE INDEPENDENT ADVOCACY**

### **Background**

Section 259(4) of the Act defines 'advocacy services' as services of support and representation for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, their care and welfare as is in the circumstances appropriate.

Independent advocacy supports a person's right to have their own voice heard in decisions made about their health and well-being. The Millan Committee noted in its support for the availability of independent advocacy services that any person can benefit from advocacy if, for whatever reason, they find it difficult to put their own case to service providers or do not feel in a strong position to exercise or defend their rights. It is particularly helpful for people who are at risk of being mistreated or ignored, or who wish to negotiate a change in their care, or are facing a period of crisis. Advocacy can be used by people with physical or mental disorders, or by people who simply feel overwhelmed and confused by institutions and care, or by their carers. It can be difficult, for a number of reasons, for service users to speak up for themselves. Advocacy can give a route by which this may be achieved.

Section 259 of the Act states that every person with a mental disorder shall have a right of access to independent advocacy. It places a duty on NHS Boards and local authorities in collaboration to secure the availability of independent advocacy services within their relevant Boards or authority.

The State Hospitals Board for Scotland has a duty to ensure advocacy services for those detained in the State Hospital. However, in the case of a State Hospital patient who is granted a conditional discharge or for whom a compulsory treatment order has been suspended, the State Hospital is required to collaborate with the local authority and NHS Board for the area in which the former patient is now residing.

Independent advocacy organisations may provide individual or group advocacy. The Act is not specific about the type or types of independent advocacy services to which a patient should have a right of access. Any or all of the various types might be appropriate depending on the circumstances and personal preferences of the service user/patient concerned.

Our consultation indicated strong support for the availability of independent advocacy with very few respondents questioning its usefulness when properly provided. However, some concerns were reported.

### **Problems Identified**

Our consultation highlighted the following:

- There was very strong support for the provision of high quality independent advocacy services to all.
- There is patchy availability of advocacy services in some areas.

- Many felt that advocacy services are having to be prioritised for people subject to compulsory powers to the detriment of those who are not.
- There is confusion around the role and function of independent advocacy services in relation to other relevant parties who may be representing the service user/patient. We address this in our section on mental health tribunals.
- Some concerns were voiced about a minority of advocates pursuing their own agenda rather than focussing on their clients' wishes.
- It is not clear how to make a complaint about an advocate.
- Particular difficulties in the provision of appropriate advocacy services were noted in relation to children and young people, people with a mental disorder who are in prison, people with dementia, people affected by learning disabilities, deaf, deafened and partially hearing people, and for service users from the black and minority ethnic communities.
- Collective advocacy is well developed in some areas but is non-existent in others.

## **Discussion**

The strong message we heard throughout our consultation was that independent advocacy is essential and that its availability should be improved, not just geographically but also to people with specific needs.

Advocacy is now part of the fabric of mental health and learning disability care in Scotland and we believe that should be celebrated and seen as an indication that the principles of the Act are being given due regard. However, given that the role of advocates includes challenging and questioning proposals and decisions made by professional staff, there is likely, at times, to be a degree of tension between those advocates and the staff providing care.

Notwithstanding the strength of support, there is still a degree of uncertainty amongst some staff about the legitimate role of independent advocates and a suspicion that, at times, advocates may be promoting their own views rather than those of their advocacy partners. Associated with this was a lack of clarity about what to do if staff believed that an advocate was not acting in the best interests of a client. While it appeared to us that a small minority of staff voiced these concerns, it is still vital that they are addressed, to ensure that the perception of the positive contribution of independent advocacy is not eroded.

During our consultation process, the Scottish Advocacy Independent Alliance published Principles and Standards for Independent Advocates and a Code of Practice for Independent Advocacy. These excellent documents address many of the issues highlighted by our consultation and we believe that their

implementation and application would address some of the concerns we identified.

The Review Group was impressed by the role of collective advocacy where groups of users come together to give common voice to their concerns and experiences. By speaking out on behalf of their community, such groups can act as powerful protectors of civil rights and can promote social justice. By gaining information on all the issues that affect their members, they are in a good position to comment on the working, and the delivery, of the principles of the Act and by so doing they can ensure that they reflect the needs of users and is sensitive to their lives.

There is a strong argument that by promoting their members' confidence, self esteem and empowerment they make it less likely that people will be subject to compulsory powers. In addition, by acting on issues that encourage a voice, challenge stigma, promote inclusion, a rights based approach and person centred ways of working, they reduce the isolation and alienation people feel and promote better practice in the operation of the services that implement the Act.

### **Recommendations**

3.1 The Government should, by whatever means it sees fit, ensure that there is appropriate provision, with associated funding, across Scotland, of independent advocacy services by NHS Boards and local authorities to ensure that the requirements of s259 of the Act are complied with in relation to all persons affected by mental disorder regardless of where they are and taking into account their specific needs.

3.2 The Mental Welfare Commission requested that service users or those with an interest in a case be empowered to report to the Commission failures to provide adequate access to advocacy services. Such failures should be raised in the first instance with the authorities statutorily obliged to provide the services.

3.3 Independent advocacy organisations should aim to work in accordance with the Scottish Independent Advocacy Alliance Principles and Standards and Code of Practice.

3.4 Carers' access to advocacy services should be ensured.

3.5 The appropriate scrutiny processes and bodies should promote and monitor the application of the Scottish Independent Advocacy Alliance Principles and Standards and Code of Practice.

3.6 NHS Boards and local authorities should support the development of collective advocacy groups in their respective areas.

## CHAPTER FOUR NAMED PERSONS

### Background

Under the 1984 Act, a person's 'nearest relative' had significant rights and duties in relation to detention. These included the right to apply for detention and to consent to its use. On occasion, these powers caused problems in relationships, resulting in a gradual expansion in the role of the mental health officer. The mental health officer was generally the person who applied for detention and who was asked to consent to detention.

The rules for determining who was nearest relative were very complex. Essentially, the nearest relative was the next of kin of the person. A relative who cared for the person was preferred to one who did not.

The service user had no right to remove a nearest relative who was not suitable or to have any say in who should be nearest relative. As well as being contrary to the Millan principle of participation, the European Court of Human Rights in a case involving the English Act (*JT v UK*) held this to be in breach of service users' human rights.

The Millan Committee therefore recommended that people should be able to appoint someone to act as their 'named person'. The named person would have the right to:

- Require an assessment of the service user's needs;
- Be notified and consulted if compulsory measures were being considered;
- Be heard at the tribunal in any proceedings about the use of compulsion and
- Appeal against the use of compulsory measures.

The Act gives service users the right to appoint a named person. This may be a relative or carer, but need not be. If a service user does not nominate anyone, the primary carer becomes the default named person, and if there is no primary carer, the nearest relative is assigned the role.

### Role of named person

The named person has various rights and responsibilities, aimed at providing safeguards for the service user if compulsory measures are used or contemplated.

He or she receives notice at various stages of the compulsion process. Those considering the use of compulsory measures should consult with the named person and should consider the named person's views when making care and treatment decisions, if practicable.

The named person can appeal against compulsory orders (except emergency certificates) and any extension or variation. The named person can also appeal against the patient's transfer to another hospital, including to the State Hospital.

The named person will generally receive full copies of all papers presented to the tribunal and is entitled to his or her own legal representative at the tribunal hearing. This is paid for on a free, non-means tested basis under the Assistance by Way of Representation (ABWOR) scheme.

The named person has one important right, which does not relate to the use of compulsion. This is the right to request that the local authority and/or the NHS Board make a formal assessment of a service user's needs for social care or health services. (The service user and primary carer also have this right.) If the authorities refuse the request, they must give their reasons. It can sometimes be difficult to access help when necessary and this is a way of ensuring that a service user's needs receive proper consideration.

### **Problems identified**

There are several concerns about the way the named person rules are working.

The main issues raised by those we consulted were:

- Many of those we spoke to expressed concern that the role of the named person was not fully understood, not just by service users and named persons, but also by professionals, including the tribunal. The Act deals with the named person in its 'patient representation' section, but the role is more complex than that. Named persons are parties to any proceedings in their own right and must act in what they see to be the best interests of the patient. This may mean that sometimes a named person may disagree with the service user, and this can cause conflict.
- Named persons told us they found it difficult to obtain information about the role and what is expected of them.

There are booklets published by the Scottish Government and by some local organisations, and we understand that mental health officers often provide verbal advice. But we have also heard from named persons that the first and only notice they received was when the papers for the tribunal were delivered through the post a few days before the hearing.

Some of these carers were quite upset about this. The papers reminded them of many things they had been through with the service user; they also provided information which was new to the carer, covering periods when the service user had lived away from home, for example. These carers would have appreciated a formal opportunity to sit with a service provider – nurse, psychiatrist or mental health officer – to go through the papers and discuss their feelings.

- A person can decline to act as a named person, even if he or she becomes named person as a primary carer or nearest relative. There is, however, no procedure for ensuring that an individual receives notice that a service user has appointed him or her. Some people only find out that they are the named person when compulsory measures are being considered. They may know nothing at all about the role, and have little information about the service user's needs at that time.
- Although statistics are not collected centrally, the general impression is that the numbers of people nominating named persons are low throughout the country. This is confirmed in the preliminary results of research carried out on behalf of the Scottish Government. At the time of a short term detention certificate, nearly three quarters of named persons were carers or nearest relatives. The number reduced to 60% if there was an application for a compulsory treatment order.

Even where staff have run active campaigns to persuade patients to nominate named persons, the take-up rate varies enormously. A person having a first contact with mental health services is unlikely to be aware of the concept of named persons, or to have appointed anyone. If this first contact with services is at a time of crisis, the person may not be legally able to nominate anyone. The primary carer or nearest relative would automatically be named person.

One of the best opportunities for nominating a named person is when a service user is recovering, and staff often try at this time to encourage people to think about a nomination. However, some service users may be reluctant at this stage to contemplate being ill again, and the opportunity is not by any means always taken.

- The Act requires the mental health officer to attempt to identify someone to act as named person. We understand that, initially, some tribunal convenors were insistent that efforts were made always to have someone acting as named person. This pressure appears to have reduced, but the Act contains a long list of possible nearest relatives, some of whom might have no real connection with the service user.

The procedure for barring a named person is complex. The service user can make a declaration naming individuals he or she does not want to act, but cannot make a general declaration. A service user must name every person whom he or she does not want in the role. If the person does not want any of a particular class, for example, brothers or sisters, each must be named individually. It is not possible for a service user to make a declaration saying he or she does not want a named person at all.

One service users' organisation said to us that:

*'Forcing a patient to have a named person in all circumstances is akin to requiring a person, by law, to have a friend.'*



Another group said that:

*'It is better to have no named person than the wrong named person.'*

The current system was seen as contrary to the Millan principles:

*'If we have the right to nominate, we should have the right not to nominate.'*

- Several service users said they were reluctant to put more responsibility on their primary carer, and asking them to act as named person at a time of crisis like hospital admission or a tribunal was felt to be too much. Equally, there could often be issues between a service user and named person afterwards, given that the named person is an independent person in proceedings and is not bound by the wishes of the service user.

These problems are potentially greater when the named person is not appointed but comes from the list of relatives. It may be that there is a history of issues which have arisen because of the state of health of the service user, or the health of the service user may itself have suffered as a result of actions by a close relative. For the family member then to have an official role in compulsion proceedings might well be highly inappropriate.

- Named persons are full parties to the tribunal hearing and receive the full application relating to the patient, and it can be difficult for the patient to ask for some material to be withheld. The paperwork could contain sensitive information about the patient's history and background, including, in some cases, details of sexual history or criminal offences.

The tribunal rules of procedure do allow the tribunal to direct that information is withheld in certain circumstances. Rule 46 allows anyone with an interest to request that information is withheld. Sometimes a mental health officer may ask for information to be withheld if the service user has requested this. Rule 47 also allows the tribunal to withhold information from the parties if passing it on would cause serious harm to the service user or any other person.

However, despite this, we heard of occasions where the sharing of sensitive information had caused significant distress, both to service users and to named persons. It was suggested that this could be a breach of service users' right to privacy under Article 8 of the European Convention of Human Rights, particularly where the service user had not consented to the sharing of information because the law had automatically imposed the named person on him or her.

It was noted that, in this respect, the 2003 legislation appeared worse than the 1984 Act. That Act allowed the patient to prevent information going to the nearest relative, except in the case of emergency detention.

- Some service users have no one who can act as a named person. A person may have no close relatives or carers and no one whom he or she wishes to nominate. It is not clear who could act for him or her in this situation. It may not be appropriate for a service provider to act in this role and the role is distinct from that of independent advocate or solicitor.
- A young person under the age of 16 cannot appoint a named person. His or her parent (or the person with parental responsibilities) will be named person. This was felt unfair and could cause real problems in practice if the young person was no longer living with his or her parents. It might be quite inappropriate for them to receive confidential information about the young person.

### **Other concerns**

The Act does not allow a service user to appoint more than one person as named person. There may be occasions where a service user wishes to make a joint appointment and it was unfortunate that the law did not allow this.

The Mental Welfare Commission told us that when it visits patients in hospital or arranges for a second opinion for medical treatment, it often finds it difficult to determine who the named person is. Hospital managers should be responsible for ensuring that the person's case records accurately record who the named person is.

### **Possible solutions**

*Understanding and support for the role* Most people saw the named person as a valuable safeguard, particularly when the service user had appointed a named person and there was a close and trusting relationship between them. On the other hand, one or two consultees questioned the value of the role and said that legal representation and independent advocacy could between them provide adequate safeguards. Others suggested that the Act itself should set out more clearly the named person's role and responsibilities.

Many of those we consulted mentioned the need for more education and training and for more information about named persons for service users and named persons. Carers' groups, advocacy organisations, service providers and bodies such as the Mental Welfare Commission could be involved in such training. Information should be available in the form of accessible leaflets, CDs and DVDs. Information should be presented in plain English and should be in an accessible format for those for whom English is not a first language. The needs of those with hearing loss were particularly mentioned.

In addition, many felt that named persons needed more help and support to enable them to carry out the role. Mental health officers might be able to do

this, although others recognised the pressure on existing services. Others thought that a service user's keyworker (whether a health or social care professional) was the appropriate person to support the named person. Carers' resource centres might also be able to offer support.

Many people suggested that the form appointing the named person should require the consent of the named person. This would allow the named person to refuse if he or she did not want the role and to seek more information at an earlier stage.

*Low take-up of nominations* More general publicity about the role and function of the named person might increase the number of nominations. Professionals should encourage service users to discuss whether they wished to appoint a named person and this should be an integral part of the care planning and patient review process.

*Named person imposed on service user.* There was almost universal unhappiness that the current system did not allow people to choose not to have a named person. Nobody we consulted believed that a service user should be 'forced' to have a named person, but some raised the question of how to protect people who lacked the capacity to appoint one.

Respondents were divided about possible solutions.

Some recommended that the existing provisions remain but the law be changed to allow a service user to 'opt out' of having a named person. Where a service user did not, or could not, nominate a named person, the primary carer and nearest relative would remain as named person. However, the service user would have the right to sign a declaration saying he or she did not want to have this person, or even to have a named person at all.

It was suggested that the tribunal should also be able to grant an oral request at the hearing, provided it was satisfied the service user understood the implications.

The current rules requiring service users to specify every individual they do not want as a named person could also easily be simplified, by allowing the service user to specify categories of person he or she did not want as named person.

Particular safeguards would be required for people who were not able to appoint a named person or to object to the appointment of a particular person. A mental health officer should not have to identify a primary carer or nearest relative if he or she did not think this would be in the interests of the service user.

The second solution was simpler. A patient should have a named person only if he or she has specifically appointed one. There would be no default position.

Some of those arguing for this position questioned the importance of the role of the named person and said that the interests of a person without a named person could be adequately protected by independent advocacy and legal representation.

On the other hand, other groups said that a person who chose not to have a named person would need to have enough support and information to be able to represent themselves effectively. Some said that it was 'essential' that if the service user did not have a named person, he or she must have some form of representation. A carers' organisation stressed that there must be efforts to involve concerned carers.

Alzheimer Scotland suggested that if a person was unable to appoint a named person but had a welfare attorney or welfare guardian under the Adults with Incapacity Act, he or she might automatically become the named person.

*Amount of confidential information the named person receives* Many of those we consulted said that the named person should not receive confidential information unless the patient had agreed, either because he or she had appointed the named person or had agreed at the tribunal itself. A named person appointed without the patient's consent should not automatically receive confidential information.

Several respondents suggested that the role of the named person could be something short of being a full party to the action. For example, the named person could be an 'interested party', rather than a full party. This would require only a change to the tribunal rules of procedure. Another suggestion was that the named person should have the full papers only when he or she had instigated the action, for example, by appealing against an order. The only papers required would be those relevant to the specific appeal.

The Mental Welfare Commission proposed that the service user should be able to select from a list of powers those that he or she would like the named person to have, for example, whether the named person should be a party to tribunal proceedings and what other duties or powers the named person should have. This would give the service user the ability to control the information available to the named person.

Others felt that it was crucial to the very role of the named person that they were full parties to the hearing and have full access to all the information, independently of the service user. This was a particularly strong argument where the service user had appointed the named person to represent the service user's interests.

Service users felt strongly that they should be the ones who had most control over what the named person found out about them. However, some service users' groups recognised that there were situations where people could be unable to make an informed decision about information sharing. In that situation it could be very important for a named person to have access to adequate information to be able to protect the service user's interests.

Several people commented that any information given to named persons should be on a 'need to know' basis and should relate to what was relevant at the time of the hearing, rather than to a detailed history of the patient's health and social circumstances. Named persons did not necessarily need to receive the patient's full case history, and social background information should not be automatically included in the application papers.

There was general support for the need to stress confidentiality in relation to information obtained as a named person, and some respondents suggested that the named person should return all papers at the end of a hearing. This could cause problems for organising any appeal. A Code of Practice for named persons might be sufficient to bring these issues to the attention of named persons.

*Where there is no one able to act as named person* We received several suggestions that there should be a pool of people prepared to act as named person when there was no-one available to act. This could be a paid, professional role or could be carried out by volunteers. Others resisted this because the named person should be someone who knew the service user well. One suggestion was the development of long-term volunteer befriending services which might include acting as named person as an outcome of the relationship.

The role of paid carers as potential named persons was mentioned. Some respondents believed, incorrectly, that the Act does not allow a person who is paid to care for a service user to act as his or her named person. Often such a carer will have known the service user for many years and may have built up a trusting relationship with him or her. It might be appropriate for certain paid carers to be eligible to act as named persons.

It was pointed out that if a service user had no one to act as named person, the importance of the role of the independent advocate is increased. The roles of named person and independent advocate are not the same, but the absence of one increased the importance of the other.

## **Discussion**

*The role of named persons* We heard of instances where the relationship between service user and named person worked well and where the named person had taken an important role in protecting the interests of the service user. We remain convinced that the named person has an important role in protecting the interests of the service user, particularly at a time when the service user may find this difficult. However, it is important to understand that the named person's role is not necessarily to represent the service user's views, but to state what he or she believes is in the person's best interests.

We do not see the role of the named person as primarily to supply the tribunal with information about the service user's medical background or social circumstances. The named person may or may not have that information. The

input of the named person should not be a substitute for the information provided by the primary carer.

We believe the named person can help protect the interests of the service user in the compulsion process, by being involved in decision-making, consulted about care and treatment options and having the option to challenge the use of compulsion where their named person considers this is appropriate. This is a role quite distinct from that of carer, independent advocate or solicitor.

We note that the named person is not notified if the police take the person to a place of safety and we think this is an omission from the Act which should be rectified. Nor is there any formal duty on the mental health officer applying for a compulsory treatment order to consult the named person on the proposed care plan. We believe the Act should be modified to require this.

*Support for named persons* There is a need for clear and accessible information about the role and duties of named persons. While the guidance from the Scottish Government is very comprehensive, some of those we consulted found it too complex. Others did not know it existed.

Named persons told us that they need both information about their role and support in carrying it out. Talking to someone was much more helpful than reading a booklet. The mental health officer already has many responsibilities in preparing for a tribunal and might be the logical person to take on this role. Some people commented that as a named person was a statutory role, someone should have the statutory duty to provide this support.

On the other hand, a named person with an ongoing role in relation to the service user is likely to know some at least of the care team involved and might find it easier to talk with someone from that team. It would be helpful if a positive offer of support were made at the earliest opportunity, acknowledging that the named person might have little time to seek legal advice and prepare for a hearing.

Scottish Government guidance to named persons is not clear who should offer support to the named person. It suggests that the named person speak to the responsible medical officer, who will be able to 'signpost' the named person to someone who will assist. We are not clear who this person will be, in light of the increased burdens being placed on mental health officers, and we believe the guidance should clarify this.

It is clearly important that named persons have time to prepare for the role, where possible. We recommend that the document appointing a named person should include the named person's written consent to act. This would enable the named person to discuss the matter with the person nominating him or her and perhaps, if a named person is not keen on performing the role, to suggest someone else.

*Where there is no one able to act as named person* We are not attracted by the suggestion that professionals should act as named person for people who do not have anyone to act in this role. We see the role of named person as essentially something which should be carried out by a friend, relative or carer of the service user.

A person with no named person needs good advice about access to advocacy and legal representation if he or she is likely to become subject to compulsory measures.

Despite it being common belief that a service user cannot appoint his or her paid carer as named person, this is not the case, although some organisations do not allow staff members to act in this capacity. There may be situations where it is appropriate for paid carers to act as named person, but they must seek guidance from their employers before agreeing to act.

It is not unusual for a service user to state that he or she needs no named person, independent advocate or solicitor at the tribunal. Service providers will need to ensure that the person understands his or her options and the tribunal must guarantee the service user's right to a fair hearing. If the tribunal considers the person is unable to instruct a solicitor, it may appoint a curator ad litem, but the tribunal may have concerns in other cases where a curator is not appropriate.

In Adults with Incapacity (Scotland) Act 2000 applications, the court can appoint a 'safeguarder'. The safeguarder meets with the adult, carers and health and social work staff and reports to the court with his or her views about the application. We think a similar power should be given to the mental health tribunal, where the person has legal capacity but has refused to appoint a named person, or cannot find anyone to act and chooses not to instruct a solicitor.

*Named person imposed on service user* We share the general unhappiness with the system as it is currently framed. This appears to be an 'unintended consequence' of the Millan reforms. We see advantages and disadvantages in both the opt out and opt in solutions.

The opt out solution, giving the service user the right to state that he or she does not want a particular named person or any named person at all, would be available only to people who have (or have had) the legal ability to make such a statement and have done so. The witness to the declaration would have to certify that the person understood the implications of making it and was not subject to any undue influence. Anyone considered to be lacking that capacity could not exclude the appointment of a named person.

To this extent, this solution has all the disadvantages of the present system for people who are unable to make declarations. The mental health officer can apply to the tribunal for the removal of an unsuitable named person, but in addition we think that the mental health officer should be given the discretion not to identify a primary carer or nearest relative as a named person if he or

she does not think this would be in the interests of the service user. If the mental health officer exercises this discretion the matter should be reported, with reasons, to the tribunal.

This solution will require publicity. It may be that one reason for low nominations is that many people are aware of the 'default' provisions and are happy for their primary carer or nearest relative to act as named person. We do not know if this is the case. But people would need to know that they could opt out of the system.

The main advantage of adopting an opt-out solution would be that most people would have someone to act as their named person at a time when they were most vulnerable, regardless of whether they were able to appoint someone.

The opt-in solution, that there should only be a named person if the patient appoints one, attracted considerable support in consultation, and, on balance, it is the solution we prefer. It has various implications:

- It is likely that a person having their first incident of mental ill health will not have a named person unless they are able to appoint one at that time.
- Everyone would need to be made aware of the importance of appointing a named person and the consequences of not doing so. There would be a need for an ongoing public information campaign, both locally and nationally, to ensure that people understand their rights and the implications of appointing, or not appointing, a named person.

While there is a need for much more general publicity to be given to the role and function of the named person, this is only likely to have a significant effect on take-up when a person's mental health may mean that compulsory measures under the Act may be considered. By this time a person may be unable to sign the forms.

If steps are taken to bring the issue to the attention of people at the earliest stage in the development of their illness, there may be some success. Otherwise, it is accepted that the best time to discuss the issue is during the recovery period and in all on-going community based contacts with the service user.

- A person whose illness means that he or she is unable to appoint a named person will not be able to have one unless and until he or she recovers sufficiently to be able to do so. Some people may never be able to make an appointment. The law would need to provide a way of protecting the person's interests in this instance.

One way of doing this would be to retain the existing system for people who are unable to appoint a named person. The primary carer or nearest relative would automatically become named person. As we say above, this has the disadvantage that someone who may have had little contact with the service user is inappropriately placed into this important role.



Another suggestion would be to restrict this role to the primary carer. If a person is unable to appoint a named person, his or her primary carer would automatically take on all the rights and duties of the role. It could be argued that the carer, who clearly has a close relationship with the service user, is the best person to carry out this role. On the other hand, there may be situations where the carer is not the best person to act as named person.

Alternatively, the law could provide that the primary carer would automatically have certain of the named person's powers if a service user was unable to appoint a named person. These powers would include the right to appeal against orders, any extension of orders and against any hospital transfer, together with the right to authorise a medical examination and access to records in connection with any such appeals. If there was no carer, the nearest relative could have these powers.

This solution would give the service user a certain amount of protection for his or her rights but would not involve the full involvement of another person as a named person.

None of the above solutions offers a solution for the person who has no carer or relative. The mental health officer would have to apply to the tribunal for the appointment of a person to take on the role of named person.

We propose a solution which would take in elements of all the above. It has three parts:

- (1) Where a person has not appointed a named person and is unable to appoint one, his or her primary carer (whom failing the nearest relative) should have an automatic right to appeal against orders, the extension of orders and against hospital transfers.
- (2) In addition, anyone with an interest, including carers, relatives and friends, should be able to apply to the tribunal to be appointed as named person. The appointment could be time limited or for an indeterminate time, if the service user was likely to remain unable to appoint a named person for the foreseeable future.
- (3) If a service user for whom compulsory measures are being contemplated is unable to appoint, and has not appointed, a named person and no-one has applied to act as named person on his or her behalf, the mental health officer should notify the tribunal, which might appoint a curator ad litem or safeguarder to protect the person's interests.

We believe this proposal balances the Millan principle of respect for the wishes and feelings of the service user with the equally important principle of ensuring that a service user lacking the ability to protect his or her interests benefits from the protections available under the Act.

We are also attracted to the suggestion that if a person is unable to appoint a named person but has a welfare attorney under the Adults with Incapacity (Scotland) Act 2000, the welfare attorney should automatically become the named person. A person appoints a welfare attorney with a view to future incapacity, much in the same way as one appoints a named person.

However, we do not consider that it would be appropriate for a welfare guardian automatically to take on the role of named person, although he or she could apply to do so under our proposals above. A welfare guardian is appointed by the court, not chosen by the adult. It would not, for example, be appropriate for a welfare guardian who is the chief social work officer of the local authority to act as named person.

*Young people* We are concerned that the law currently does not respect the right of young people who are able to make their own medical decisions to appoint a named person. We believe that a young person who is able to consent to medical treatment should be allowed to make his or her own decision about who is to be named person, in the same way as the Age of Legal Capacity (Scotland) Act 1991 allows a young person with capacity to decide about medical treatment.

*The amount of confidential information named persons receive* We heard of inconsistencies in the amount of information available at the tribunal. Sometimes the application form is accompanied by a considerable amount of background information. Information of a sensitive nature, for example concerning past abuse, the patient's sexual history or criminal record, may be relevant to the subject of the application, but it is important to stress that only information which is relevant to the application should be included in the papers.

There may be training issues for mental health officers to ensure that only information relevant to the hearing application is submitted to the tribunal. Several of those commenting to us said that information should be submitted on a "need to know" basis. Irrelevant personal information should not be included.

We recommend that the Mental Health Act Code of Practice should remind professionals of their powers under the tribunal rules of procedure to request that sensitive information be withheld from one or more of the parties.

Those we consulted were particularly concerned about the situations where a named person who had not been appointed by the service user received confidential information. On the other hand, a service user appointing a named person, should understand this would involve the named person receiving confidential medical information.

We were interested in the suggestion that a person appointing a named person should be able to choose from a list of powers which ones he or she wished to give to the named person. This might more clearly reflect the

principle of respect for the wishes of the service user. It would require those dealing with the named person to check the paperwork to establish the scope of his or her powers, in the same way as those dealing with an attorney (in financial or welfare matters) have to check this. We were not able to consult further about whether this would cause problems in practice. It seems to us that this would be difficult to operate in practice and might compromise the very concept of the named person.

We do not recommend a blanket change to the tribunal rules of procedure so that the named person is not a full party to tribunal proceedings or is a party only if he or she has initiated the action. A party to the action has rights in addition to those available to 'interested parties', such as the primary carer. This includes the important right to hear the evidence and cross-examine witnesses. There may be situations where this could be extremely important in protecting a service user's rights.

### **Recommendations**

We therefore recommend the following changes in relation to named persons:

4.1 A service user should have a named person only if he or she has appointed one.

4.2 Where a person is unable to appoint a named person, his or her primary carer (whom failing the nearest relative) should not act as named person but should have an automatic right to appeal against orders, the extension of orders and against hospital transfers.

4.3 If a service user who has not appointed a named person is at the relevant time unable to appoint a named person and has not signed an advance statement or other document expressing a wish not to have a named person, anyone with an interest should be able to apply to the tribunal to be appointed as a named person.

4.4 In addition to its power to appoint a curator ad litem, the tribunal should be able to appoint a safeguarder where a person appearing before it has no lawyer, independent advocate or named person.

4.5 If a service user for whom compulsory measures are being contemplated is unable to appoint, and has not appointed, a named person and no-one has applied to act as his or her named person, the mental health officer should notify the tribunal, which should consider whether to appoint a curator ad litem or safeguarder to protect the person's interests.

4.6 If, at a time when compulsory measures are being used or contemplated, a service user is unable to understand the effect of nominating a named person, but has previously appointed a welfare attorney under the Adults with Incapacity (Scotland) Act 2000, the welfare attorney should be able to act as the named person.

4.7 There should be a nationwide publicity campaign to advise everyone about the role and function of the named person and the consequences of appointing or not appointing one.

4.8 Special efforts should be made by service providers to encourage service users to consider appointing a named person as early in their illness as possible and at appropriate stages in the recovery process.

4.9 Information about the role and functions of named persons should be made more widely available and such information should be in accessible form and formats and targeted at those who might need it.

4.10 The form appointing the named person should require the written consent of the named person.

4.11 The form should also contain a box setting out the consequences of appointing a named person, including the sharing of confidential information. The box should be signed by the person nominating a named person and confirm that the information set out in the box has been read out and the person signing understands it.

4.12 The named person should be offered support from either the mental health officer or another service provider as soon as possible after he or she needs to act in any capacity.

4.13 Hospital managers should be responsible for ensuring that the person's case records accurately record who the named person is.

4.14 Named persons should continue to have all powers currently exercised by them. In addition, they should receive notification from the police if the service user for whom they are named person is taken to a place of safety.

4.15 When a mental health officer is making an application for a compulsory treatment order, he or she should have a statutory duty to consult with the named person on the proposed care plan. In addition, the responsible medical officer should have a statutory obligation to consult the named person on the final care plan.

4.16 A young person under the age of 16 who has adequate understanding of the consequences of appointing a named person should be able to do so.

4.17 The Mental Health Act Code of Practice should be updated to reflect the provisions of the Mental Health Tribunal for Scotland's practice and procedure rules.

4.18 There is a need for further discussion about good practice concerning the amount and quality of information included in the papers sent to the tribunal, with a view to ensuring that information is only ever shared on a need to know basis.

4.19 The Scottish Government should draw up a Code of Practice for named persons, covering matters such as confidentiality.

## CHAPTER FIVE      MEDICAL MATTERS

### Medical examinations for compulsory treatment orders

#### Background

Several problems have been identified with the provision of medical reports for applications for compulsory treatment orders. These problems relate to the involvement of general practitioners, perceptions of independence between the two reports that are required and of perceived conflicts of interest.

The Act requires that two medical reports accompany the application made to a mental health tribunal by a mental health officer. Section 58(2)(a) states that each medical examination shall be carried out by an approved medical practitioner. Section 58(4) states that the patient's general practitioner *may* carry out one of the medical examinations even though not an approved medical practitioner (the emphasis here is different to that of the 1984 Act, where it was stated that the second recommendation *should* be given *where practicable* by the patient's general practitioner)

The Code of Practice to the Act makes it clear that it is best practice that one of the reports should be provided by the patient's responsible medical officer and the other, wherever possible, by the patient's general practitioner. The Code of Practice goes on to say that the general practitioner can draw on the knowledge and experience of the family and can often bring the benefits arising from a pre-existing relationship with the patient. In addition, the general practitioner can provide an assessment of the patient's mental state which incorporates other dimensions of the patient's medical history, including physical illnesses and history. The general practitioner can also identify the potential contribution of primary care services to a patient's treatment and recovery.

When a general practitioner does not provide a report, then another approved medical practitioner can provide a report. If both the medical reports are provided by approved medical practitioners there are safeguards against any perceived conflict of interest. The second approved medical practitioner must not work directly with the other approved medical practitioner. Conflict of interest regulations do allow a report from an approved medical practitioner employed in the same hospital where failure to do so would involve "serious risk to the health, safety or welfare of the patient or safety of other persons.

#### Problems identified

- Tribunal statistics indicate that only around 50% of second medical reports for compulsory treatment orders are provided by a general practitioner.
- The requirements to ensure the independence of an approved medical practitioner who provides a second report are difficult to comply with, especially in rural areas distant from other hospitals.

- Some respondents to the Review’s consultation reported a perception that general practitioners simply “rubber stamp” the psychiatrists’ reports. This view is associated with a perception that general practitioners see the approved medical practitioner as a specialist, in the same way as they would a gastro-enterologist or an orthopaedic surgeon, and as a consequence are less likely to challenge their “expert” view.
- General practitioners may be reluctant to provide reports as they are rarely involved in applications for compulsory treatment orders and may not feel confident about the requirements of the legislation.
- The organisation of primary care services makes it less likely that a patient has long term contact with an individual general practitioner.
- During our consultation it was suggested by clinical psychologists that it may be appropriate, in some circumstances, particularly where a clinical psychologist is the lead clinician in a person’s care, that if compulsory measures are required then the psychologist should take on the role currently carried out by the responsible medical officer. Consequently, one of the examinations required for a compulsory treatment order application would then be carried out by the clinical psychologist.

### **Possible solutions**

- The application is accompanied by only one medical report from an approved medical practitioner. This report would include information from the patient’s general practitioner about their history and primary care needs.
- The current arrangements should remain unchanged but there should be increased education of general practitioners and support to them in providing a report.
- Remove the option of having reports from two approved medical practitioners. One report would be from an approved medical practitioner and give a specialist’s view on the patient’s mental disorder, current and past mental state, and the need for compulsory treatment. There would also be a requirement for the approved medical practitioner to consult with relevant others in the care team. This report would be called the “psychiatrist’s report”.

The other report must come from the patient’s general practitioner. This report would be in a different form to the approved medical practitioner’s report. The general practitioner would not be acting as a “second specialist”. The report would give a view on the patient’s mental disorder and need for compulsory treatment, to a level appropriate for a general practitioner. The report would include a medical history from a primary care perspective, any relevant information about the patient’s physical health and comment on any

prospective primary care involvement. Overall, the report would give a holistic view of the patient from a general practitioner's primary care perspective. This report would be called the "general practitioner's report".

In order to address the issue of the general practitioner's perceived independence, the requirement that the general practitioner has to state that all the grounds set out in s57(3) of the Act are met could be amended to a requirement that the general practitioner gives a view on the approved medical practitioner's report, similar to that required of the mental health officer by s61(4)(f). It would then be for a mental health tribunal to take into account any differing views on whether the grounds for compulsion are met.

## **Discussion**

Our consultations indicated little support for applications for compulsory treatment orders being based on a single medical report from an approved medical practitioner. We heard widespread support for primary care being involved in long term compulsory treatment, ensuring an active continuity of general practice expertise and connection to primary care services, both retrospectively and prospectively. This was the view expressed by the Millan Committee in its deliberations and strongly supported by the Royal College of General Practitioners during our consultation.

Some concerns were expressed about the availability of general practitioners to provide a report and how to get a report when a patient is not registered with a general practitioner. We acknowledge that general practitioner availability may present a challenge, particularly in rural areas. Notwithstanding, we do not believe, given that it is a rare event for a general practitioner to be involved in providing a report for a compulsory treatment order, that it would be insurmountable to make arrangements for the patient's general practitioner to be involved in what is a very significant event for one of their patients.

Comment was made during our consultation that patients may not always see the same general practitioner, or that the general practitioner who knows the patient best may not be available. In these circumstances, we believe that it would still be preferable to have a primary care perspective from a general practitioner who has access to the patient's primary care records.

NHS Boards have a duty to provide a general practitioner for patients who are not registered. We think it possible for NHS Boards to make arrangements for a person who is not registered to have access to an appropriate primary care service. While the general practitioner allocated may not have prior knowledge of the patient, this arrangement would still bring a primary care perspective to the process and help engage the patient in primary care services with a view to future care outwith hospital.

A relatively small number of patients who are in long term NHS mental health or learning disability care may not be registered with local general

practitioners. If an application for a compulsory treatment order was being made for a person in these circumstances, we believe that it would be very much in his or her interests to have local primary care involvement in their care.

While we believe that the “default” position should be that general practitioners provide a report, there may be exceptional circumstances where this cannot be done. In such cases it may be prudent to have a provision that where the failure in the provision of general practitioner’s report would result in a delay, which would involve serious risk to the health, safety and welfare of the patient or to the safety of other persons, then an approved medical practitioner should provide the other report. This arrangement would be similar to the current regulations on conflict of interest.

We note that in England and Wales the Approved Clinician for medical reports can now include a clinical psychologist, nurse or occupational therapist. The role of the responsible medical officer is replaced by that of Responsible Clinician, who must be an Approved Clinician. While clinical psychologists proposed to us that, in certain circumstance, it may be appropriate for a psychologist to carry out the role of the responsible clinician this was not suggested to us by any other consultees. This is a complex issue and overlaps with the inclusion of learning disability in mental health legislation (we refer to this later in our report). We believe that this matter lies outwith our limited review and make no formal recommendation. However, the Government may wish to consider whether such a change would have merit in Scotland.

### **Recommendations**

5.1 An application for a compulsory treatment order should continue to be accompanied by two medical reports. One report would be called the psychiatrist’s report and be provided by an approved medical practitioner following examination of the patient. The other report would be called a general practitioner’s report and be prepared by the patient’s general practitioner following examination of the patient. The form of these reports should be specified in regulations.

5.2 The requirement that the general practitioner has to state that all the grounds set out in s57(3) of the Act are met should be changed to a duty to give a view on the approved medical practitioner’s report, similar to the duty placed on mental health officers by s61(4)(f).

5.3 In exceptional circumstances set out in regulations, the general practitioner’s report may be provided by a second approved medical practitioner. When a general practitioner’s report is not submitted to a mental health tribunal, there should be a requirement for the relevant NHS Board to notify the Mental Welfare Commission.



## **Medical examinations – conflict of interest**

### **Problems identified**

Currently, regulations state that the medical examination for an application for a compulsory treatment order for a patient to a private hospital must be by an approved medical practitioner not employed by that private hospital, to ensure there is no financial incentive in detaining and admitting patients. However, this is not a requirement for extending compulsory treatment orders. The Mental Welfare Commission has highlighted in its submission that if it is a conflict of interest in relation to granting an order, it must also be in relation to extending one.

### **Discussion**

This situation appears to be an anomaly, given that the continuation of compulsory powers is as significant an event as the granting of those powers.

### **Recommendation**

5.4 Regulations should be amended to require that a medical examination for an extension of a compulsory treatment order applying to a patient in a hospital run by an independent healthcare provider must be made by an approved medical practitioner independent of that service.

## **Revocation of emergency detention certificates**

### **Problems identified**

An emergency detention certificate can currently only be revoked by an approved medical practitioner. This can present problems in rural areas where access to an approved medical practitioner may be difficult. The consequence could be delays in revoking emergency detention certificates where the grounds are no longer met. The Review Group has no data on how often this occurs.

### **Current arrangements**

When discussing emergency detention certificates it is important to remember that the preferred “gateway order” to compulsory treatment is a short term detention certificate. A short term detention certificate should be granted in preference to an emergency detention certificate as it can only be granted by an approved medical practitioner, with the mandatory consent of a mental health officer, and confers on the patient and his or her named person a more extensive set of rights, including a right of “appeal” by applying to the mental health tribunal for revocation.

However, the Act recognises that the circumstances of the need for a compulsory admission to hospital might mean that it is not practicable to fulfil the requirements for a short term detention certificate and, because of this, provision is made for any medical practitioner to complete an emergency detention certificate.

While the emergency detention certificate can allow for the detention of the patient for up to 72 hours, its primary purpose is to permit a full assessment of a person’s mental state. The Act places a duty on hospital managers to ensure that the patient is examined by an approved medical practitioner as soon as is practicable after admission to hospital. The approved medical practitioner will then determine whether the detention criteria continue to be met and consider whether the emergency detention certificate should be revoked, or whether it would be appropriate to grant a short term detention certificate.

### **Discussion**

There is an argument that if a medical practitioner is competent to grant an emergency detention certificate then why should he or she not be able to revoke the certificate? This would ensure that a patient was only subject to an order for the minimum necessary period of time and be in line with the principle of least restrictive care.

We considered this view but think that it does not give due regard to the primary purpose of an emergency detention certificate, that of ensuring a full assessment by a specialist i.e. the approved medical practitioner. One of the successes of the Act has been that the number of emergency detention certificates has reduced without a corresponding rise in the number of short term detention certificates being granted.

While we accept that there have been difficulties in some rural areas in providing prompt access to an approved medical practitioner, we think that this is a practical problem that should be addressed by local service providers. Removing the requirement for an approved medical practitioner to revoke an emergency detention certificate carries the risk of people being detained on an emergency detention certificate and it being revoked without a full mental health assessment by a specialist in the form of an approved medical practitioner.

**Recommendation**

5.5 We do not recommend any change to current arrangements. Revocation of an emergency detention certificate should only take place following assessment by an approved medical practitioner.

## **Compulsory treatment orders – suspension of hospital detention requirement**

### **Problems identified**

The current arrangements for suspension of detention, although well intentioned, are inflexible and difficult to manage and have resulted in the development of excessively bureaucratic systems to count up the number of days a patient has had his or her detention requirement suspended.

There has also been confusion over the calculation of the time limits. On relatively rare occasions a patient can reach the 9 month limit in a 12 month period while at the same time, because of his or her mental state and care circumstances, it is not appropriate to apply for a variation to the powers of the compulsory treatment order. There is no provision in the Act for this situation, which can leave the patient in an uncertain status. The responsible medical officer then has to decide whether to revoke the suspension in circumstances where the patient who does not, in the short term, require to return to hospital.

### **Current arrangements**

Section 127 of the Act provides that where a patient is subject to a compulsory treatment order that authorises detention in hospital, the responsible medical officer can grant a certificate suspending that detention for up to 6 months. Section 127(2) places a limit on the maximum amount of time for which a responsible medical officer may grant a suspension certificate for. In effect, this limits suspension to no more than 9 months in any 12 month period.

A certificate suspending the detention requirement of a compulsory treatment order may be granted for a number of reasons, including a compassionate visit, brief treatment in another hospital or any other reason requiring a short time out of hospital. However, the main use of suspension of detention is providing time away from hospital as part of rehabilitation and recovery programmes. This may include periods of time at home or in a community based care setting. Suspension of detention in practice is often used as a precursor to an application for a variation of a compulsory treatment order to make it community based.

### **Discussion**

The challenge in providing arrangements for suspension of the detention component of a compulsory treatment order is to acknowledge the need to have a system that is flexible enough to respond to practical issues of day to day care and treatment and at the same time provide safeguards against its use in situations where an application for variation of the order would be more appropriate. Millan recommended that the then 12 month period allowed for leave of absence be reduced to 6 months.

### **Recommendations**

5.6 *For brief periods out of hospital (not overnight)* Suspension would be explicitly authorised by the responsible medical officer and recorded in the

patient's casenotes. This would not count towards any cumulative limit on any total time out of hospital whilst subject to detention.

5.7 *For overnight and longer periods of suspension* The responsible medical officer would complete a suspension certificate. Such certificates could cumulatively authorise up to 200 overnight periods out of hospital in any 12 month period. The cumulative total would be counted retrospectively from any point in the patient's compulsory treatment.

5.8 The responsible medical officer would continue to assess whether an application for a variation of the order should be applied for, taking into account the patient's mental state and the principles of the Act.

5.9 Where it appeared that the time limit might be exceeded, an application to a mental health tribunal would be required to be made. The tribunal hearing would then consider whether the grounds for continued compulsory treatment were met or whether a variation was appropriate. Where the grounds for compulsion continued to be met and a variation was not appropriate, the limit on suspension would be "reset" and up to a further 200 overnight stays could be authorised by the responsible medical officer.

## **Consent**

### **Problems identified**

Section 238 of the Act refers to treatments mentioned in ss237(3) and 240(3). Treatment can only be given in accordance with this section if the patient, amongst other conditions, consents in writing to the treatment. The Mental Welfare Commission has posed the question whether written consent is valid over a period of time. The Commission also highlights the situation where a patient is capable of giving informed consent but does not wish to do so in writing. The Commission suggested that it could be disempowering and a breach of the principle of participation for a person not to be able to give verbal consent if he or she chooses.

### **Discussion**

We considered the option of recommending the removal of the requirement for written consent. This requirement is a safeguard for patients to ensure that their view about treatment is recorded. The Act recognises that consent can vary and makes provision for this eventuality in s238(2). We concluded that the requirement for written consent promotes participation and ensures that a patient's consent status is clearly recorded. It also provides a history of the patient's view about treatment over time.

### **Recommendation**

5.10 We do not recommend any change to the current requirement for the patient's consent in writing. In situations where a patient refuses to sign but does indicate verbal consent, we recommend that an opinion from a designated medical practitioner should be sought.

## **Care plans**

### **Problem Identified**

Our consultation has highlighted widespread confusion about the purpose, content and format of care plans. We have received comments from service users, tribunal members, medical and social work staff, NHS management and others that highlight some of the consequences of this confusion.

### **Discussion**

In mental health and learning disability services, care plans are a key mechanism by which an individual's care, support and treatment can be planned, documented and shared. Care plans are dynamic documents which should reflect the changing needs of the individual in the context of his or her recovery.

Implemented well, and in accordance with the principles of the legislation, care plans and care planning provide a participatory framework for agreeing and reviewing the benefits of any programme of care, support and treatment whether in a hospital or community based setting.

The 2003 Act requires the preparation of documented care plans for people who are subject to compulsion. There are various points in time, throughout the life of a compulsory treatment or compulsion order, where there is a formal requirement for a care plan to be produced.

The first care plan is required at the point when an application for a compulsory treatment order is first made. At this stage a “proposed care plan” is prepared by a mental health officer (s62) as part 3 of the application itself. The second is the production of a s76 care plan which has to be completed by the Responsible Medical Officer ‘as soon as practicable after appointment under s230’. There is no existing recommended template for deployment and there appears to be no specified timeframe for the completion of the s76 care plan in the Act, Regulations or Code of Practice.

The s76 care plan is then subject to review at points of extension, variation, and review by the tribunal. For individuals subject to compulsion orders, the responsible medical officer is required to produce a “Part 9” care plan which is essentially the same as a s76 care plan.

There can be a tendency for the responsible medical officer to view the s76 Care Plan as the responsible medical officer care plan focussing specifically on medical treatment as distinct from the overarching care plan which aims to reflect the care, support and treatment delivered to the individual by a range of disciplines and agencies.

We are aware that the Mental Welfare Commission has carried out consultations in connection with publishing guidance on the preparation of care plans. We believe that this work could provide a basis for the Government to provide a national template for care plans with the aim of promoting consistency of practice across the country. We believe that this would be of benefit to service users, staff and the tribunal.

## **Recommendations**

5.11 The Scottish Government should, by regulations, provide a template for the s76 care plan with a recommended timeframe for its completion at the various stages it is required.

5.12 The template should reflect the proposed care plan currently incorporated as part 3 of the initial compulsory treatment order application.

5.13 The template should incorporate a guidance note that its content should reflect the overarching care plan inclusive of the care, support and treatment delivered to the individual by a range of disciplines and agencies.

5.14 The template should conclude with a section noting those consulted in its compilation and to whom it has been circulated and when.

5.15 The template should include the option to attach the CEL 13 care plan (enhanced care programme approach care plan) for those subject to a

compulsion order/compulsion order and restriction order to prevent duplication.

5.16 Given that the act has now been in operation for some time, there may be benefit in formalising the recommended forms to prescribed status.



## CHAPTER SIX TRIBUNALS

### Background

One of the biggest changes introduced by the Act was the setting up of a tribunal system for making decisions about the care and treatment of people with serious mental health problems, including decisions about the need for compulsory measures of care. Previously, such decisions were made by sheriffs in the person's local sheriff court but, by 2003, there was a general recognition that courts were not the best venues for such cases. The vision for the future was to create a new organisation made up of people with expertise in mental health issues, who would be able to draw upon that expertise when making decisions about a person's need for care and treatment.

The new system was set up in accordance with the Millan principles and the experience of attending a tribunal was intended to be more inclusive and less daunting for the service user than having their case dealt with in a court. It was expected that, in the less formal atmosphere of a tribunal setting, people could participate more effectively and contribute in a much more meaningful way to the making of critical decisions relating to their care and treatment.

The Mental Health Tribunal for Scotland was set up and the new system has been running since October 2005. As more than three years have passed, it is time to look at how the new system is working in practice and consider whether the system is working in the way that was intended. Even if it is accepted that it is, the system may still benefit from some adjustments being made in the light of experience to date.

The operation of mental health tribunals was the single subject that generated most debate throughout the consultation process entered into by the Review Group. Most people welcomed the introduction of the mental health tribunal system and agreed that it was a significant step in the right direction.

*"Tribunals are more inclusive and participatory than the old sheriff court system"*

*"I think the current Mental Health Act overall is a good Act and that the tribunals work well"*

However, many people felt that there is still room for improvement.

*"The best interests of the service user seem at times lost in the procedures".*

*"Whilst we felt that the tribunal tried to be welcoming and informal, and to hold it in attractive surroundings, and also to provide us with information, many of us who attended tribunals had problems with it"*

*"Far too often we feel that our voice is the least heard and the least effective and that we are "outnumbered by everyone else. In many ways we feel that*

*we are a token voice where decisions about our detention are already inevitable”.*

While most who participated in the consultation process regarded the new system as being an improvement on the old, it is clear that some issues are causing significant problems.

The major issues concerning tribunals which were identified to the group were:

- The large number of cases (more than 50%) which require more than one hearing to reach a conclusion – i.e. the problem of multiple hearings;
- A perception of excessive formality and legality at some tribunal hearings;
- The availability, quality and style of legal representation.

Each of these major issues will be considered separately.

## Multiple hearings

### Background

The problem of multiple hearings was raised repeatedly during the consultation process as one of the most pressing issues to which attention should be paid. Service users, carers and named persons all found the need to attend repeated hearings stressful and demanding. For many, the situation is made worse by the need for the same painful information to be repeated at each new hearing in front of different tribunal members. Having attended the first few hearings, some patients simply refused to attend further hearings because they found the process too stressful. The message from the consultation process was loud and clear – repeated hearings cause major problems for the very people the new system was intended to benefit most.

*“At each new tribunal there were 3 new strangers with no knowledge of the full Findings and Reasons of the previous tribunal and no knowledge of my brother’s previous mental health history, so the evidence had to be repeated each time. This is distressing”.*

Repeated hearings also cause problems for the professionals involved in the service user’s care and treatment. Mental health officers, medical and nursing staff have to juggle their professional commitments and often have to attend hearings at the expense of other work and other patients.

*“It is often very disruptive to the care of non-detained patients when staff have to attend tribunals”.*

*“The amount of time spent at tribunals is high and you have to clear a full half day minimum from your diary if there is a tribunal as you never know how long it is going to take and usually I average about two hours of time per tribunal minimum”.*

Independent advocates and solicitors must make themselves available at short notice and on repeated occasions. Last minute cancellation of hearings can mean that lawyers have set aside valuable working hours for no ultimate fee, and the risk of this may discourage some lawyers from taking on such work. This may well reduce the quantity, and perhaps also the quality, of legal representatives working in the mental health field.

For the tribunal service also, repeated hearings cause problems. Time, effort and public money are wasted setting up hearings which then fail to reach a satisfactory outcome. This takes up resources which could be better used by actively managing cases in such a way as to have them fully prepared and ready to proceed in the shortest period of time. Ideally, the first hearing of an application should be the only hearing required in order for a full and proper assessment of the application to be made.

During the consultation process, therefore, we set out to establish what factors were causing additional hearings to be required.

### **Problems identified**

The following factors were identified as causing, or at least contributing to, the need for multiple hearings:

- The very tight timescales set out in the Act often result in the hearing being convened before parties are ready to proceed;
- As applications for compulsory treatment orders are usually lodged with the tribunal service very close to the end of the 28 day period of the short term detention certificate, the tribunal service often has little or no time to identify and resolve problems in advance of a hearing;
- Serving the hearing papers by post reduces the period of notice given to the patient and any named person, giving them less time to prepare for the hearing;
- Patients can have difficulty in finding and instructing a suitable solicitor within the short time frame available;
- Where a curator ad litem is needed (*in cases where a patient is not considered to be able properly to instruct a solicitor*), he or she often cannot prepare fully for the hearing within the short timescale available;
- Where an independent medical or other expert report is required, a suitable person to provide the report has to be identified and instructed, then given the opportunity to prepare the report within a very tight timescale;
- In the interests of justice, parties must be given time properly to prepare their case.

The above issues were identified through the consultation process as being the most significant factors resulting in a final decision being put off until a later date. Additional factors reported by consultees included:

- Poor quality of legal representation;
- Absence of key participants at the hearing;
- Poor quality or missing documentation;
- Poor use of technology, e.g. failure to notify parties by phone or email when tight timescales apply;
- Inappropriate decisions by tribunal members, e.g. tribunals ignoring stated wishes of patient and insisting upon patient's attendance;
- Inappropriate selection of date of hearing, sometimes despite advance warning by parties that a particular date is not suitable;
- Inappropriate venues being selected for hearings, e.g. community venue when a hospital setting is required;
- The present method of paying fees to legal representatives and tribunal members is thought to encourage a culture of repeat hearings.

### **Consideration of the problems identified**

It is clear, not just from the anecdotal evidence of those who took part in the consultation process but also from the statistics provided by the tribunal service, that the first calling of an application for a compulsory treatment order before a tribunal very often finds the parties not ready to proceed for a variety

of different reasons. The main reason for this is that the timescales for compulsory treatment order applications as set out in the Act are very tight.

Most patients who are the subject of an application for a compulsory treatment order will first be subject to a short term detention certificate, which lasts for only 28 days unless it is extended. In many cases, it will not need to be extended because the patient's health will have improved. The short term detention certificate can be extended for a further period of 3 working days, but only in circumstances where a patient's health deteriorates in the days immediately prior to the expiry of the certificate, leaving insufficient time for an application for a compulsory treatment order to be made. The other way in which a period of short term detention can be extended is where an application for a compulsory treatment order is made to the Tribunal. In these circumstances, the patient's detention in hospital continues to be authorised for a further 5 working days from the time when the short term detention certificate would otherwise have expired. This is to allow the hearing to take place.

For most patients, therefore, the tribunal hearing must take place within five days of the expiry of the 28 day short-term detention certificate. In many cases, however, it will not become clear until well into the 28 day period whether or not an application for a compulsory treatment order will be necessary. Mental health conditions often require a reasonable period of time before medication begins to take effect and a proper assessment can be made. Applications must contain reports from two doctors and the patient's mental health officer, and these take time to obtain. In line with the principle of "least restriction" service providers will want to be sure that compulsory measures of care are necessary before making an application for a compulsory treatment order. For all these reasons, the vast majority of compulsory treatment order applications are received by the tribunal service on days 26–28 of the short-term detention certificate. This puts considerable pressure on the system and leaves very little time for either the tribunal service or the parties to make all the necessary preparations for the hearing.

The process of making the application, and of notifying the parties that there will be a hearing, uses up even more of the limited time available. Applications are sent by post or courier to the Hamilton office of the tribunal service, where they are then logged, copied and sent by post to the patient and the named person. Although the patient will have been told about the application by the mental health officer, this is the first time the patient will have seen it. Postal delays can mean that those involved receive very little notice of the date fixed for hearing. A lack of adequate notice can cause very significant practical problems for named persons or carers, especially those living in remote rural areas or on one of the Scottish islands.

*"Because my Mum was only told about the hearing the day before, there was no ferry she could get to be with me at my hearing. She just couldn't get there in time. That made being at the hearing harder for me".*

The patient is entitled to legal representation and the services of an advocacy organisation, but such representation has to be organised within a very short space of time. Once appointed, the solicitor needs to meet with the patient and take instructions. In practical terms, it is probably only after the solicitor

has access to the application that the issue of whether an independent psychiatric report is required can be properly considered. If an independent psychiatric report is to be obtained, then this has to be instructed and prepared.

Almost all cases are covered by the Assistance by Way of Representation (ABWOR) programme of the Scottish Legal Aid Board, a non-means based system for financing legal representation and any expert reports required for a hearing. The Review Group was assured that there are no delays in authorising expenditure for obtaining expert reports, but it still takes time to identify an available expert, have the expert examine the patient and prepare a written report. This is difficult to achieve within the current timescale.

Named persons may also experience problems because of the tight timescales. A named person may have no idea of what is happening. The arrival of the papers in their morning post may be their first intimation that they are a named person and therefore involved in a case. With only a few days warning, they then have to decide whether to instruct a solicitor, meet with the patient and prepare for a hearing.

If the patient is *unable* to instruct a solicitor (as opposed to deciding not to instruct one), a curator ad litem will be appointed to look after the patient's interests throughout the tribunal process. If a curator ad litem is required, then he or she must be instructed and must prepare for the hearing. The process of the appointment of curators has been speeded up considerably in recent months, but around 40% of interim orders at first hearings arise because of issues relating to curators. In addition, the tribunal service has to arrange the hearing within a very tight timescale and so has little room to manoeuvre to suit the convenience of parties or to avoid dates at the request of those involved. In these circumstances, it is hardly surprising that problems occur.

Under the current system, hearings are often arranged before the parties have had time to sort these issues out. Appeal decisions by sheriff principals early in the life of the Tribunal made clear that tribunals *must* allow parties reasonable time to instruct their lawyers, or obtain independent psychiatric reports if they wish to do so. In many cases, tribunals have no option but to make a temporary or "interim" order, but this, of course, results in the problem of multiple hearings.

### **Possible solutions to the problem of multiple hearings**

Two possible solutions were set out in the Review Group's consultation document. These were to:-

- Lengthen the timescales in the Act by which a first hearing must be held; and/or (option 1)
- Allow short preliminary hearings and interim orders without the need for all parties to be present. (option 2)

It should be noted that within each of the above solutions there is a variety of different possible options. The Review Group invited respondees' views on these suggestions and also sought alternative suggestions for reducing the number of hearings required in a way that benefits the service user.

The following suggestions were made in response to the consultation document:

- Introduce a Code of Practice for legal representatives
- Make better use of fast access technology, e.g. phone or email
- Set more realistic hearing dates
- No independent reports to be obtained in “clear-cut” cases
- Extend the short-term detention certificate by 14 days
- Use procedural/preliminary hearings where appropriate
- Reduce payments to tribunal members and legal representatives where a hearing is adjourned
- Improve the tribunal service’s case management system
- Reduce the expectation that all persons involved will be present at a hearing
- Encourage better preparation by legal representatives
- Need for independent medical report should automatically delay first hearing
- Change constitution of tribunal membership
- Increase the number of solicitors specialising in mental health issues
- Earlier appointment of curator ad litem in appropriate cases
- The medical member of the tribunal should examine the patient and provide a report
- Paper hearings should be used where appropriate, with the consent of the service user
- Same tribunal members should be reserved for the progression of the case
- Appoint a “Reporter to the hearing” to ensure that all statutory and independent reports are available to the tribunal
- Tribunals need to adopt a softer, easier, less legalistic approach.
- Establish and maintain a list of medical practitioners able to provide medical opinions.

## **Discussion**

### **Option 1**

One possible solution was a simple extension of the validity of a short-term detention certificate to, say, 40 days. Not only would this reduce the pressure on mental health officers and responsible medical officers to submit the application, but it would also allow more time for the patient to advance in recovery and may thus reduce the number of short-term detention certificates which need to be converted into compulsory treatment orders. However, this “solution” met with almost universal disapproval. The obvious breach of the principle of minimum intervention was the primary reason for resistance, but it was also felt that there was a significant risk that it would merely extend the initial period of detention without providing a benefit for the patient. Mental health officers and responsible medical officers would still be likely to leave applications until near the end of whatever period the initial order ran for, in order to see if there had been sufficient recovery to make the compulsory treatment order unnecessary. Having considered the arguments for and

against, the Review Group considered that simply extending the validity of a short-term detention certificate was not a solution consistent with the Millan principles.

As many interim orders are necessitated by the obtaining of independent psychiatric reports, the Review Group considered ways of improving upon the current system. The idea of setting up a pool of “independent” medical practitioners who, immediately upon receipt of an application based on the responsible medical officer’s report, would provide the second medical report on the instruction of the tribunal service was discussed but rejected. It was considered that the requirement for a second medical report to be obtained before the submission of an application was an essential safety check in the system, and should not be departed from. We also considered that patients would not necessarily regard a report obtained in such circumstances as being truly independent.

We did not agree with the suggestion that a patient’s right to obtain an independent report should be curtailed. The Review Group considered that the opportunity to obtain an independent report was a patient’s fundamental right and one which must be preserved not diluted.

The suggestion that the medical member of the tribunal provide a report was also rejected as undesirable. The independence of the medical member as a decision maker could be compromised if he or she was required to examine the patient and offer a professional opinion. He or she would hardly be regarded as objective if a key piece of evidence was their own report.

The solution which gained most approval was an extension of the time allowed for the fixing of a hearing once an application has been made within the 28 day period. At the moment, the law allows only five working days for this; we recommend that this be extended to ten working days. In order to preserve the principle of least restriction, however, this additional five days, where utilised, would still count towards the maximum 56 day period permitted for an interim compulsory treatment order. The expectation is that, where possible, hearings should take place within the current five day period. However, we recommend that this should no longer be mandatory. Ten working days would become the new mandatory limit.

The extension of the five day limit to ten days would have the following benefits:

- It would allow for a much more proactive and effective case management system to operate at tribunal headquarters;
- Staff and legally qualified conveners would have time to scrutinise applications and identify and address potential problems;
- Conveners could make use of existing powers to review and proactively manage cases in advance of setting a hearing date to ensure that, as far as possible, only one full hearing needs to be held;
- Where the need for a curator ad litem is identified, a curator can be appointed in sufficient time to prepare fully for the first hearing;



- While continued efforts should be made to make electronic submission of tribunal applications the norm, extending the time frame for fixing a hearing by five days would allow for the vagaries of the postal system and give parties more notice of hearings;
- More advance notice of hearings should reduce the disruption caused by parties and their representatives needing to attend;
- Much greater account could be taken of participants' diaries in setting tribunal dates and times;
- Patients' representatives could reasonably be expected to obtain independent psychiatric reports in advance of the first hearing;
- All parties, but especially service-users, carers and named persons, would have significantly more opportunity to prepare for the hearing.

## **Option 2**

The Review Group also considered that greater use should be made of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone. There was no general feeling that these powers were excessive or were being used inappropriately. Greater use should also be made in appropriate circumstances of the power to decide a case without a hearing, which is contained within paragraph 58 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005. There are already a number of safeguards built into this provision, the primary safeguards being that the relevant persons must agree to this in writing, the tribunal must be satisfied that sufficient evidence is available to enable it to come to a decision, and that to do so would not be contrary to the interests of the patient.

The Review Group considered that what was required in this respect was primarily a change of attitude and approach, rather than a change in either the primary or secondary legislation. More proactive use of the powers that already exist, coupled with the extension of the five working day time limit to ten working days in relation to compulsory treatment order applications, should resolve many of the difficulties that currently exist. The Review Group understands that the new President of the tribunal service is in favour of such a change of approach and has already introduced measures to facilitate greater use of the powers already contained within the Act and the Rules.

In relation to applications for compulsory treatment orders, there were conflicting views voiced in relation to the idea of having shorter preliminary hearings and interim orders being made without the need for all parties to be present. Some people welcomed this, but many did not.

*"I am wholly opposed to the second suggestion which seriously violates the principle of patient participation. It would smack of rubber-stamping applications, if only on an interim basis."*

*"We believe the service user is the most important person in the process. Cutting them out seems to compromise their rights."*

*“We agree that numerous hearings cause anxiety and expense but feel that the proposals restrict our rights and our right to participate and have a voice in decisions concerning our care.”*

Quite rightly, to date great emphasis has been placed by the tribunals upon the principle of participation, which is of course a key feature in the Millan principles. A clear message from the consultation process has been that excessive insistence on patient participation, at stages of the process where a final decision cannot yet be made, is both distressing to, and damaging for, some patients. That said, deep concern was expressed by patients about the prospect of hearings from which they perceived themselves to be excluded. This concern was particularly strong in relation to the idea of paper hearings.

Weighing up these conflicting perspectives, the Review Group considered that, while greater use of short procedural hearings should be encouraged, such hearings should be limited to situations where the patient (after discussion with the legal representative if one has been instructed) has agreed not to proceed to a full hearing until such time as the reason for the delay has been resolved (e.g. an independent report has been obtained). We also considered that the patient and named person should have the right to attend even a procedural hearing, if so wished. The distress of multiple hearings could be significantly reduced if the limited purpose and likely outcome of the hearing were clear to the patient from the outset. This scenario would allow for procedural issues to be dealt with without the necessity of *all* parties attending, thus relieving pressure on responsible medical officers and other professional staff, but would not create the perception that the service user or named person was being excluded.

At the present time, where an interim compulsory treatment order is being made, the tribunal is required under s65(6)(a) of the Act to be satisfied that the conditions for the order are met. As a result, the evidence must be vigorously tested even although only an interim order is contemplated. This is so even where the patient, having taken advice from his or her legal representative, is not contesting the granting of an interim order on a short term basis. This often has the consequence of requiring patients and those close to them to listen to distressing details being repeated on more than one occasion.

The Review Group considered that the criteria for granting an interim order, in situations where this is being done on an unopposed basis for a short period pending the obtaining of a report or some other such procedural matter, should be amended. We considered that, in these circumstances, the tribunal should be able to grant an interim order if the conditions for the order “appear to be met”. This would reduce the need for the tribunal vigorously to test the evidence before granting an interim order. This proposed amendment would require legislative change. We considered, however, that an interim order made on the basis of the “appear to be met” test should be subject to a time limit of a maximum of 28 days. After that period of time, a tribunal would require to be satisfied that the conditions for the order are indeed met.

The Review Group considered the possible use of paper hearings but this was not considered to be a desirable step forward. The Review Group considered that the current problems in the system could be adequately addressed by the measures recommended without the need for the introduction of paper hearings. The Review Group also considered the use of Minutes of Agreement but did not consider such agreements to be appropriate in proceedings of this type.

The variation in public holidays in different geographical areas can lead to hearing dates being fixed for days regarded locally as a public holiday. The suggestion was made that the President of the tribunal service be given the power to nominate up to 15 non-working days per year, to cover public and traditional holidays. We agreed that this would allow for a degree of flexibility in the fixing of holidays and accordingly we recommend that this be implemented.

### **Recommendations**

6.1 The time limit of five working days contained in s68(2)(a) of the Act should be increased to ten working days.

6.2 Where the additional five day period is utilised, the maximum period of time permitted for extension of interim compulsory treatment orders will be reduced by five working days from the present maximum of 56 days as set out in s65(3) of the Act.

6.3 Service users who want to appoint a solicitor should be encouraged to do so at the earliest opportunity within the period of the short term detention certificate.

6.4 A copy of the application for a compulsory treatment order should be given to the patient and/or the patient's solicitor (if already appointed) by the mental health officer at the same time as it is being sent to the tribunal office. (This would not remove from the tribunal service the duty of serving formal notice as is done at present but would give the patient advance notice of the impending application).

6.5 Codes of Conduct should be prepared by the tribunal service for curators ad litem and tribunal members.

6.6 Where an interim order is proposed for a short period in order to allow for some specified action to be taken on behalf of the patient, the tribunal should be able to grant an interim order if the conditions for the order "appear to be met".

6.7 An interim order made on the basis of the "appear to be met" test should be subject to a time limit of a maximum of 28 days.

6.8 Greater use should be made of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone.

6.9 The President should be given the power to nominate up to 15 non-working days per year.

## Excessive formality and legality

### Discussion

A major objective in the move from the sheriff court to a tribunal system in the new Act was to improve user and carer participation in the hearing by reducing formality and moving away from a forum more commonly associated in the public's minds with civil disputes and criminal cases. Some people who participated in the consultation process objected to the level of formality and legality which tribunals continue to adopt. Some felt that tribunals had not fully lived up to the expectations of the Millan Committee.

*“Less legality in approach and manner would improve the process.”*

*“The hearing process has improved, but it can still be inconsistent and too bureaucratic. How the convener operates is therefore crucial.”*

It must be borne in mind, however, that, although intended to be less daunting and more inclusive, tribunal hearings are still legal proceedings and, to a greater or lesser degree, the freedom, as well as the well being, of an individual is at stake in every case. A degree of formality is therefore appropriate to proceedings of such significance to the individual concerned. It must also be remembered that in order to ensure proceedings are conducted *“as fairly, expeditiously and efficiently as possible”*, which is the overriding objective as set out in the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005, the appropriate measure of control must be maintained. The degree of control required will vary depending upon the particular individuals involved in each case. The personality, experience and approach of the convener will also have a significant effect upon the way in which the tribunal hearing is handled.

*“Different conveners put different emphasis on the client. Some put them at the centre of proceedings, others keep them marginalised, or at least that is the perception.”*

The change to a tribunal system required the recruitment and training of tribunal members in three different categories; qualified lawyers with more than ten years' experience to act as conveners, psychiatrically qualified doctors and general members with some knowledge or experience of the mental health system. The new system also required the identification of premises throughout the country which would be suitable venues for hearings, with appropriate waiting and interviewing facilities and located close to where the majority of users are based.

The feedback from those who had experience of attending a number of tribunals was that, while some tribunal hearings were handled very well, others were handled with excessive firmness, and a lack of flexibility. Some service users and carers complained about the overly legalistic approach of some conveners. Everyone agreed that the ambience of the tribunal hearing was greatly influenced by the personality of the convener. Some conveners,

perhaps the more experienced, were described as excellent, and adopted a relaxed, friendly and encouraging approach. Others appeared to follow a strict set of orders prepared in advance, allowed no flexibility in the proceedings and were very strict in setting out the rules for the hearing. A few conveners adopted attitudes considered more appropriate to courtrooms than mental health tribunals. Such conveners were, however, considered to be in the minority.

It is recognised that some conveners will have more experience than others of operating within a tribunal setting. We consider that continued regular, focused and high quality training of tribunal members, and especially conveners, will, through time, address many of the issues raised and should provide the members and conveners with the skills and confidence to meet the challenges of their role. Feedback from tribunal conveners indicates that the initial training they received was thorough and highly relevant, but that, for a time, follow-up training was more restricted, with much of the training budget having been consumed by the intensive initial programme. Recent initiatives, however, have included the setting up of a training group made up of tribunal members and this group will be influential in ensuring that future training events are focused and relevant to the developing needs of the members. We acknowledge the commitment made to the training of members to date, and would urge that the training programme continue to receive a high level of priority in the months and years to come. The tribunal service appraisal scheme should also assist by spreading good practice and picking up on areas where there is room for improvement.

It is more difficult to provide the same kind of training to the private practitioners who represent users and carers. Many service providers who engaged in the consultation process were vociferous in their complaints about what they saw as the adversarial tactics adopted by many solicitors. It is right and proper that the evidence should be properly tested, but some representatives cross-examined with such vigour that witnesses found it to be a traumatic experience. Mental health law is not an area that has hitherto attracted a broad range of practitioners. Some practitioners carry on the habits and practices of their other court work when they appear at tribunals. Tactics that may be appropriate in the criminal courts are not necessarily appropriate in mental health tribunal hearings. It requires very strong, but sensitive, chairing by the convener to encourage a solicitor out of this "courtroom" role without appearing to restrict that solicitor's representation of the client.

One of the areas which attracted particular comment from users and carers was the order of events at the hearing, and especially the order in which people were invited to speak. Traditional adversarial proceedings in Scottish civil and criminal courts have a strict order of turn-taking, with the pursuer or prosecutor starting and the defender or accused speaking last. This is, of course, logical in that the pursuer or prosecutor has to make a case for the other side to answer. It goes further, however, in allowing each witness to be led in turn without interruption from the other side and then cross-examined, again without interruption. While this is logical in a court setting, and lawyers are well used to it, it is not a normal mode of social discourse. Following it

slavishly in a tribunal can make even the represented patient or carer feel irrelevant to the proceedings, not being involved in speaking until last, by which stage they may well have forgotten the points they wanted to make.

*“We are always heard last. Carers and users should get to speak first, or at least early on in the proceedings.”*

A second issue which attracted adverse comments was the presence of microphones in the tribunal room. All proceedings are tape recorded from beginning to end, but the tapes are not routinely transcribed and seem to be available only for use by the tribunal afterwards. Some people who had been involved in appeals had asked, through their lawyers, to have a copy of the tapes, but their requests were refused. The very presence of the recording devices was seen by some respondents as off-putting.

Under the existing Rules, a variety of persons could be present at a tribunal. The service user, their lawyer, curator ad litem and independent advocate, the named person, their lawyer and independent advocate, the mental health officer and responsible medical officer, with a possible lawyer, carers and family members, nurses as escorts or witnesses and the three person tribunal with a clerk. If all such persons turned up at the same time, it could make preserving informality – and order - very difficult indeed. In practice, it appears that conveners are generally very good at keeping the numbers under control and we heard very few complaints about this issue.

Tribunal hearings take place in a wide variety of venues, many of them in rooms in hospital premises. Some people subject to a community based compulsory treatment order disliked the idea of having to return to the hospital for hearings – it brought back memories of experiences they would rather forget. The rooms themselves varied in size, shape and quality of acoustics. People felt that some hearing rooms were not appropriate for hearings because of poor acoustics, over-large tables or too cramped conditions. There were also complaints that some venues lacked proper waiting or refreshment facilities, or even easy access to toilet facilities. Others lacked private interview rooms where lawyers could meet with clients before the hearing or during adjournments.

Schedule 2, Part 2, paragraph 8(4) of the Act places the responsibility for providing accommodation for tribunal hearings jointly with NHS Boards and local authorities (and, in appropriate cases the State Hospitals Board, but this falls outwith the remit of the Review Group). The Review Group had access to the Memorandum of Understanding between the tribunal service and Health Boards throughout Scotland. Annexes and appendices to the Memorandum of Understanding set out the guidelines and preferred standards for venues used for holding tribunal hearings.

The Review Group considered that the preferred standards as set out in the Memorandum of Understanding were adequate and appropriate, but the anecdotal evidence received during the consultation process suggests that the preferred standards are not always being met. The Memorandum of

Understanding acknowledges that *“on some occasions it may not be possible or practicable to meet all the specified requirements”*. The Review Group accepts that this may be so. However, we considered it a matter of concern if some hearings are being held in venues which fall far below the preferred standard.

The Review Group considered that, if the standards set out in the Memorandum of Understanding were adhered to, the issues complained of would not arise. The Memorandum already recognises that *“venues must be provided which fully meet the user’s needs as well as supporting the requirements of the Act. That is to say, that all venues must allow for hearings to be conducted in privacy whilst allowing openness for sensitive discussions to take place. There is also a requirement for patient/representative discussion to take place privately away from the main hearing room.”* The Memorandum states that *“the venue must include at least one hearing room of a suitable size, with a minimum of two waiting rooms for all parties. There should be an ante-room for the tribunal members and a small interview room.”* The Memorandum further states that *“the hearing room, interview room and toilets should all be directly accessible from the reception area”*. The Review Group considered that these were all basic requirements which should be met in all but the most exceptional circumstances. We considered that these represented the minimum standards which should be adhered to. We also considered that the minimum standard should include ready access to drinking water for all those involved.

The Review Group recommends that the preferred standards already contained within the Memorandum of Understanding be retained and maintained, but that greater emphasis should be placed on ensuring that those preferred standards are met. We recommend that a separate annexe be prepared setting out the minimum standards which **must** be met before a venue will be considered suitable for use. These are already contained within the Memorandum, but we consider that a clearer base line must be set. We recommend that if a venue is assessed as inadequate in terms of paragraph 2.2.2 of the Memorandum, that venue should **not** be used until the issues which have caused it to be so assessed have been addressed.

At present, the Memorandum provides that the tribunal service will assess the suitability of each venue provided at least once a year. We recognise that the Scottish Committee of the Administrative Justice and Tribunals Council (AJTC) also has a role in monitoring tribunal standards. We consider that these two bodies have a significant role to play in ensuring that inadequate accommodation is not used.

We note that there is no Memorandum of Understanding between the tribunal service and the local authorities, although local authorities share with NHS Boards responsibility for providing accommodation for tribunal hearings. We consider that it would be beneficial if similar prescribed minimum and preferred standards could also be agreed between the tribunal service and local authorities.



The Review Group considered the issue of whether hospital venues are suitable for hearings concerning patients who have returned to the community. We accept that returning to hospital premises will evoke unhappy memories for some patients. However, we also recognise that facilities and resources are finite and that best use has to be made of such resources as are available. We considered that although, where possible, suitable and appropriate community venues should be used in such circumstances, it may be necessary to make use of hospital venues when no suitable community venues are available. We make no recommendation in respect of this matter.

### **Recommendations**

6.10 Ongoing training in tribunal skills must be maintained for all members, especially conveners.

6.11 Conveners should be encouraged to be flexible in their approach to the way in which tribunal hearings are managed.

6.12 Consideration should be given to whether the use of tape recorders adds value to the tribunal process. If it does, then the purpose of recording the proceedings should be explained to the parties and all parties should be given equal access to the transcript or recording taken. If it is accepted that little or no value is added, then the practice of routinely recording hearings should be discontinued.

6.13 A Code of Conduct should be prepared by the Law Society of Scotland for legal representatives working in the field of mental health law and appearing at mental health tribunals.

6.14 The preferred standards already contained within the Memorandum of Understanding should be retained and maintained, but greater emphasis should be placed on ensuring that those preferred standards are met.

6.15 Rooms used for holding tribunal hearings should be required to meet prescribed minimum standards.

6.16 The prescribed minimum standards must include ready access to toilet facilities and drinking water, adequate waiting facilities and access to a separate private interview area for the use of the patient and his or her advisers.

6.17 A venue which does not meet these requirements should be assessed as inadequate.

6.18 If a venue is assessed as inadequate, that venue must not be used until the issues which have caused it to be so assessed have been addressed.

## **Availability, quality and style of legal representation**

### **Discussion**

Many sources reported that there are particular problems with availability of legal services in areas outside the central belt. This results in services being provided from within the central belt, which has two undesirable consequences.

The first is that the service is often restricted to providing representation at a tribunal hearing, with little contact before the hearing and very little after it. Ideally, tribunal representation would be only one facet of the relationship between the service user or carer and the lawyer. An ongoing relationship would benefit the client, and could also improve the quality of representation provided at the hearing as the lawyer would have a thorough knowledge of the client and the case. Some service users complained that the same lawyer did not appear for each of their continued hearings, and this caused additional consternation and concern. Many service users need time to establish trust in a new face.

The second problem is the cost. The Scottish Legal Aid Board, which finances the Assistance by Way of Representation (ABWOR) scheme refunds travelling expenses incurred by solicitors in attending to take client's instructions and to represent them at tribunal. It is concerned at the rising cost of funding tribunals and at the proportion of the funding spent on travel and subsistence costs. The Board is considering extending the remit of its salaried lawyers to cover Mental Health Act cases and thus reduce the burden on the public purse. This would be an effective way of covering the service until private practitioners become more involved in this area.

Scottish Legal Aid Board figures indicate that the average cost of assistance by way of representation per mental health tribunal is £1,143. As this includes travelling and subsistence, the fees of the independent psychiatrist providing the report, the lawyer's fees for taking instructions *and* providing representation at the hearing, this figure is not unreasonable. Reducing the number of hearings and making legal services more locally available could, however, make a major impact on the figure.

Mental health law is not currently an area of law which attracts a broad interest from within the profession. It is a source of disappointment that the Law Society of Scotland's accreditation scheme for specialists in mental health law has attracted very few applicants for accreditation. The legal aid board's statistics show that ten firms are carrying out 85% of all assistance by way of representation work in relation to tribunals; three of these ten firms cover 70% of the cases and one firm covers a staggering 35% of cases. This level of specialisation in any area of work is unusual. It may be that the practices of short notice for hearings, frequent interim orders, hearings being postponed at short notice and multiple hearings make it more difficult for

smaller firms to manage cases economically. Tackling these problems may lead to an increased interest within the legal profession.

We heard anecdotal evidence concerning the quality of legal representation, with particular comments about the adversarial approach taken by some solicitors whose main practice is or has been in the criminal courts. Such comments were made by service providers rather than users or carers. We also heard that the large firms involved did not always send the same solicitor for each hearing of a user's case, and this did cause some upset to service users. Equally, we heard that some lawyers, on receipt of an independent psychiatric report which confirms the responsible medical officer's report, advise their clients that there is no point in proceeding with a hearing. This means that the opportunity to test the evidence in front of the tribunal is lost, as is the opportunity to examine in detail the provisional care plan presented to the tribunal. Clients can thus be left with the feeling that it has all been decided before the hearing.

The Scottish Legal Aid Board carries out quality control assessments of files in relation to cases, but has received no complaints from clients in relation to tribunals. The Board has indicated that it would appreciate further feedback from those involved in tribunals. Resolving the problems of short notice, frequent cancellations and multiple hearings might increase the number of solicitors interested in this area, and it is hoped that the recommendations in this report will go some way towards that.

There are, however, other issues which need to be addressed. Mental Health Law is not part of the normal curriculum of Scottish Law Faculties. Such establishments should be encouraged either to introduce a mental health law course into the undergraduate programme, or to offer it as a postgraduate short course, with some form of certification for successful completion of the course. In-service courses could be offered to solicitors to provide training in the proper evaluation of care plans and other aspects of the mental health system with which they are not likely to be familiar. Such courses could also provide training in tribunal skills which are somewhat different from the more traditional courtroom skills. The Law Society of Scotland indicated to the Review Group that they would be willing to provide such training if there was a demand for it.

The Law Society accreditation scheme does not seem to have been effective, whether because accreditation brings no financial or other benefits or because few solicitors consider this as a significant area of likely practice for them. Consideration should be given as to how to encourage more solicitors to become involved in this particular area of law.

Another issue raised by a number of people related to the current system of remuneration for legal representatives. There is a perception that some lawyers are abusing the system by deliberately prolonging the tribunal process in order to charge additional fees. Although there was general anecdotal evidence to this effect, the Review Group was provided with no details of any specific complaints. The Review Group, therefore, makes no

specific recommendation in relation to this perceived problem, other than to advise anyone who feels that they have been a victim of such abuse to make a complaint to the Law Society of Scotland.

Some people also perceived that the system of paying tribunal members per day was disadvantageous, in that tribunal members had a financial incentive to allow multiple hearings to occur. In this respect, the evidence was again anecdotal and speculative rather than based on specific examples of this having occurred. In fact, the percentage of cases where a further hearing is reserved to the same tribunal is relatively small, and attempts to reserve cases to the same three members are subject to the tribunal service agreeing that this should happen. Often, reserving a case to a particular tribunal is simply impracticable. Tribunal members hearing the case at one stage therefore, have no guarantee that they will hear it at the next, although many service users expressed a strong desire for that continuity of personnel. The Review Group considered that this was a theoretical rather than an actual problem and make no recommendation in relation to the system of paying members a fee per day of sitting.

### **Recommendations**

6.19 Encouragement should be given to the introduction of mental health law as part of the LLB undergraduate programme, or to the setting up of a postgraduate short course, with some form of certification for successful completion of the course.

6.20 In-service courses could be offered to solicitors to provide training in the proper evaluation of care plans and other aspects of the mental health system with which they are not likely to be familiar.

6.21 In-service courses could also provide training in tribunal skills.

6.22 Consideration should be given as to how to encourage more solicitors to become involved in this particular area of law.

## **Independent advocacy**

### **Discussion**

The Act foresees that all service users coming to a tribunal should be able to avail themselves of the services of an independent advocate, and resources are made available for the provision of this service. Some advocates are paid employees, but many are volunteers. Almost inevitably, we heard many complaints about underfunding. The major impact of this is not necessarily on tribunals, but rather on the other advocacy services provided. Tribunals appear to be given priority in every area, with a high level of input both in preparing for the hearing and during the hearings themselves. Many people thought that non-tribunal service users, and service users after tribunals, were being deprived of a service, or at least having to wait too long for the service, as a result.

The role of the advocate at the tribunal is not always fully understood. The advocate's task is to assist service users to present their *own* views to the tribunal, preferably by themselves. It is not for the advocate to voice his or her opinions on behalf of the service user or to suggest to the service user what they should or should not say. There was anecdotal evidence that some tribunal members appeared to be unclear as to the role of the advocate, with some tribunals allowing advocates to question other witnesses. This was considered to be particularly inappropriate when the service user was legally represented.

We also heard from particular service users' groups that certain minority groups were suffering through a lack of sufficient advocates trained and skilled for the particular issues which arise in these areas. Groups affected included people living with dementia and learning difficulties, people from black and minority ethnic backgrounds and deaf, deaf blind or deafened service users. Overall, however, carers, users and service providers generally spoke highly about the quality of service offered by advocacy organisations and advocacy workers at tribunals.

There was general recognition that advocates have a distinctive and valuable contribution to make. The role of the advocate is quite different from that of the named person and the advocate is often able to spend much more time getting to know and gaining the trust of the service user than a solicitor could be expected to do. The Review Group considered that there is a need for greater education about the role of the independent advocate, a stronger funding base for the service and broader recruitment and more training, especially in specialist areas.

### **Recommendations**

6.23 The tribunal service training programme for members should include training on the role of the advocate at the tribunal hearing with a view to improving understanding of the role and enhancing consistency of treatment of advocates at hearings.

6.24 Service providers should ensure that their training programmes include training on the role of the advocate for health care staff.

6.25 The Government should ensure that NHS Boards and local authorities make available sufficient resources to provide an equity of prompt access to advocacy services for all service users.

6.26 Service providers should recruit and train sufficient numbers of advocates to allow for those groups with special needs to be adequately provided for.

## **Interpretation**

### **Discussion**

Groups representing people from black and minority ethnic backgrounds and deaf, deaf/blind and deafened service users raised issues about interpretation problems. A particular concern was the use of family members as interpreters. It was felt that this might restrict the ability and willingness of the service user to challenge evidence and fully present their case. Professionally qualified interpreters, especially those with knowledge or experience in the area of mental health, provide an independent and reliable service, albeit at a price. The price is worth paying to ensure full participation, both emotionally and professionally.

### **Recommendation**

6.27 Professional interpretation services should always be offered when a service user does not have English as a first language.

## **Appeals and review right of the President**

### **Time limits for appeals**

At present, the Act does not specify any time limits for the hearing of appeals. The consultation document invited responses as to whether this situation should be changed. The overwhelming response was that there should be a timeframe set out in the Act to regulate the hearing of appeals and that this should impose specific time limits.

In respect of appeals against s44 short-term detention certificates, it was argued that the time limit should be narrow. Several respondents suggested that an obligation should be imposed to dispose of such an appeal within three working days of the date of the lodging of the appeal. This would be in line with the provisions for appeals against “place of safety warrants” imposed under the Children (Scotland) Act 1995. In other appeals, a period of 28 days for the hearing of an appeal was considered to be an appropriate time limit.

The Review Group considered that time limits should be set for the hearings of appeals, allowing a reasonable period of time depending upon the nature of the decision in question. We considered that a time limit of three working days for the disposal of the appeal could create similar problems to those experienced as a result of the tight timescales in relation to compulsory treatment orders. We did, however, consider that all appeals against s44 short-term detention certificates should be heard as soon as possible and certainly within the period of the certificate, unless the appeal is lodged so late in the period of the certificate as to render this impracticable. We agreed with the general view that, in all other cases, an appeal should be heard within 28 days of the date of lodging of that appeal.

### **Recommendations**

6.28 In relation to s44 short-term detention certificates, we recommend that a time limit should be imposed to require the appeal to be disposed of within the period of the certificate, or within five working days of the appeal being lodged if the appeal is lodged within the last five working days of the certificate.

6.29 In relation to appeals other than those relating to s44 short-term detention certificates, we recommend that a time limit be imposed to require a hearing to take place within 28 days of the lodging of that appeal.

### **Review right of President**

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 clear legal error. At present, where there is an error in the decision made by a tribunal, the only way this error can be rectified is by appealing the decision to the sheriff principal. Where the tribunal service acknowledges that the tribunal in question has made an error of law, the appeal is not defended. It has been suggested, however, that this approach is akin to using a sledgehammer to crack a nut. It was argued that giving the President the power sought would



allow him or her to rectify such errors as quickly as possible and get the case back on the rails again.

There was a mixed response to this suggestion. Some respondents regarded the power sought as interference in the principle of judicial independence, and were strongly opposed to the idea of one individual having the power to overturn decisions made by a tribunal of three drawing on their respective fields of expertise.

*“Appeals should always go before the Courts. It may be the President was the convener at the hearing in question therefore it would be inappropriate for the President to have powers to review a decision that they were involved with.”*

Others approved of the proposed change and believed it would improve the system and allow errors to be put right more quickly.

*“The President should be able to review decisions and amend clear legal errors.”*

The Review Group considered the arguments presented for and against the proposed change. On the one hand, the present system means that delay and expense occurs in circumstances where it is accepted by all parties that the decision which has been made is wrong. On the other hand, judicial independence requires that decisions made by the tribunal charged with that duty should not be capable of being overturned other than by due process of law. The law is constantly evolving and case law is a vital part of that process. What may be an error of law on the basis of current case law may not be interpreted as an error in the future.

The Review Group accepted that, in certain limited circumstances, the power sought would be advantageous and would assist in disposing of decisions which are clearly wrong or incompetent at the earliest opportunity. However, on balance, we considered that an extension of the power of review would not be appropriate, and that the present safeguard of having appeals considered by the relevant sheriff principal should be preserved. The Review Group was not persuaded that the present situation was causing such difficulties as to justify the proposed change. Accordingly we make no recommendation that the President be given the power to review decisions of individual tribunals and set aside decisions where there is perceived to be an error of law. The Review Group took the view that the power to correct clerical mistakes or errors arising from an accidental slip or omission, which is currently contained within rule 72(8) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005, should not be extended.

## **Production of independent reports**

Paragraph 62(5) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005 places an obligation upon relevant persons to provide the tribunal with a copy of any written expert report obtained. In practice, this rule is often not complied with and there is no sanction which can be applied if it is not.

### **Recommendations**

6.30 The obligation contained in paragraph 65(5) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 should be removed.

6.31 The procedure for obtaining permission not to produce the report could then be dispensed with.

### **Recorded matters at the interim order stage**

The Act as presently worded makes no provision for recorded matters to be specified in relation to an interim order. There appears to be no good reason for this, and it may simply be the result of oversight.

### **Recommendations**

6.32 The Act should be amended to allow for recorded matters to be made at the time when an interim order is made, if considered appropriate.

6.33 Tribunals should be encouraged to make greater use of recorded matters, and training may be required to achieve this aim.

## **Issues now resolved**

The Review Group initially discussed and considered the operation of Rules 42, 46, 47 and 72 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005. These are the provisions relating to the conditions by which an individual shall be disqualified from serving as a member of a tribunal (Rule 42), the distribution and disclosure of documents (Rule 46), the withholding of documents and reports from disclosure in exceptional circumstances (Rule 47), and the copying of decisions to the Mental Welfare Commission (Rule 72). However, since the Review Group was set up, these issues have been addressed by the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Amendment Rules 2008 (SSI 2008/396) which came into effect on 20 December 2008. That being so, no detailed analysis of these issues is now required.

## **Conclusion**

The tribunal system is generally working well, but could be improved by resolving the various problems identified. The tribunal service has now been operational for over three years and health care professionals, tribunal members and members of tribunal service staff have all had time to gain experience and confidence in dealing with the provisions of the Act. The system has gained a certain maturity, and the time has come to build upon the mainly positive experience of the last three years and make such changes as are necessary to ensure that the tribunal system fully lives up to the vision for the future envisaged by the Millan Committee.

The Review Group recognises and acknowledges that measures are already being taken within the tribunal service to address some of the issues raised by those who took part in our consultation process. The Review Group agrees that much can be done to improve the efficiency of the service by making better use of the procedural powers already available. However, the Review Group considers that some further changes are required in order most effectively to address the current issues of concern. The recommendations of the Review Group are as follows:

## **Recommendations**

6.34 The time limit of five working days contained in s68(2)(a) of the Act should be increased to ten working days.

6.35 Where the additional five day period is utilised, the maximum period of time permitted for extension of interim compulsory treatment orders will be reduced by five working days from the present maximum of 56 days as set out in s65(3) of the Act.

6.36 Service users who want to appoint a solicitor should be encouraged to do so at the earliest opportunity within the period of the short term detention certificate.

6.37 A copy of the application for a compulsory treatment order should be given to the patient and/or the patient's solicitor (if already appointed) by the mental health officer at the same time as it is being sent to the Tribunal office. This would not remove from the tribunal service the duty of serving formal notice as is done at present but would give the patient advance notice of the impending application.

6.38 Codes of Conduct should be prepared by the tribunal service for curators ad litem and tribunal members.

6.39 A Code of Conduct should be prepared by the Law Society of Scotland for legal representatives working in the field of mental health law and appearing at mental health tribunals.

6.40 Where an interim order is proposed for a short period in order to allow for some specified action to be taken on behalf of the patient, the tribunal should be able to grant an interim order if the conditions for the order "appear to be met".

6.41 An interim order made on the basis of the "appear to be met" test should be subject to a time limit of a maximum of 28 days.

6.42 The Act should be amended to allow for recorded matters to be made at the time when an interim order is made, if considered appropriate.

6.43 Tribunals should be encouraged to make greater use of recorded matters, and training may be required to achieve this aim.

6.44 Greater use should be made of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone.

6.45 The President should be given the power to nominate up to 15 non-working days per year.

6.46 Ongoing training in tribunal skills must be maintained for all members, especially conveners.

6.47 Conveners should be trained to be flexible in their approach to the way in which tribunal hearings are managed.

6.48 Consideration should be given as to whether the use of tape recorders adds value to the tribunal process. If it does, then the purpose of recording the proceedings should be explained to the parties and all parties should be given equal access to the transcript or recording taken. If it is accepted that little or no value is added, then the practice of routinely recording hearings should be discontinued.

6.49 Rooms used for holding tribunal hearings should be required to meet prescribed minimum standards.

6.50 The preferred standards already contained within the Memorandum of Understanding should be retained and maintained, but greater emphasis should be placed on ensuring that those preferred standards are met.

6.51 The prescribed minimum standards must include ready access to toilet facilities and drinking water, adequate waiting facilities and access to a separate private interview area for the use of the patient and his or her advisers.

6.52 A venue which does not meet these requirements should be assessed as inadequate.

6.53 If a venue is assessed as inadequate, that venue must not be used until the issues which have caused it to be so assessed have been addressed.

6.54 Consideration should be given as to how to encourage more solicitors to become involved in this particular area of law.

6.55 Encouragement should be given to the introduction of mental health law as part of the LL.B. undergraduate programme, or to the setting up of a postgraduate short course, with appropriate certification being awarded on successful completion of the course.

6.56 In-service courses should be offered to solicitors to provide training in the proper evaluation of care plans and other aspects of the mental health system with which they are not likely to be familiar.

6.57 In-service courses for solicitors should also provide training in tribunal skills.

6.58 The tribunal service training programme for members should include training on the role of the advocate at the tribunal hearing with a view to improving understanding of the role and enhancing consistency of treatment of advocates at hearings.

6.59 Service providers should ensure that their training programmes include training on the role of the advocate for health care staff.

6.60 The Government should ensure that NHS Boards and local authorities make available sufficient resources to provide an equity of prompt access to advocacy services for all service users.

6.61 Service providers should recruit and train sufficient numbers of advocates to allow for those groups with special needs to be adequately provided for.

6.62 The obligation contained in paragraph 65(5) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005 should be removed.

6.63 The procedure for obtaining permission not to produce the report could then be dispensed with.

6.64 In relation to s44 short-term detention certificates, a time limit should be imposed to require the appeal to be disposed of within the period of the certificate, or within five working days of the appeal being lodged if the appeal is lodged within the last five working days of the certificate.

6.65 In relation to appeals other than those relating to s44 short-term detention certificates, a time limit should be imposed to require a hearing to take place within 28 days of the lodging of that appeal.





## CHAPTER SEVEN OTHER ISSUES

In the course of our consultation, we received extensive submissions from several bodies, especially the Mental Welfare Commission, the Royal Colleges, carers and users groups and the Tribunal service. Many of the points raised are covered in the substantive text above. However, some of the points did not fall neatly within our headings and we propose, in this chapter, to address the outstanding points with which the Review Group is in agreement.

*Independent oversight of treatment of compulsory patients* The Mental Welfare Commission has an overarching responsibility for ensuring that people who have a mental disorder, wherever they are, are properly treated and it must report to any relevant body on any impropriety it finds in the process. In carrying out these duties the Commission visits people in hospitals, care homes, community settings and prisons. The number of people who receive treatment voluntarily greatly exceeds those who receive treatment in hospital. Nonetheless, there are around 1500 patients receiving treatment under long term detention orders in Scottish hospitals at any one time.

The Mental Welfare Commission is one of the central safeguards of the Act. The proposal which emerged towards the end of our review to merge the Mental Welfare Commission into one of two scrutiny bodies would not, in our view, have recognised the unique role of the Mental Welfare Commission and its need for independence. We are pleased, therefore, about the decision to review this proposal. However, we would hope that any further review of the Mental Welfare Commission will fully address the need for a body which can perform all the functions of a National Preventative Mechanism under the United Nations Optional Protocol for the Prevention of Torture, Inhuman or Degrading Treatment or Punishment.

*Reference to Mental Welfare Commission* While there is currently no bar on the tribunal making a reference to the Mental Welfare Commission where it appears to the tribunal that the Commission's involvement might improve a service user's care or treatment, the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 make no mention of this option. We propose that specific mention is made in the Tribunal Rules to the tribunal's right to make a reference to the Commission.

*Suspension* Under s56 of the Act, a short term detention certificate suspends the measures in a coexisting compulsory treatment order. It should be made clear that this also applies to an interim compulsory treatment order.

*Reports to the Mental Welfare Commission* Under the Act, various matters have to be reported to the Mental Welfare Commission. The Commission has informed us that some of the matters which require notification need no action on its behalf and has suggested that notification could stop, with no effect for

the safeguards available to the individual service user. Conversely, there are other matters which are not currently notified to the Commission where awareness would be helpful. A list of what is considered to be useful, and what is not, is set out below:

*Not Useful:*

Notification under s60 from a mental health officer to the Commission before applying for a compulsory treatment order;  
Notification under s91 by the responsible medical officer when there is an application to extend and vary a compulsory treatment order;  
Notification under s94 of application to vary an order;  
Section 157 requires the responsible medical officer to notify the Commission before applying to extend and vary a compulsion order and s169 requires the same of an application to vary a compulsion order. Neither of these prompts any action from the Commission.

*Would be useful:*

Notification from either hospital managers or responsible medical officer when a compulsory treatment order, a short term detention certificate, an emergency detention certificate or a compulsion order expires without authority to extend;  
Notification from Ministers when there is a variation in conditions imposed in conditional discharge under s200;  
The outcome of applications for warrants for removal under ss292 and 293 of the Act should be reported, as is already the case for warrants under s35;  
While s241 of the Act requires a designated medical practitioner to make an additional statement when a capable patient refuses treatment beyond two months, this is significantly less than the notification in writing to the Commission required when treatment conflicting with an advance statement is given. There seems no logic, in terms of the principle of participation, in the lesser protection being applied to the competent patient.  
Data on the ethnicity of persons subject to the Act are only patchily notified to the Commission; this should be a legal requirement.

*Transfer of patients* Section 124 of the Act provides for the transfer of detained persons, but no procedure is provided for the transfer the responsibility from one hospital to another of a person subject to a community compulsory treatment order. This would thus require a, generally unnecessary, application to tribunal to vary the order. It would appear to be an omission which could be readily corrected.

*Restraint* The issue of the use of forcible administration of treatment and the use of restraint, both in hospital and in community settings, was raised with us by several parties, including the Mental Welfare Commission. The situations described included the forcible administration of medication for mental disorder and other conditions and the use of force in ensuring that service users' other care and treatment needs are met. We support the intention of the current arrangements that the unavoidable forcible administration of

medication for mental disorder should not take place outwith hospital except in situations of extreme emergency. However, the increase of care in community settings has highlighted uncertainties for care providers where a degree of force or sedation may be required to provide care essential to the interests of the service user. This has been particularly apparent for a few people with learning disability and challenging behaviour who live in their own, highly supported, tenancies.

One of the difficulties is that the legitimate desire to prevent the inappropriate use of force in one set of circumstances has an unintended negative consequence on another set of circumstances where the use of force may be justified. We recognise that this is a very complex area involving the use of, and interaction between, the 2003 Act and the Adults with Incapacity (Scotland) Act 2000. We recommend that there is a review of this important and complex area of care and treatment before considering whether any legislative changes are required. Such a review could also address the very limited guidance available for Scottish mental health and learning disability hospitals on the use of force in hospital settings.

*Part 16 certificates* Certificates granted under Part 16 of the Act, authorising special treatments, have no expiry date. We suggest that maximum times be set by law for each type of treatment.

*Appeals against transfer* In one case brought to our attention, a person successfully appealed against a transfer to the State Hospital after the transfer had taken place. The sending hospital refused to take the person back and there appears to be neither a time limit nor any remedy in this situation. The law must provide an effective way of enforcing such rulings.

*Appeals against excessive security* The provisions relating to excessive security (ss264-273 of the Act) do not seem to be operating in full compliance with the Millan principles (and, possibly, Article 5 of the ECHR). First, there is no timescale for determining an application to recall an order under s271, leading to delays in resolving service users' situations. Secondly, while the Mental Welfare Commission and others with title and interest can petition the Court of Session under s272 for enforcement of statutory duty to move a service user to conditions of lower security, it is not clear that the court can order Scottish Ministers to perform their part in ensuring compliance with the ruling. This effectively means that the tribunal order is not ultimately enforceable and this is unacceptable.

*Expiry of orders* Confusion seems to have arisen over the calculation of expiry dates of initial and subsequent interim orders and compulsory treatment orders. It would seem best that any tribunal imposing an order should specify the start date of that order as well as the expiry date.

*Learning disability and the law* Persons with learning disability complained to the Review Group about the inclusion of learning disability in the Act. We understand the Millan Committee recommended that this should be reviewed and that the then Government accepted this in its policy paper "Reviewing

Mental Health Law”. Now, eight years on from Millan, the Review Group feels that it is time this was done.

*Hospital services* The recent research on service users’ levels of satisfaction with mental health services directly correlates those levels with the physical state of hospital premises (*Experience and Views of the Mental Health (Care and Treatment) (Scotland) Act 2003*, Ridley et al, 2008). While the Care Commission registers and inspects care facilities against a set of published standards, there is no equivalent body within the NHS. Consideration should be given to establishing such a body with a remit to set and monitor standards for hospitals.

*Age appropriate facilities* Statistics from the Mental Welfare Commission show that there is still a problem with people under the age of 18 being kept in adult wards of hospitals, and this was confirmed to us by NHS managers. We are encouraged by the Government’s commitment to reducing inappropriate admissions, but would remind NHS Boards that they have a legal duty to provide appropriate services to young persons.

*Mental health officer availability* Section 32(1) of the Act requires local authorities to appoint a sufficient number of mental health officers. We understand from the service users’ research (Ridley et al, supra, para 2.32) that the numbers of qualified mental health officers willing to practice is a matter of concern and we would remind local authorities of their statutory duty.

# **FULL LIST OF RECOMMENDATIONS**

## **Chapter Two      Advance Statements**

Encouraging and maximising service users' participation in their own care and treatment is a dominant feature of the Act, and any steps which can be taken to increase the take-up of advance statements can only improve the realisation of this goal. We believe the following recommendations would address these issues:

2.1 Clarify what can be in an advance statement, taking an holistic approach to treatment.

2.2 Provide much greater publicity, addressed to everyone, and place responsibility on designated members of staff to facilitate the making of advance statements.

2.3 Make it easier to make a valid advance statement, perhaps by combining them with living wills and personal statements.

2.4 Extend the range of persons who can witness advance statements to include independent advocates and all staff. It is important to stress that the witness's function is simply to certify that the person is competent to intend the wishes expressed. It does not indicate that the witness endorses the wishes expressed by the person making the statement.

2.5 Encourage all staff involved during the recovery stage to discuss advance statements with service users and to record reasons for decisions not to make one.

2.6 Give much greater publicity to the low number of advance statements being over-ridden reported upon by the Mental Welfare Commission.

2.7 Require responsible medical officers to review regularly any treatment in conflict with an advance statement and provide a written record of efforts made to address the person's stated wishes.

2.8 Introduce a central register of advance statements, with copies also retained in medical records. The Mental Welfare Commission has indicated that it would be prepared to hold the central register.

## **Chapter Three      Independent Advocacy**

3.1 The Government should, by whatever means it sees fit, ensure that there is appropriate provision, with associated funding, across Scotland, of independent advocacy services by NHS Boards and local authorities to ensure that the requirements of s259 of the Act are complied with in relation to

all persons affected by mental disorder regardless of where they are and taking into account their specific needs.

3.2 The Mental Welfare Commission requested that service users or those with an interest in a case be empowered to report to the Commission failures to provide adequate access to advocacy services. Such failures should be raised in the first instance with the authorities statutorily obliged to provide the services.

3.3 Independent advocacy organisations should aim to work in accordance with the Scottish Independent Advocacy Alliance Principles and Standards and Code of Practice.

3.4 Carers' access to advocacy services should be ensured.

3.5 The appropriate scrutiny processes and bodies should promote and monitor the application of the Scottish Independent Advocacy Alliance Principles and Standards and Code of Practice.

3.6 NHS Boards and local authorities should support the development of collective advocacy groups in their respective areas.

## **Chapter Four          Named Persons**

We recommend the following changes in relation to named persons:

4.1 A service user should have a named person only if he or she has appointed one.

4.2 Where a person is unable to appoint a named person, his or her primary carer (whom failing the nearest relative) should not act as named person but should have an automatic right to appeal against orders, the extension of orders and against hospital transfers.

4.3 If a service user who has not appointed a named person is at the relevant time unable to appoint a named person and has not signed an advance statement or other document expressing a wish not to have a named person, anyone with an interest should be able to apply to the tribunal to be appointed as a named person.

4.4 In addition to its power to appoint a curator ad litem, the tribunal should be able to appoint a safeguarder where a person appearing before it has no lawyer, independent advocate or named person.

4.5 If a service user for whom compulsory measures are being contemplated is unable to appoint, and has not appointed, a named person and no-one has applied to act as his or her named person, the mental health officer should notify the tribunal, which should consider whether to appoint a curator ad litem or safeguarder to protect the person's interests.

4.6 If, at a time when compulsory measures are being used or contemplated, a service user is unable to understand the effect of nominating a named

person, but has previously appointed a welfare attorney under the Adults with Incapacity (Scotland) Act 2000, the welfare attorney should be able to act as the named person.

4.7 There should be a nationwide publicity campaign to advise everyone about the role and function of the named person and the consequences of appointing or not appointing one.

4.8 Special efforts should be made by service providers to encourage service users to consider appointing a named person as early in their illness as possible and at appropriate stages in the recovery process.

4.9 Information about the role and functions of named persons should be made more widely available and such information should be in accessible form and formats and targeted at those who might need it.

4.10 The form appointing the named person should require the written consent of the named person.

4.11 The form should also contain a box setting out the consequences of appointing a named person, including the sharing of confidential information. The box should be signed by the person nominating a named person and confirm that the information set out in the box has been read out and the person signing understands it.

4.12 The named person should be offered support from either the mental health officer or another service provider as soon as possible after he or she needs to act in any capacity.

4.13 Hospital managers should be responsible for ensuring that the person's case records accurately record who the named person is.

4.14 Named persons should continue to have all powers currently exercised by them. In addition, they should receive notification from the police if the service user for whom they are named person is taken to a place of safety.

4.15 When a mental health officer is making an application for a compulsory treatment order, he or she should have a statutory duty to consult with the named person on the proposed care plan. In addition, the responsible medical officer should have a statutory obligation to consult the named person on the final care plan.

4.16 A young person under the age of 16 who has adequate understanding of the consequences of appointing a named person should be able to do so.

4.17 The Mental Health Act Code of Practice should be updated to reflect the provisions of the Mental Health Tribunal for Scotland's practice and procedure rules.

4.18 There is a need for further discussion about good practice concerning the amount and quality of information included in the papers sent to the tribunal, with a view to ensuring that information is only ever shared on a need to know basis.

4.19 The Scottish Government should draw up a Code of Practice for named persons, covering matters such as confidentiality.

## Chapter Five      Medical matters

5.1 An application for a compulsory treatment order should continue to be accompanied by two medical reports. One report would be called the psychiatrist's report and be provided by an approved medical practitioner following examination of the patient. The other report would be called a general practitioner's report and be prepared by the patient's general practitioner following examination of the patient. The form of these reports should be specified in regulations.

5.2 The requirement that the general practitioner has to state that all the grounds set out in Section 3 of the Act are met should be changed to a duty to give a view on the approved medical practitioner's report, similar to the duty placed on mental health officers by s61(4)(f).

5.3 In exceptional circumstances set out in regulations, the general practitioner's report may be provided by a second approved medical practitioner. When a general practitioner's report is not submitted to a mental health tribunal, there should be a requirement for the relevant NHS Board to notify the Mental Welfare Commission.

5.4 Regulations should be amended to require that a medical examination for an extension of a compulsory treatment order applying to a patient in a hospital run by an independent healthcare provider must be made by an approved medical practitioner independent of that service.

5.5 We do not recommend any change to current arrangements. Revocation of an emergency detention certificate should only take place following assessment by an approved medical practitioner.

5.6 *For brief periods out of hospital (not overnight).* Suspension would be explicitly authorised by the responsible medical officer and recorded in the patient's casenotes. This would not count towards any cumulative limit on any total time out of hospital whilst subject to detention.

5.7 *For overnight and longer periods of suspension.* The responsible medical officer would complete a suspension certificate. Such certificates could cumulatively authorise up to 200 overnight periods out of hospital in any 12 month period. The cumulative total would be counted retrospectively from any point in the patient's compulsory treatment.

5.8 The responsible medical officer would continue to assess whether an application for a variation of the order should be applied for, taking into account the patient's mental state and the principles of the Act.

5.9 Where it appeared that the time limit might be exceeded, an application to a mental health tribunal would be required to be made. The tribunal hearing would then consider whether the grounds for continued compulsory treatment were met or whether a variation was appropriate. Where the grounds for compulsion continued to be met and a variation was not appropriate, the limit



on suspension would be “reset” and up to a further 200 overnight stays could be authorised by the responsible medical officer.

5.10 We do not recommend any change to the current requirement for the patient’s consent in writing. In situations where a patient refuses to sign but does indicate verbal consent, we recommend that an opinion from a designated medical practitioner should be sought.

5.11 The Scottish Government should, by regulations, provide a template for the s76 care plan with a recommended timeframe for its completion at the various stages it is required.

5.12 The template should reflect the proposed care plan currently incorporated as part 3 of the initial compulsory treatment order application.

5.13 The template should incorporate a guidance note that its content should reflect the overarching care plan inclusive of the care, support and treatment delivered to the individual by a range of disciplines and agencies.

5.14 The template should conclude with a section noting those consulted in its compilation and to whom it has been circulated and when.

5.15 The template should include the option to attach the CEL 13 care plan (enhanced care programme approach care plan) for those subject to a compulsion order/compulsion order and restriction order in full to prevent duplication.

5.16 Given that the act has now been in operation for some time, there may be benefit in formalising the recommended forms to prescribed status.

## **Chapter Six Tribunals**

6.1 The time limit of five working days contained in s68(2)(a) of the Act should be increased to ten working days.

6.2 Where the additional five day period is utilised, the maximum period of time permitted for extension of interim compulsory treatment orders will be reduced by five working days from the present maximum of 56 days as set out in s65(3) of the Act.

6.3 Service users who want to appoint a solicitor should be encouraged to do so at the earliest opportunity within the period of the short term detention certificate.

6.4 A copy of the application for a compulsory treatment order should be given to the patient and/or the patient’s solicitor (if already appointed) by the mental health officer at the same time as it is being sent to the tribunal office. (This would not remove from the tribunal service the duty of serving formal notice as is done at present but would give the patient advance notice of the impending application).

6.5 Codes of Conduct should be prepared by the tribunal service for curators ad litem and tribunal members.

6.6 Where an interim order is proposed for a short period in order to allow for some specified action to be taken on behalf of the patient, the tribunal should be able to grant an interim order if the conditions for the order “appear to be met”.

6.7 An interim order made on the basis of the “appear to be met” test should be subject to a time limit of a maximum of 28 days.

6.8 Greater use should be made of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone.

6.9 The President should be given the power to nominate up to 15 non-working days per year.

6.10 Ongoing training in tribunal skills must be maintained for all members, especially conveners.

6.11 Conveners should be encouraged to be flexible in their approach to the way in which tribunal hearings are managed.

6.12 Consideration should be given to whether the use of tape recorders adds value to the tribunal process. If it does, then the purpose of recording the proceedings should be explained to the parties and all parties should be given equal access to the transcript or recording taken. If it is accepted that little or no value is added, then the practice of routinely recording hearings should be discontinued.

6.13 A Code of Conduct should be prepared by the Law Society of Scotland for legal representatives working in the field of mental health law and appearing at mental health tribunals.

6.14 The preferred standards already contained within the Memorandum of Understanding should be retained and maintained, but greater emphasis should be placed on ensuring that those preferred standards are met.

6.15 Rooms used for holding tribunal hearings should be required to meet prescribed minimum standards.

6.16 The prescribed minimum standards must include ready access to toilet facilities and drinking water, adequate waiting facilities and access to a separate private interview area for the use of the patient and his or her advisers.

6.17 A venue which does not meet these requirements should be assessed as inadequate.

6.18 If a venue is assessed as inadequate, that venue must not be used until the issues which have caused it to be so assessed have been addressed.

6.19 Encouragement should be given to the introduction of mental health law as part of the LLB undergraduate programme, or to the setting up of a postgraduate short course, with some form of certification for successful completion of the course.

6.20 In-service courses could be offered to solicitors to provide training in the proper evaluation of care plans and other aspects of the mental health system with which they are not likely to be familiar.

6.21 In-service courses could also provide training in tribunal skills.

6.22 Consideration should be given as to how to encourage more solicitors to become involved in this particular area of law.

6.23 The tribunal service training programme for members should include training on the role of the advocate at the tribunal hearing with a view to improving understanding of the role and enhancing consistency of treatment of advocates at hearings.

6.24 Service providers should ensure that their training programmes include training on the role of the advocate for health care staff.

6.25 The Government should ensure that NHS Boards and local authorities make available sufficient resources to provide an equity of prompt access to advocacy services for all service users.

6.26 Service providers should recruit and train sufficient numbers of advocates to allow for those groups with special needs to be adequately provided for.

6.27 Professional interpretation services should always be offered when a service user does not have English as a first language.

6.28 In relation to s44 short-term detention certificates, we recommend that a time limit should be imposed to require the appeal to be disposed of within the period of the certificate, or within five working days of the appeal being lodged if the appeal is lodged within the last five working days of the certificate.

6.29 In relation to appeals other than those relating to s44 short-term detention certificates, we recommend that a time limit be imposed to require a hearing to take place within 28 days of the lodging of that appeal.

6.30 The obligation contained in paragraph 65(5) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 should be removed.

6.31 The procedure for obtaining permission not to produce the report could then be dispensed with.

6.32 The Act should be amended to allow for recorded matters to be made at the time when an interim order is made, if considered appropriate.

6.33 Tribunals should be encouraged to make greater use of recorded matters, and training may be required to achieve this aim.

6.34 The time limit of five working days contained in s68(2)(a) of the Act should be increased to ten working days.

6.35 Where the additional five day period is utilised, the maximum period of time permitted for extension of interim compulsory treatment orders will be reduced by five working days from the present maximum of 56 days as set out in s65(3) of the Act.

6.36 Service users who want to appoint a solicitor should be encouraged to do so at the earliest opportunity within the period of the short term detention certificate.

6.37 A copy of the application for a compulsory treatment order should be given to the patient and/or the patient's solicitor (if already appointed) by the mental health officer at the same time as it is being sent to the Tribunal office. This would not remove from the tribunal service the duty of serving formal notice as is done at present but would give the patient advance notice of the impending application.

6.38 Codes of Conduct should be prepared by the tribunal service for curators ad litem and tribunal members.

6.39 A Code of Conduct should be prepared by the Law Society of Scotland for legal representatives working in the field of mental health law and appearing at mental health tribunals.

6.40 Where an interim order is proposed for a short period in order to allow for some specified action to be taken on behalf of the patient, the tribunal should be able to grant an interim order if the conditions for the order "appear to be met".

6.41 An interim order made on the basis of the "appear to be met" test should be subject to a time limit of a maximum of 28 days.

6.42 The Act should be amended to allow for recorded matters to be made at the time when an interim order is made, if considered appropriate.

6.43 Tribunals should be encouraged to make greater use of recorded matters, and training may be required to achieve this aim.

6.44 Greater use should be made of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone.

6.45 The President should be given the power to nominate up to 15 non-working days per year.

6.46 Ongoing training in tribunal skills must be maintained for all members, especially conveners.

6.47 Conveners should be trained to be flexible in their approach to the way in which tribunal hearings are managed.

6.48 Consideration should be given as to whether the use of tape recorders adds value to the tribunal process. If it does, then the purpose of recording the proceedings should be explained to the parties and all parties should be given equal access to the transcript or recording taken. If it is accepted that little or no value is added, then the practice of routinely recording hearings should be discontinued.

6.49 Rooms used for holding tribunal hearings should be required to meet prescribed minimum standards.

6.50 The preferred standards already contained within the Memorandum of Understanding should be retained and maintained, but greater emphasis should be placed on ensuring that those preferred standards are met.

6.51 The prescribed minimum standards must include ready access to toilet facilities and drinking water, adequate waiting facilities and access to a separate private interview area for the use of the patient and his or her advisers.

6.52 A venue which does not meet these requirements should be assessed as inadequate.

6.53 If a venue is assessed as inadequate, that venue must not be used until the issues which have caused it to be so assessed have been addressed.

6.54 Consideration should be given as to how to encourage more solicitors to become involved in this particular area of law.

6.55 Encouragement should be given to the introduction of mental health law as part of the LL.B. undergraduate programme, or to the setting up of a postgraduate short course, with appropriate certification being awarded on successful completion of the course.

6.56 In-service courses should be offered to solicitors to provide training in the proper evaluation of care plans and other aspects of the mental health system with which they are not likely to be familiar.

6.57 In-service courses for solicitors should also provide training in tribunal skills.

6.58 The tribunal service training programme for members should include training on the role of the advocate at the tribunal hearing with a view to improving understanding of the role and enhancing consistency of treatment of advocates at hearings.

6.59 Service providers should ensure that their training programmes include training on the role of the advocate for health care staff.

6.60 The Government should ensure that NHS Boards and local authorities make available sufficient resources to provide an equity of prompt access to advocacy services for all service users.

6.61 Service providers should recruit and train sufficient numbers of advocates to allow for those groups with special needs to be adequately provided for.

6.62 The obligation contained in paragraph 65(5) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005 should be removed.

6.63 The procedure for obtaining permission not to produce the report could then be dispensed with.

6.64 In relation to s44 short-term detention certificates, a time limit should be imposed to require the appeal to be disposed of within the period of the certificate, or within five working days of the appeal being lodged if the appeal is lodged within the last five working days of the certificate.

6.65 In relation to appeals other than those relating to s44 short-term detention certificates, a time limit should be imposed to require a hearing to take place within 28 days of the lodging of that appeal.

# APPENDIX A

## Biographies

### *Chair*

**Jim McManus** is professor of Criminal Justice at Glasgow Caledonian University. He was previously chair of the Parole Board for Scotland and the first Prisons Complaints Commissioner. He regularly works for the CPT, a branch of the Council of Europe which inspects detention facilities, including psychiatric hospitals, throughout Europe and was the co-editor of *Mental Health and Scots Law in Practice* (Greens, Edinburgh, 2005).

### *Members*

**Shaben Begum** is the Director of the Scottish Independent Advocacy Alliance. Previously she managed the Patients Advocacy Service at the State Hospital. She has been involved in a number of groups concerned with the implementation of the Mental Health Act.

**Iain Boddy** trained as a psychiatric nurse in Dumfries & Galloway and worked in a variety of clinic specialties before working with Admission & Assessment of elderly, functional mental illness. He moved to work in Quality Assurance/Clinical Governance and from there to a number of management roles across the community. Iain took up his current post as General Manager for Mental Health Services in 2000 and during that period has managed the integrated, joint service for both health & the local authority.

**Carolyn Little** is a carer. She is Chairperson of the National Schizophrenia Fellowship (Scotland) and also Project Coordinator for User and Carer Involvement (UCI) - a Scottish Charity operating across the Dumfries and Galloway Health Board area which ensures that people who have mental illness, dementia and learning disabilities and their carers, have a voice.

Carolyn is a member of several local and national groups both in her capacity as Chair of NSF (Scotland) and personally, and has contributed at several conferences both in facilitating workshops and in presentations given. Prior to becoming involved with UCI, Carolyn was a freelance writer and continues to contribute to publications on mental health issues.

**Jamie Malcolm** was the first full-time Nurse Commissioner appointed to the Mental Welfare Commission. He previously worked as the Nursing Officer at the Commission. He has experience in forensic and acute psychiatry, has worked at the State Hospital, and was a member of the MacLean Committee on serious violent and sexual offenders. He has been closely involved in the Commission's work on the implementation of the 2003 Act.

**John Mitchell** is consultant liaison psychiatrist in North Glasgow, based at Stobhill Hospital. He is Associate Medical Director for the Addictions

Partnership in Glasgow and Clyde. He was for a period seconded part time to the Scottish Government to assist in the creation of the Code of Practice to the Mental Health (Care and Treatment) Act (Scotland) 2003. His clinical interest lies in the area of mental disorder and physical illness interaction.

**Isabel Montgomery** is a solicitor with a background in civil and criminal litigation. Since 1999 she has taken on a decision making role in various Tribunals. She is currently President of the Private Rented Housing Panel for Scotland, and also sits as a part-time Immigration Judge sitting in venues throughout the UK. She is a part-time Judge of the First-tier Tribunal (Social Entitlement Chamber) hearing a variety of Social Security appeals, and is a convener and appraiser within the Mental Health Tribunal for Scotland. She is also a trained mediator.

**Graham Morgan** is the advocacy project manager for Highland Community Care Forum, working mainly with Highland Users Group (HUG) and, to a lesser extent, People First Highland. HUG represents the views of people with a mental illness and People First, the views of people with learning disabilities. Graham was previously involved with the Edinburgh Users Forum, East Lothian Involvement Group, Midlothian Users Forum and, to a lesser degree, with the Royal Edinburgh Hospital Patients Council and West Lothian Users Forum. A number of years ago, Graham helped establish McMurphy's, one of the first user run drop-in centres in the UK. Graham is a board member of Vox (Scotland's national user voice) and a member of the management group of See Me (Scotland's campaign against stigma). He also served on the Millan Committee that carried out the review of the 1984 Mental Health Act. Graham was awarded an MBE for services to mental health some years ago. Graham is a user of services and has been sectioned in the past.

**Annie McGeeney** is currently employed as Fieldwork Manager Mental Health in South Lanarkshire Council. Since qualifying as a Mental Health Officer, Annie has worked in a variety of mental health settings and is an active participant in a range of working groups involved in progressing the mental health agenda in Scotland.

**Hilary Patrick** is qualified as a solicitor and has worked in mental health law and policy for many years. She was a member of the steering group for the Promotion of the Incapable Adults Bill and of the Millan Committee, which reviewed mental health law in Scotland. She has written widely on mental health law and her latest book was published in 2006. She is an Honorary Fellow in the Law School at Edinburgh University.



## APPENDIX B

### Principles Of the 2003 Act

The Act enshrines a set of 10 principles which had been proposed by the Millan Committee. These are:

(i) *Non discrimination* - People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.

(ii) *Equality* - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

(iii) *Respect for Diversity* - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

(iv) *Reciprocity* - Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

(v) *Informal Care* - Wherever possible, care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

(vi) *Participation* - Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

(vii) *Respect for carers* - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

(viii) *Least restrictive alternative* - Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

(ix) *Benefit* - Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.

(x) *Child welfare* - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

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