

# **The Mental Health Tribunal for Scotland’s Response to the Scottish Government’s Consultation on the Review of the Mental Health (Care and Treatment) (Scotland) Act 2003**

## **Introduction**

The Mental Health Tribunal for Scotland (“the Tribunal”) welcomes the opportunity to respond to the Scottish Government's consultation on the review of the Mental Health (Care and Treatment) (Scotland) Act 2003, the recommendations contained in the Report on the Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Scottish Government's own options for discussion.

The Tribunal is conscious that while some of the recommendations may, if acted upon, cost little, others may have a significant financial impact. The Tribunal is of the view that the financial impact of changes to be made to the mental health system should be borne in mind to ensure that the maximum financial resources remain available for front line mental health services.

In this response to the Scottish Government's consultation on the Review of the Mental Health (Care and Treatment) (Scotland) Act 2003:

“the 2003 Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003; and

“the Tribunal’s Rules” means the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (as amended).

The Tribunal trusts that the Scottish Government's consultation on the Review of the 2003 Act, the Limited Review of the 2003 Act, and the responses to it will spark a constructive debate which will result in amendments to the 2003 Act, to subordinate legislation and to changes in practice amongst stakeholders that will further strengthen Scotland’s mental health system and lead to improvements in the experience of all who take part in and contribute to that system, in particular the experience of patients who are at the heart of the system of mental health care in Scotland.

## **Question 1: Advance Statements**

### *Review Group Limited Review Report recommendations*

- 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.

## ***Discussion***

While bearing in mind that no person is obliged to make an advance statement, the Tribunal notes the problems identified by the Review Group. The Tribunal considers that some of the Review Group's recommendations would assist in remedying some of the problems identified. The Tribunal agrees that it is useful if there is clarity as to what can be in an advance statement and that advance statements should have greater publicity. The Tribunal regrets that the recommendations 2.1 and 2.2 do not specify *who* should clarify what can be in an advance statement or *who* should provide much greater publicity to advance statements.

The Tribunal considers that some of the recommendations would not assist in addressing the problems identified and, indeed, may exacerbate those problems. For example, it appears to the Tribunal that combining advance statements with living wills and personal statements is likely to introduce into discussions concerning advance statements consideration of documents with entirely separate purposes, increase misunderstanding, cause confusion and potentially render the process of making an advance statement less appealing than it is at present. Further, it appears to the Tribunal that creating a Central Register of advance statements would be a measure that restricts flexibility and increases formality and, by doing so, would render the process of making an advance statement less appealing than it is at present. It is not clear from the recommendations whether it is the intention that the proposed registration of advance statements on a Central Register would be required for an advance statement to be "valid". It is not clear what weight medical professionals or the Tribunal should give to a properly executed advance statement which has not yet been registered and which postdates an advance statement which has been registered.

From the perspective of the Tribunal, the issue to be addressed is the issue of people not actually making advance statements (bearing in mind that it is the right of an individual *not* to make an advance statement). Accordingly, it appears to the Tribunal that the issue is essentially one of raising awareness about advance statements and ensuring that the process for making an advance statement is as clear, straightforward and flexible as possible and remains unburdened by unnecessary bureaucratic processes.

## *The Tribunal's view*

The Tribunal supports recommendation 2.1.

The Tribunal supports recommendation 2.2, to the extent that greater publicity be given to advance statements.

It appears to the Tribunal that mental health officers, due to their existing role, are best placed to raise with patients for whom they are mental health officer the issue of advance statements, their purpose, what they may contain and in what circumstances they will be had regard to.

It appears to the Tribunal that the matter of advance statements could usefully be highlighted by advocacy workers and solicitors and that such a role for advocacy workers and solicitors could be encouraged or coordinated by a body such as the Mental Welfare Commission.

The Tribunal does not support recommendation 2.3 on the ground that combining advance statements with living wills and personal statements is likely to introduce into discussions concerning advance statements consideration of documents with entirely separate purposes, increase misunderstanding, cause confusion and potentially render the process of making an advance statement less appealing than it is at present.

The Tribunal does not support recommendation 2.4 on the ground that the assessment and certification that the person making the advance statement has the capacity of properly intending the wishes specified in the advance statement is an onerous task, and that the categories of people empowered to do so should be extended only with care and not to "all staff", the meaning of which term is unclear.

With regard to recommendation 2.5, the Tribunal supports the concept that the issue of advance statements should be appropriately raised with patients during the recovery stage. However, the Tribunal does not consider it appropriate for "all staff involved during the recovery stage" to discuss advance statements with the patient, as this would appear to be likely to lead to repetition, overload and confusion. Again, the meaning of the term "all staff involved during the recovery stage" is unclear. Further, the Tribunal does not consider that it is necessary for the reasons for a patient's decision not to make an advance statement to be recorded, given that there is no requirement for a patient to provide any person with reasons for the patient's decision not to make an advance statement.

Recommendation 2.6 appears to the Tribunal to be uncontentious.

With regard to recommendation 2.7, it appears to the Tribunal that it would be a matter of good practice for responsible medical officers to review regularly any treatment in conflict with advance statements and to *keep* a written record of efforts made to address the person's stated wishes. However, the Tribunal does not consider that this issue of good practice requires to be made a statutory obligation.

The Tribunal does not support recommendation 2.8 on the ground that the introduction of a Central Register of advance statements would increase formality, restrict flexibility, raise issues as to whether an advance statement required to be registered to be "valid", and would make the process unnecessarily bureaucratic and thereby render the process of making an advance statement less appealing than it is at present.

## **Question 2: Independent Advocacy**

### *Review Group Limited Review Report 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.

### ***Discussion***

The Review Group's proposals in respect of independent advocacy appear to the Tribunal to be uncontentious, with the exception of proposal 3.5, the terms of which are somewhat obscure.

The Tribunal is unclear what "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" means. The Tribunal is concerned that the "appropriate scrutiny processes", whatever they may be, may impinge upon patients' right to privacy.

The Tribunal supports the Scottish Independent Advocacy Alliance's Principles and Standards and Code of Practice.

### ***The Tribunal's view***

**The Tribunal supports recommendations 3.1, 3.2, 3.3, 3.4 and 3.6.**

**The Tribunal does not support recommendation 3.5, on the ground that its terms are unclear.**

### **Question 3: Named Persons**

#### *Review Group Limited Review Report recommendations*

- 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.

### *Scottish Government's options for discussion*

2.9 (1) Whether the default named person scheme under the 2003 Act is appropriate, in light of service users' practical experience of the scheme in operation.

2.9 (2) What is the appropriate stage at which the named person should become involved under the 2003 Act when compulsory measures of treatment are in contemplation.

## ***Discussion***

The Tribunal notes the problems identified by the Review Group. From the perspective of the Tribunal, the principal issues to be addressed are the effects of the "default named person scheme" (as it is termed at paragraph 2.9 of the Scottish Government's consultation paper) under the 2003 Act and the sometimes deleterious impact this has on patients' privacy.

The Tribunal fully accepts that a patient should have a named person *only* if the patient has nominated a named person. Accordingly, the Tribunal supports recommendation 4.1 and responds in the negative to the question posed at paragraph 2.9 of the Scottish Ministers' consultation paper. Therefore, the Tribunal considers that, in logic, it cannot support recommendations 4.2 and 4.3 (or, indeed, recommendation 4.6: see below), each of which recommendations could result in a person who is *not* nominated as named person by a patient coming into a position as named person – without the consent or participation of the patient – to initiate legal proceedings in respect of the patient and/or to have access to papers in respect of the patient containing sensitive and confidential information about the patient.

The Tribunal notes that the terms of recommendation 4.4 are that "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". The Tribunal notes that it has power to appoint a curator *ad litem* where the patient lacks capacity to instruct a solicitor. The Tribunal notes that a patient has the right to decide not to instruct a lawyer, not to engage an independent advocate and not to nominate a named person. In the circumstances, the Tribunal is unclear as to the basis upon which it would appoint a safeguarder in respect of a patient where that patient has exercised his/her right not to instruct a lawyer, not to engage an independent advocate and not to nominate a named person or what test it is proposed that the Tribunal should apply in determining whether to appoint a safeguarder.

With regard to recommendation 4.5, bearing in mind the views of the Tribunal in respect of a safeguarder expressed in the preceding paragraph, the Tribunal already has in place

procedures for applications for compulsory measures to be scrutinised to ascertain whether a curator *ad litem* is required and for the Tribunal, internally at Hamilton, to appoint a curator *ad litem* at the earliest opportunity and before the calling of the case before a 3-member tribunal panel.

With regard to recommendation 4.6, the Tribunal does not accept that, where a patient has already appointed a welfare attorney under the Adults with Incapacity (Scotland) Act 2000, the welfare attorney should be able to act as the named person, subject to that welfare attorney being entitled to decline to act as named person. It appears to the Tribunal that a patient should be able to appoint a welfare attorney with the certainty that the welfare attorney will not, in the event that the patient becomes “unable to understand the effects of nominating a named person”, be able to act as the patient’s named person and so receive paperwork containing sensitive and confidential information about the patient. If a welfare attorney is able to act as a named person without being nominated by the patient, it appears to the Tribunal that such a state of affairs is in conflict with recommendation 4.1 and may restrict the group of persons whom a patient may be prepared to appoint as welfare attorney: it is not difficult to imagine that a person may be quite happy to have his or her sister act as welfare attorney but would not wish the sister to have access to the paperwork made available to a named person.

The Tribunal notes recommendation 4.7. The Tribunal does not believe that it is necessary or proportionate for there to “be a nationwide publicity campaign to advise everyone about the role and function of the named person and the consequences of appointing one”. It appears to the Tribunal that it would be more useful for information about the role and functions of named persons to be more readily available to those most likely to need it and, therefore, such information should be more carefully targeted. The Tribunal prefers recommendation 4.9, that “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”.

Recommendation 4.8 appears to the Tribunal to be uncontentious and to reflect good practice.

The Tribunal supports recommendations 4.10 and 4.11 requiring the consent of the named person to his/her appointment and the written indication of the nominator that he/she understands the consequences of appointing a named person.

The Tribunal notes recommendation 4.12. The Tribunal considers that contact should be made and support should be offered to a named person as soon as possible after the named person is nominated and should not wait to be offered until a nominated person “needs to act”. The Tribunal notes the recommendation that the support offered should be from either “the mental health officer or any other service provider”. In this context, for the avoidance of doubt, should the Tribunal be regarded as a “service provider”, the Tribunal is of the view that it would not be appropriate for the Tribunal, given that a named person would take part in proceedings before it, to offer this support.

Recommendation 4.13 appears to the Tribunal to be uncontentious and to reflect good practice.

The Tribunal notes the terms of recommendation 4.14. With regard to the recommendation that “Named persons should continue to have all powers currently exercised by them”, the Tribunal is of the view that consideration should be given to removing from named persons the status of a party to proceedings before the Tribunal. The Tribunal notes that where the patient and the named person adopt the same position in respect of the Tribunal proceedings, then there can be unnecessary duplication of effort and legal representation by and on behalf of the patient and the named person. Where there is profound conflict between the patient and the named person, it would appear unlikely that a patient would be prepared to tolerate such a conflicting position being adopted by the named person and would simply revoke the

nomination of the named person. The Tribunal is of the view that it is worth giving consideration to the removal of a named person's status as a party to proceedings before the Tribunal. This would allow the named person to act as a supporter of the patient at Tribunal hearings. The named person would have access to only such documents as the patient chose to allow the named person to have access to (the named person would no longer receive copies of documents from the Tribunal, as the named person would no longer be a party to proceedings before the Tribunal). One of the problems with the "default named person scheme" is that it has required the Tribunal to provide to the named person all of the documentation which must be provided to a party to Tribunal proceedings, and this has caused distress to patients and named persons alike. Where it was appropriate, it would be open to a named person to apply to the Tribunal under rule 48 of the Tribunal's Rules to be treated as a party or as a relevant person.

With regard to the recommendation that named persons should receive notification from the police if the service user for whom they are the named person is taken to a place of safety, the Tribunal considers that it is not for the police to provide such information to a named person. Further, the Tribunal recognises that it may not be appropriate for the named person to be provided with this information. However, in circumstances in which it is appropriate for the named person to be notified that the patient has been taken to a place of safety, it appears to the Tribunal that the mechanism for providing this information to the named person would lie most appropriately with the responsible medical officer or the mental health officer. Whether it is intended from this recommendation that there should be a statutory obligation to provide this notification to the named person is unclear to the Tribunal. The Tribunal is of the view that there should not be such a statutory obligation.

With regard to recommendation 4.15, the Tribunal is not opposed to mental health officers or responsible medical officers consulting named persons, but would be concerned if a statutory obligation upon the mental health officer or the responsible medical officer to do so would allow the process of applying for a compulsory treatment order to be halted or delayed if that statutory obligation was not complied with. Accordingly, the Tribunal is of the view that if such an obligation is to be imposed, it should be imposed only on the basis "so far as reasonably practicable", to ensure that lack of cooperation of the named person, for example, does not in itself prevent the application process from progressing.

The Tribunal agrees with recommendation 4.16.

With regard to recommendation 4.17, the Tribunal is in the process of undertaking a review of the Tribunal's Rules and will thereafter make the results of that review known to the Scottish Government with a request that it revoke the Mental Health (Practice and Procedure) (No. 2) Rules 2005 (as amended) and make new rules. Thereafter, the Tribunal anticipates that the Mental Health Act Code of Practice will be updated to reflect the provisions of the new rules.

The Tribunal notes recommendation 4.18. The Tribunal regrets that the recommendation does not specify *who* should hold "further discussion about good practice concerning the amount and quality of information included in the papers sent to the tribunal". The papers lodged with the Tribunal include reports of responsible medical officers (current and historical), reports of other psychiatrists, reports of mental health officers, reports of clinical psychologists, risk assessments, minutes of Care Programme Approach and other meetings and statements made by parties. These papers are circulated to all parties to proceedings before the Tribunal, as all parties require to have access to all the papers being considered by the Tribunal, subject to the provisions of rules 46, 46A and 47 of the Tribunal's Rules.

The Tribunal notes recommendation 4.19. The Tribunal notes that named persons are neither a specific group of professionals (such as lawyers, doctors, social workers or nurses) nor homogeneous but, instead, are friends, relatives and other individuals who are significant to

patients. It appears to the Tribunal to be inappropriate and unworkable to attempt to subject such a wide-ranging and disparate group of individuals to a Code of Practice. In addition, it appears to the Tribunal that it is inappropriate to attempt to subject to a Code of Practice a group of people who are in fact parties to judicial proceedings (or indeed, whose role in proceedings is to act as a supporter of the patient, in the event that the Tribunal's proposal is accepted that the status of named person as parties be removed. With regard to the Scottish Government's option for discussion 2.9(1), the Tribunal, as it has indicated above, is of the view that the "default named person scheme" (as it is termed at paragraph 2.9 of the Scottish Government's consultation paper) under the 2003 Act is not appropriate.

With regard to the Scottish Government's option for discussion 2.9(2), the Tribunal is of the view that the stage at which it is appropriate for a named person to become involved under the 2003 Act is when the 2003 Act is engaged and its provisions apply to the patient (for example where the patient becomes subject to a short-term detention certificate or an application is made for the patient to become subject to a compulsory treatment order). Prior to this, it appears to the Tribunal that the patient will be engaging voluntarily with mental health services, and so there is no stand alone role for the named person.

### ***The Tribunal's view***

**The Tribunal supports recommendation 4.1 and fully accepts that a patient should have a named person *only* if the patient has nominated a named person.**

**The Tribunal does not support recommendations 4.2 and 4.3, given that they appear to be in conflict with recommendation 4.1.**

**The Tribunal does not support recommendation 4.4, there being no indication of the basis on which a safeguarder might be appointed by the Tribunal or the test to be applied by the Tribunal in determining whether a safeguarder should be appointed.**

**With regard to recommendation 4.5, given the Tribunal's position in respect of recommendation 4.4, the Tribunal does not support recommendation 4.5 in so far as it refers to a "safeguarder"; with regard to consideration of the appointment of a curator *ad litem*, it appears to the Tribunal that recommendation 4.5 simply reflects the factual position as it is currently.**

**The Tribunal does not support recommendation 4.6. In supporting recommendation 4.1, the Tribunal fully accepts that the patient should have a named person *only* if the patient has nominated a named person. Recommendation 4.6 appears to be in conflict with recommendation 4.1. It appears to the Tribunal that the recommendation that a welfare attorney should automatically be in a position to act as a named person risks restricting the group of persons whom a patient may be prepared to appoint a welfare attorney.**

**The Tribunal does not support recommendation 4.7, on the basis that a "nationwide publicity campaign to advise everyone" about named persons is disproportionate.**

**Recommendation 4.8 appears to the Tribunal to be uncontentious and to reflect good practice.**

**The Tribunal supports recommendations 4.9, 4.10, 4.11, 4.12 and 4.13.**

**With regard to recommendation 4.14, the Tribunal is of the view that consideration should be given to removing from named persons the status of a party in Tribunal proceedings. It appears to the Tribunal that the removal of such a status would prevent named persons receiving any paperwork other than the paperwork that the patient**

explicitly chose to provide to the named person; would stop unnecessary duplication of effort and legal representation, as between the patient and the named person; and would leave the named person to act as a supporter of the patient in respect of Tribunal proceedings, while leaving open the possibility, in appropriate circumstances, for the named person to apply to the Tribunal under rule 48 of the Tribunal's Rules to be treated as a party or as a relevant person to the proceedings before the Tribunal.

Further with regard to recommendation 4.14, the Tribunal considers that it is not for the police to notify a named person if a service user is taken to a place of safety. The Tribunal is also of the view that there may be circumstances in which it would be entirely inappropriate for the named person to be provided with such information.

The Tribunal supports recommendation 4.15, subject to the *caveat* that such a statutory duty should be imposed only on the basis "so far as reasonably practicable".

The Tribunal supports recommendation 4.16.

The Tribunal supports recommendation 4.17 to the extent that it accepts that the Mental Health Code of Practice should reflect the provisions of the Tribunal's Rules. The Tribunal is in the process of undertaking a review of the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (as amended) and anticipates that in the event that the Rules are revoked and replaced, the Mental Health Act Code of Practice will be updated to reflect the provisions of the new Practice and Procedure Rules.

With regard to recommendation 4.18, the Tribunal is in ongoing discussion, internally and with stakeholders, as to the information included in the papers lodged with the Tribunal. Those papers are provided to all parties to the particular proceedings before the Tribunal, as required by the Tribunal's Rules, on the basis that all parties to the proceedings before the Tribunal require to know what is contained within the papers that the Tribunal is considering. That sharing of papers is, of course, subject to the provisions of rules 46, 46A and 47 of the Tribunal's Rules and, of course, subject to the concerns of the Tribunal and many others in respect of papers being made available to named persons, which concerns are addressed elsewhere within the consultation document and this response.

The Tribunal does not support recommendation 4.19, on the ground that it is inappropriate and unworkable to seek to subject private individuals to a Code of Practice.

2.9(1) In response to the Scottish Government's options for discussion at paragraph 2.9 of the consultation document, the Tribunal considers that the "default named person scheme under the 2003 Act" is not appropriate, principally because it results in persons who are not appointed by the patient as a named person – or indeed with their consent – becoming a patient's named person and being in a position to initiate legal proceedings in respect of, and to have access to papers containing sensitive and confidential information about, the patient.

2.9(2) In response to the Scottish Government's options for discussion at paragraph 2.9 of the consultation document, the Tribunal considers that the stage at which it is appropriate that the named person should become involved under the 2003 Act is the stage when the 2003 Act is engaged and its provisions apply to the patient: before such a stage, it appears to the Tribunal that the patient is engaging voluntarily with mental health services.

## **Question 4: Medical Matters**

### **Preparation of medical reports for compulsory treatment orders**

#### *Review Group Limited Review Report 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 of 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.

#### *Scottish Government's options for discussion*

Option 5A: One medical report from an approved medical practitioner, within which report there is encapsulated information from the patient's GP, where available, about their history and primary care needs.

Option 5B: One medical report from an approved medical practitioner only, with no further information from the patient's GP. Pursuing this option would mean that an application for a CTO would contain no medical history from the patient's GP, unless this were to be provided elsewhere, for example, within the MHO's report.

Option 5C: The Tribunal might instead in future be responsible for appointing the second medical report in relation to all applications for compulsory treatment orders.

Option 5D: The current MHO report might be adjusted to include in future a medical history from the patient's GP.

### ***Discussion***

The Tribunal notes recommendation 5.1 and that "an application for a compulsory treatment order should continue to be accompanied by two medical reports". This recommendation appears to arise from the fact that the Review Group's "consultations indicated little support for applications for compulsory treatment orders being based on a single medical report from an approved medical practitioner".

While the Tribunal notes that the Review Group “heard widespread support for primary care being involved in the long-term compulsory treatment, ensuring an act of continuity of general practice, expertise and connection to primary care services, both retrospectively and prospectively”, the Tribunal also notes:

- “that only around 50% of second medical reports for compulsory treatment orders are provided by a general practitioner”;
- that “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”;
- that some respondents to the Review Group’s consultation “reported a perception that general practitioners simply ‘rubber stamp’ the psychiatrists’ reports. This view is associated with the perception that general practitioners see the approved medical practitioner as a specialist ...”;
- that general practitioners “may be reluctant to provide reports as they are rarely involved in applications for compulsory treatment orders”; and
- that the “organisation of primary care services makes it less likely that a patient has long-term contact with an individual general practitioner”.

The Tribunal notes recommendations 5.2 and 5.3. The Tribunal has carefully considered the Review Group’s recommendations and the basis given for those recommendations set out in the Review Group’s Report.

In all of the circumstances, given the importance that no person should be subject to restrictions on their liberty on the ground of mental disorder without there being medical evidence; the clear difficulty in involving general medical practitioners in the process for the application for compulsory treatment orders; and the concern that such input is, in the phrase of the Review Group, a “rubber stamp” of the recommendations of the psychiatrist, the Tribunal does not see that the Review Group’s recommendations 5.1 and 5.2 offer improvement upon the current situation. Further, the Review Group appears not to have considered the preparation of medical reports for compulsory treatment orders in the context of addressing the issue of multiple hearings. Given the Tribunal’s rejection of recommendations 5.1 and 5.2, the Tribunal does not support recommendation 5.3.

The Tribunal welcomes the Scottish Government’s further options for consideration, set out in its Consultation on the Review of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Tribunal has carefully considered the Scottish Government’s options for discussion. The Tribunal agrees that in terms of an application to the Tribunal for a compulsory treatment order, what would seem to be desirable in addition to a report from a psychiatrist addressing the relevant statutory tests set out in section 57(3) of the 2003 Act would be information from the general practitioner (if any), the possibility of some form of independent report and a timely tribunal to make a determination on detainability.

The Tribunal has carefully considered the Scottish Government’s options for discussion 5A to 5D and the thinking that has resulted in those options for discussion being put forward in this consultation. Having done so, the Tribunal proposes an amalgamation of options 5B, 5C and 5D.

The Tribunal is of the view that the issue of multiple hearings and the issue of medical reports are linked. It appears to the Tribunal that by allowing an application for a compulsory treatment order to be lodged with the Tribunal on the basis of a report by the patient’s responsible medical officer, or another suitable approved medical practitioner, addressing the statutory tests set out in section 57(3) of the 2003 Act and an enhanced report by the mental

health officer incorporating the views of the patient's general practitioner (if any) would open the way to allowing a second medical report by a suitable approved medical practitioner to be instructed at the time of the making of the application by some independent body, such as the Mental Welfare Commission (in this respect it is noted that the Commission currently receives notification of the making of compulsory treatment order applications by virtue of section 60(1)(c) of the 2003 Act).

The Tribunal supports the protection of the interests of the patient and in this respect the Tribunal notes that its proposal would require reports from two suitable approved medical practitioners and a report from the mental health officer (incorporating information from the patient's general practitioner, if any) in order for an application for a compulsory treatment order to be considered by the Tribunal; the patient would continue to have the protection afforded by the statutory obligations on the responsible medical officer and the mental health officer; the availability of advocacy services and legal representation to patients; and the inquisitorial role of the Tribunal itself.

If the Tribunal's proposal was combined with the Review Group's recommendation 6.1 of its report (that the time limit of five working days contained in s68(2)(a) of the Act should be increased to 10 working days), then it appears to the Tribunal that this would provide a realistic opportunity to have before the Tribunal on the first calling of the application not only the views of the responsible medical officer, the mental health officer and the patient's general practitioner (if any), but also a report of a suitable approved medical practitioner instructed and prepared quite separately from, and independently of, those applying for and with an interest in the application for a compulsory treatment order. The benefit of such a report instructed by an independent body such as the Mental Welfare Commission would be that it would provide the Tribunal (in the event that the patient was unrepresented) and the patient's solicitor (in the event that the patient was legally represented) with a basis in precognition for cross-examination of the responsible medical officer. In the event that it was identified, whether by the Tribunal or by the patient's solicitor, that there were further specific issues which required to be addressed by a further medical report, it should be open to the Tribunal to adjourn the hearing and instruct such a report or, on the motion of the patient's solicitor, on cause shown, to adjourn the hearing for the instruction of a further medical report.

### *The Tribunal's view*

**The Tribunal does not support recommendations 5.1 and 5.2 and, consequently, does not support recommendation 5.3.**

**The Tribunal has considered the Scottish Government's options for discussion numbers 5A, 5B, 5C and 5D. The Tribunal does not support the Scottish Government's option for discussion 5A.**

**The Tribunal proposes an amalgamation of the Scottish Government's options for discussion 5B, 5C and 5D.**

**The Tribunal proposes that an application for a compulsory treatment order proceeds on the basis of:**

- **an application made by a mental health officer incorporating a mental health officer's report (see section 61(2)(e) and (4) of the 2003 Act), with an obligation on the mental health officer to consult with and include in the mental health officer's report the views of the patient's general practitioner (if any);**

- a report from the patient's responsible medical officer or from another suitable approved medical practitioner addressing the relevant statutory tests set out in section 57(3) of the 2003 Act;
- a report from a suitable approved medical practitioner instructed by an independent body, such as the Mental Welfare Commission, at the time the application is made.

### **Medical examinations – conflict of interests**

#### *Review Group Limited Review Report recommendations*

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.

### ***Discussion***

The Tribunal notes recommendation 5.4. It appears to the Tribunal that it is appropriate for a patient's responsible medical officer to carry out a medical examination with a view to determining whether to apply for an extension of a compulsory treatment order in respect of a patient. That is so even where the patient is detained in a hospital operated by an independent healthcare provider. However, the Tribunal accepts that such an application for extension should not proceed only on the basis of a medical examination carried out by an approved medical practitioner employed by that independent healthcare provider, but should be supported by a report prepared following a medical examination of the patient carried out by an approved medical practitioner independent of that healthcare provider.

### ***The Tribunal's view***

**The Tribunal supports the thrust of recommendation 5.4 subject to the caveat that while a medical examination should be carried out by the responsible medical officer, where that responsible medical officer is employed by the independent healthcare provider which operates the hospital in which the patient is detained, such an application for extension of a compulsory treatment order should be supported by a report following a medical examination carried out by an approved medical practitioner independent of that healthcare provider.**

### **Revocation of emergency detention certificates**

#### *Review Group Limited Review Report recommendations*

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

## *Discussion*

The Tribunal accepts that it is appropriate that revocation of an emergency detention certificate should take place only following an assessment by an approved medical practitioner.

## *The Tribunal's view*

**The Tribunal supports recommendation 5.5.**

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

#### *Review Group Limited Review Report 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.

## *Discussion*

The Tribunal notes recommendation 5.6. The Tribunal notes that the recommendation does not define "brief periods out of hospital", except to the extent that it does not include overnight periods out of hospital. The recommendation is that such suspension of detention should be "explicitly authorised by the responsible medical officer". The Tribunal's understanding is that currently any suspension of detention is explicitly authorised by the responsible medical officer in terms of section 127 of the 2003 Act. The recommendation is that such "brief periods out of hospital (not overnight)" would not count towards any cumulative limit on any total time out of hospital while subject to detention. However, the

recommendation gives no indication of how many “brief periods out of hospital (not overnight)” should be allowable – consecutively or not – in any specified period.

The Tribunal notes recommendation 5.7. This recommendation is in respect of “overnight and longer periods of suspension”. The recommendation is that such periods of suspension of detention should be authorised by a suspension certificate and that “Such certificates could cumulatively authorise up to 200 overnight periods out of hospital in any 12 month period”. The Tribunal notes that this appears to be a significant reduction in the amount of suspension of detention in a 12 month period allowed in terms of section 127 of the 2003 Act (9 months in a 12 month period). The Tribunal notes that the recommendation is that “the cumulative total [of suspension of detention authorised by a certificate] would be counted retrospectively from any point in the patient’s compulsory treatment”. The Tribunal does not see that this part of the recommendation differs in any material respect from the position set out in section 127(2) of the 2003 Act.

Recommendation 5.8 appears to the Tribunal to reflect good practice and the terms of section 93(2) of the 2003 Act.

The Tribunal notes recommendation 5.9. This recommendation is that where it appears that the time limit might be exceeded – which the Tribunal understands to mean where it appears to the responsible medical officer that the patient might be on overnight suspension of detention for more than 200 overnights in any 12 month period, counted retrospectively from any point in the patient’s compulsory treatment – then an application would require to be made to the Tribunal. The recommendation is that “The tribunal hearing would then consider whether the grounds for continued compulsory treatment were met or whether a variation was appropriate”. However, it appears to the Tribunal that the issue as to “whether the grounds for continued compulsory treatment were met” and “whether a variation was appropriate” are not alternatives or mutually exclusive.

It appears to the Tribunal that recommendations 5.6, 5.7 and 5.9 lack clarity and measurability.

It appears to the Tribunal that the principal problem in respect of suspension of detention is not inflexibility or difficulty in keeping track of the period of time for which detention has been suspended (which difficulty these recommendations do not in any event appear to address), but is a problem of patients having their detention suspended by their responsible medical officer for a period in excess of the current limit of 9 months in a 12 month period. This has even raised questions before tribunals as to whether the fact of the breach of the maximum time period has an impact on the validity of the compulsory treatment order itself. The Tribunal is of the clear view that there is no such impact on the validity of a compulsory treatment order itself.

The Tribunal is not aware that there is any sanction in respect of a responsible medical officer who purports to suspend a patient’s detention in excess of the maximum statutory period set out in section 127 of the 2003 Act. It appears to the Tribunal that it may be appropriate for Health Boards or for a body such as the Royal College of Psychiatrists to issue guidance to psychiatrists in respect of their authorisation of suspension of detention, to ensure that applications for variation of a compulsory treatment order from a hospital to a community based order are made to the Tribunal sufficiently in advance of the expiry of the statutory maximum period for suspension of detention, to allow the Tribunal to consider and determine that application prior to the statutory maximum period being exceeded.

In such circumstances, picking up on recommendation 5.9, the Tribunal proposes that where the Tribunal is not satisfied that the compulsory treatment order should be varied from a hospital based to a community based order, but is satisfied that the patient should remain on suspension of detention, the Tribunal could make an order authorising suspension of detention for a further period of, say, 3 months.

## *The Tribunal's view*

The Tribunal does not support recommendations 5.6, 5.7 and 5.9 on the ground that they lack clarity and it is not clear that they offer any improvements on the suspension of detention provisions as currently set out in section 127 of the 2003 Act.

Recommendation 5.8 appears to be uncontentious and to reflect good practice and the provisions of section 93(2) of the 2003 Act.

Picking up on recommendation 5.9, the Tribunal proposes, in the event that the current suspension of detention provisions at section 127 of the 2003 Act remain in force, that further provision be made to allow the Tribunal the option, when considering an application for variation of a compulsory treatment order from a hospital based to a community based order, to refuse the variation but to authorise continued suspension of detention for a period of, say, 3 months.

## Consent

### *Review Group Limited Review Report recommendations*

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.

## *Discussion*

The Tribunal supports the provision at section 238(1)(b) of the 2003 Act that the consent of the patient to medical treatment mentioned in section 237(3) or 240(3) of the 2003 Act should be consented to in writing by the patient. Accordingly, the Tribunal supports the recommendation that there be no change to the current requirement for the patient's consent in writing. The Tribunal notes the recommendation that "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". The Tribunal notes that the recommendation does not indicate what matter the opinion should address or to what end.

## *The Tribunal's view*

The Tribunal supports recommendation 5.10 to the extent that it does not recommend any change to the current requirement for the patient's consent in writing as provided for by section 238(1)(b) of the 2003 Act.

## **Care Plans**

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.

## ***Discussion***

The Tribunal notes recommendation 5.11. The Tribunal notes that section 325 of the 2003 Act empowers the Scottish Ministers by regulations to prescribe “the form of any document that is required or authorised to be prepared by virtue of this Act”. This power would be sufficient for the Scottish Ministers to prescribe the form of a care plan. The Tribunal notes that section 76(2)(b) empowers the Scottish Ministers to prescribe by regulations “such other information relating to the care of the patient” which should be set out in the care plan. The Tribunal notes that section 76(4) of the 2003 Act empowers the Scottish Ministers to prescribe circumstances in which a patient’s responsible medical officer is required to amend the patient’s care plan and to prescribe information in a care plan which may not be amended.

The Tribunal notes that the Mental Health (Content and amendment of care plans) (Scotland) Regulations 2005 (SSI 2005/309) and the Mental Health (Content and amendment of Part 9 care plans) (Scotland) Regulations 2005 (SSI 2005/312) prescribes the information to be included in a care plan in addition to the medical treatment.

The Tribunal is of the view that it should be left to the relevant professionals to present the required information in a form they consider appropriate.

The Tribunal notes that neither section 325 nor section 76 of the 2003 Act empower the Scottish Ministers to recommend a timeframe for the completion of the care plan. Rather, section 76(1) provides that “As soon as practicable after the patient’s responsible medical officer is appointed under section 230 of this Act, the responsible medical officer shall... prepare a plan (any such plan being referred to in this Act as a “care plan”) relating to the patient”.

Accordingly, it appears to the Tribunal that while the Scottish Ministers do have power to prescribe the form of a care plan, they do not have power to provide by regulations a “recommended timeframe for its completion at the various stages it is required”.

Accordingly, it appears to the Tribunal that the Scottish Ministers do not have power by regulations to do what is recommended by recommendation 5.11.

The Tribunal is not aware of a widespread issue in respect of care plans, their purpose, content and format.

The Tribunal notes recommendation 5.16. Recommendation 5.16 does not appear to the Tribunal to make clear what “recommended forms” it is recommended be given “prescribed status”.

From the perspective of the Tribunal, the issue to be addressed is the issue of the content of care plans themselves: i.e. the issue is one of substance over form. Accordingly, it appears to the Tribunal that the issue is essentially one of raising awareness about care plans, their content and format.

### *The Tribunal’s view*

**The Tribunal does not support recommendation 5.11, as the Scottish Ministers do not appear to have the power to do by regulations what is recommended at recommendation 5.11.**

**The Tribunal does not support recommendations 5.12, 5.13, 5.14 or 5.15.**

**The Tribunal does not support recommendation 5.16, it not being clear what “recommended forms” it is recommended be given “prescribed status”.**

**It appears to the Tribunal that responsible medical officers, given their statutory duty to prepare a care plan under section 76(1)(a) of the 2003 Act, are best placed to address the matter of care plans, their purpose, content and format.**

**It appears to the Tribunal that the matter of care plans, their purpose, content and format, could usefully be addressed by responsible medical officers and that such a role for responsible medical officers could be encouraged or coordinated by a body such as the Royal College of Psychiatrists. The Tribunal is happy to work with the Royal College of Psychiatrists and with responsible medical officers and others on the matter of care plans, their purpose, content and format.**

## **Question 5: Tribunals**

### *Review Group Limited Review Report 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 notices 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.

#### *Scottish Government’s options for discussion*

4.16 Require that an application for a compulsory treatment order must be made no later than 21 days into the cycle of the short-term detention certificate to which the patient is subject.

4.17 Reduce the period of detention authorised by a short-term detention certificate to a period of 21 days; the period of detention would be automatically extended, as at present, where a compulsory treatment order has been applied for.

4.23 A different split of the 42 calendar days detention, which would be authorised if the Review Group’s recommendation 6.1 was given effect to (the total amounting to 42 days, consisting of 28 days detention under the short-term detention certificate and a further 14 calendar days detention by operation of section 68 of the 2003 Act; for example, 21 calendar days in which to lodge a compulsory treatment order application, plus 15 working days extension of the short-term detention certificate, where an application for a compulsory treatment order has been lodged.

4.24 Preparation of certain documents, for example the GP report and care plan, to take place after the application for a compulsory treatment order has been lodged with the Tribunal.

4.26 Abolition of interim compulsory treatment orders.

4.31 The Tribunal to be given a new role in instructing independent medical reports for patients, in order to ensure that they are available at a much earlier stage in the proceedings.

### ***Discussion***

The Tribunal supports recommendation 6.1. Applications for compulsory treatment orders are regularly received by the Tribunal on the 26th, 27th or 28th day of the short-term detention certificate. The effect of this is that in reality the Tribunal has only the 5 working day period provided by section 68 of the 2003 Act in which to intimate the application for a compulsory treatment order to the parties, arrange the availability of a 3-member tribunal panel, arrange a venue and intimate that venue to all of the parties, and to provide all the papers to the patient, named person and tribunal members. This provides a significant logistical and administrative burden upon the Tribunal. The increase of the section 68(2)(a) 5 working day period to 10 working days (effectively a 14 calendar day period) would be extremely welcome, not only in alleviating the logistical and administrative burden upon the

Tribunal, but in increasing the opportunity before the first hearing of the compulsory treatment order application for the patient to have been able to instruct legal representation.

The Tribunal accepts recommendation 6.2 and is of the view that any extension of the period of detention provided for by section 68(2)(a) of the 2003 Act should not result in an increase in the continuous period of detention of 56 days provided for by section 65(3) of the 2003 Act.

Recommendation 6.3 appears to the Tribunal to be uncontentious and to reflect good practice.

With regard to recommendation 6.4, the Tribunal supports the concept that an application for a compulsory treatment order should be intimated to the patient and to the patient's solicitor (if known) by the mental health officer at the same time as it is sent to the Tribunal for lodging. However, the Tribunal goes further. The Tribunal is of the view that the mental health officer should be under an obligation to formally serve a compulsory treatment order application on the patient, the patient's solicitor (if known to the mental health officer) and the named person (if named persons are to remain parties to proceedings before the Tribunal); the obligation on the Tribunal under rule 6(2) of the Tribunal's Rules to send a copy of the application and any accompanying documents to the patient and the patient's named person should be removed; it should be for the mental health officer to provide to the Tribunal proof of service of the application and any accompanying documents.

With regard to recommendation 6.5, the Tribunal notes that curators *ad litem* are already subject to a Tribunal Guidance Note issued on 6 November 2008. The Tribunal considers that it would be inappropriate for the Tribunal to seek to interfere with the independence of a curator *ad litem* by seeking to make the curator *ad litem* subject to a Code of Conduct. Further, the Tribunal is of the view that members of the Tribunal are judicial officers exercising a judicial function and that it would be inappropriate to seek to subject them to a Code of Conduct. The Tribunal notes that its members and shrieval conveners will become subject to the Statement of Principles of Judicial Ethics for the Scottish Judiciary in due course.

The Tribunal does not support recommendation 6.6. The Tribunal does not accept that it is appropriate for it to subject a patient to restrictions on that patient's liberty on the basis that the criteria for a compulsory treatment order "appear to be met". In the view of the Tribunal, the test currently is that a tribunal is satisfied that the conditions mentioned in section 64(5) of the 2003 Act are met. If the Tribunal is not satisfied that the conditions mentioned in section 64(5) of the 2003 Act are met, then it should not make an order, whether a compulsory treatment order or an *interim* compulsory treatment order. In the view of the Tribunal, the introduction of a test that the criteria "appear to be met" is a confused and confusing half-way house which should not be accepted.

The Tribunal does not support recommendation 6.7 for the same reasons as given in the preceding paragraph.

The Tribunal notes recommendation 6.8. The Tribunal notes that preliminary and procedural hearings with conveners sitting alone are already being used and that the Tribunal is already taking steps to increase the use of such preliminary and procedural hearings where appropriate, both in restricted and in non-restricted patient cases. The Tribunal is also already actively pursuing identifying cases which could appropriately be decided under rule 58 (power to decide case without a hearing) of the Tribunal's Rules.

The Tribunal accepts recommendation 6.9.

The Tribunal notes the Scottish Government's option for discussion 4.16, which it would find helpful in alleviating the significant pressure on the Tribunal to fix hearings on applications for compulsory treatment orders, caused by the fact that the majority of applications for

compulsory treatment orders are received by the Tribunal on days 26, 27 and 28 of the period authorised by the short-term detention certificate.

The Tribunal notes the Scottish Government's option for discussion 4.17. The Tribunal is of the view that if the period of detention authorised by a short-term detention certificate was reduced to 21 days, this would likely provide an inadequate period in order for mental health professionals to assess the patient, prepare the necessary paperwork and submit it to the Tribunal sufficiently in advance of the 21 day period to allow the Tribunal to complete all the work it requires to complete to enable a hearing to proceed on the compulsory treatment order application. In short, this recommendation does not appear to offer any improvement over the current situation.

The Tribunal notes the Scottish Government's option for discussion 4.23.

The Tribunal notes the Scottish Government's option for discussion number 4.24. The Tribunal is of the view that it is inappropriate for an application for a compulsory treatment order to be lodged with the Tribunal where all of the relevant paperwork is not in place. In the view of the Tribunal, the applicant mental health officer should remain responsible for obtaining, collating and lodging all of the relevant paperwork in support of an application for a compulsory treatment order and that such paperwork should all be lodged with the Tribunal at the same time. The Tribunal notes that there would be the potential for various difficulties to arise, where it was not in the position to be able to provide all of the relevant papers at one time to the Tribunal members (and to the patient and named person, if the Tribunal's proposal that responsibility for serving these documents be transferred to the mental health officer is not accepted). The logistical difficulties created by putting in place a system where the relevant papers for an application for a compulsory treatment order required to be provided to parties and Tribunal members in tranches, appears to the Tribunal to be undesirable and unnecessary.

The Tribunal notes with interest the Scottish Government's option for discussion number 4.26. The Tribunal is of the view that serious consideration should be given to the radical step of abolishing *interim* compulsory treatment orders. However, the Tribunal is clear that such abolition could only be considered if other measures are put in place – some of which are addressed in the Review Group's Report on the Limited Review of the Act, the Scottish Government's consultation document and this response. The Tribunal considers that it would be desirable for the Scottish Ministers to constitute a short-term working party, comprising representatives of the Tribunal and other stakeholders, to consider the ramifications of this proposal and other measures that would require to be put in place to allow this proposal to function effectively and in the best interests of the patient.

The Tribunal notes the Scottish Government's option for discussion number 4.31. The Tribunal considers that it would be preferable for an independent medical report to be instructed by a body other than the Tribunal. The Tribunal refers to the third bullet point of its proposal at the "Preparation of medical reports for compulsory treatment orders" above.

### ***The Tribunal's view***

**The Tribunal supports recommendation 6.1. In the view of the Tribunal, increasing the time limit of 5 working days specified in section 68(2)(a) of the 2003 Act to 10 working days (in effect 14 calendar days) would be a significant move towards enabling an application for a compulsory treatment order to be determined at its first calling.**

The Tribunal supports recommendation 6.2. The Tribunal accepts that the present maximum period during which a patient should be subject to the measures authorised by an *interim* compulsory treatment order should not extend beyond 56 days.

Recommendation 6.3 appears to the Tribunal to be uncontentious and to reflect good practice.

The Tribunal supports recommendation 6.4 to the extent that it recommends that a copy of the application for a compulsory treatment order should be given to the patient and/or patient's solicitor by the mental health officer at the same time as it is sent to the Tribunal. However, the Tribunal goes further. The Tribunal is of the view that the mental health officer should be under an obligation to formally serve a compulsory treatment order application on the patient, the patient's solicitor (if known to the mental health officer) and the named person (in the event that named persons are to remain parties to Tribunal proceedings); the obligation on the Tribunal under rule 6(2) of the Tribunal's Rules to send a copy of the application and any accompanying documents to the patient and the patient's named person should be removed; it should be for the mental health officer to provide to the Tribunal proof of service of the application and any accompanying documents.

The Tribunal does not support recommendation 6.5. The Tribunal considers that it is inappropriate for the Tribunal to seek to interfere with the independence of curators *ad litem* by seeking to make them subject to a Code of Conduct. The Tribunal notes that its members and shrieval conveners will, in due course, become subject to the Statement of Principles of Judicial Ethics for the Scottish Judiciary.

The Tribunal does not support recommendation 6.6. The Tribunal considers that the test that conditions for an order "appear to be met" is a confused and confusing half-way house which should not be accepted. The Tribunal is of the view that the test should remain as it is: that in the event that the Tribunal is satisfied that the conditions mentioned in section 64(5) of the 2003 Act are met, it should make an order, and if it is not so satisfied, it should not make an order.

The Tribunal does not support recommendation 6.7 for the same reasons that it does not support recommendation 6.6.

The Tribunal notes recommendation 6.8. The Tribunal is already making use of the powers that already exist in relation to preliminary and procedural hearings and for conveners sitting alone and is taking steps to increase the use of such hearings where appropriate.

The Tribunal supports recommendation 6.9.

The Tribunal supports the Scottish Government's option for discussion 4.16.

The Tribunal does not support the Scottish Government's option for discussion 4.17.

The Tribunal does not support Scottish Government's option for discussion 4.23.

The Tribunal does not support Scottish Government's option for discussion 4.24.

The Tribunal notes with interest the Scottish Government's option for discussion 4.26. The Tribunal is of the view that this radical recommendation should be given serious and detailed consideration. The Tribunal is of the view that a short-term working party should be constituted by the Scottish Government to give consideration to this recommendation.

The Tribunal does not support the Scottish Government's option for discussion 4.31.

## **Excessive formality and legality**

### *Review Group Limited Review Report 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.

## ***Discussion***

The Tribunal notes recommendation 6.10. The Tribunal provides ongoing training in tribunal skills for all of its members. The Tribunal does not accept that training in tribunal skills is training that should be provided especially to conveners. Tribunal skills are important for each member of a tribunal.

The Tribunal has over 100 conveners, each of whom has their own particular style and each of whom, along with their fellow tribunal members, seeks to tailor the approach taken by individual tribunals to the particular circumstances of the proceedings before it. The Tribunal encourages its members to adopt the least formal approach to proceedings where appropriate. However, the Tribunal recognises that in cases of particular complexity, or where there is a high number of witnesses or productions, or where emotions are running high, it may be appropriate to adopt a more formal procedure. This decision is at the discretion of the convener and the two other tribunal panel members.

The Tribunal is currently undertaking a consultation on the matter of recording of its proceedings. The Tribunal will consider its position in due course.

The Tribunal notes recommendation 6.13. The Tribunal notes that solicitors are already subject to the Solicitors (Scotland) (Standards of Conduct) Practice Rules 2008. Whether solicitors should be subject to a Code of Conduct specifically in respect of working in the field of mental health law is a matter for the Law Society of Scotland.

The Tribunal supports recommendation 6.14 subject to the observation that the Tribunal works closely with Health Boards to ensure that suitable standards in venues are achieved.

Recommendation 6.15 generally reflects current practice.

Recommendation 6.16 generally reflects current practice.

Recommendation 6.17 generally reflects current practice.

The Tribunal does not support recommendation 6.18. The Tribunal considers that in deciding whether to use a specific venue to hold a hearing or not, it requires to weigh the venue against the desirability of having to use another venue, perhaps many miles away. It appears to the Tribunal that recommendation 6.18 is too rigid and would prevent the Tribunal appropriately exercising its discretion for the purpose of ensuring that patients are not inconvenienced and required to travel long distances unnecessarily.

### *The Tribunal's view*

**Recommendation 6.10 reflects the factual position as it is currently, subject to the caveat that the Tribunal does not accept that training in tribunal skills is something which should be provided especially to conveners: such training is essential for all Tribunal members.**

**Recommendation 6.11 reflects the factual position as it is currently.**

**The Tribunal supports recommendation 6.12. The Tribunal is currently undertaking a consultation on the issue of recording its proceedings and will determine whether to continue with such recording or to cease such recording in due course.**

**Recommendation 6.13 appears to the Tribunal to be a matter for the Law Society of Scotland.**

**Recommendations 6.14, 6.15, 6.16 and 6.17 generally reflect current practice.**

**The Tribunal does not support recommendation 6.18, as it appears to the Tribunal to be too rigid, removing from the Tribunal the discretion that enables it to make an appropriate decision, taking account of the whole facts and circumstances, on whether to use a venue, balancing the needs of the patient, parties, witnesses and tribunal members against the benefits of using such a venue or using another venue perhaps some miles distant from the patient.**

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

#### *Review Group Limited Review Report 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.

## ***Discussion***

The Tribunal supports recommendation 6.19.

The Tribunal supports recommendations 6.20 and 6.21, subject to the caveat that the Tribunal considers that it would be inappropriate for the Tribunal to be the provider of such in-service courses. However, the Tribunal would be happy to provide input or a contribution to such in-service courses.

The Tribunal supports recommendation 6.22. The Tribunal regrets that the recommendation does not give any indication as to steps which could be taken, or by whom, to encourage more solicitors to become involved in mental health law.

## ***The Tribunal's view***

**The Tribunal supports recommendation 6.19.**

**The Tribunal supports recommendations 6.20 and 6.21, subject to the caveat that the Tribunal considers that it would be inappropriate for the Tribunal to be the provider of such in-service courses. However, the Tribunal would be happy to provide input or a contribution to such in-service courses.**

**The Tribunal supports recommendation 6.22.**

## **Independent advocacy**

### *Review Group Limited Review Report 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.

## ***Discussion***

The Tribunal is generally supportive of recommendation 6.23. However, the Tribunal recognises that there is ongoing debate amongst independent advocates as to the role which they serve. The Tribunal notes that there are different models of independent advocacy being practised.

The Tribunal is generally supportive of recommendation 6.24 and refers to the preceding paragraph.

The Tribunal is generally supportive of recommendations 6.25 and 6.26.

## ***The Tribunal's view***

**The Tribunal is generally supportive of recommendations 6.23, 6.24, 6.25 and 6.26.**

## **Interpretation**

### *Review Group Limited Review Report recommendations*

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

## ***Discussion***

The Tribunal supports recommendation 6.27. The Tribunal notes that section 261(2) of the 2003 Act places an obligation on hospital managers to make arrangements or provide assistance appropriate to the patient's needs to ensure that the patient is able to communicate. The hospital managers have a duty to provide interpretation services. The Tribunal accepts that such interpretation services as are provided should be provided by professionals.

## ***The Tribunal's view***

**The Tribunal supports recommendation 6.27.**

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

### *Review Group Limited Review Report 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 certificate, 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.

## *Discussion*

The Tribunal notes recommendation 6.28. The Tribunal understands that the term “the appeal” referred to in recommendation 6.28 refers to an application under section 50 of the 2003 Act for revocation of the short-term detention certificate. The Tribunal notes that a short-term detention certificate authorises detention for a period of 28 days. The Tribunal notes the recommendation “that a time limit should be imposed to require the appeal to be disposed of within the period of the certificate”. Except in relatively rare circumstances, section 50 applications for revocation of short-term detention certificates are determined within the period of the certificate; clearly, if they are not determined within that period, then they serve no purpose, as there would be no short-term detention certificate to revoke if it was sought to be determined outwith the 28 day period of the certificate. The Tribunal notes the recommendation that section 50 applications for revocation of a short-term detention certificate should be dealt with “within 5 working days of the appeal being lodged if the appeal is lodged within the last five working days of the certificate”. This would appear to allow an appeal to be heard outwith the 28 day period of the certificate if the appeal was lodged on day 28. This would appear to conflict with the recommendation that the appeal be disposed of within the period of the certificate. The Tribunal strives to hear section 50 applications during the currency of the short-term detention certificate, however it is clear that if a section 50 application for revocation of a short-term detention certificate is lodged with the Tribunal on the 28th (the last) day of the short-term detention certificate, then it is all but impossible for the Tribunal to intimate the application to parties, arrange a venue and a 3-member tribunal panel to hear that application prior to the expiry of that time limit.

The Tribunal proposes that a section 50 application for revocation of a short-term detention certificate should require to be lodged with the Tribunal within 21 days of the making of the short-term detention certificate and that the Tribunal shall be obliged to hear that application within 7 days of receipt by the Tribunal of that application.

The Tribunal notes recommendation 6.29. The Tribunal notes that the recommendation refers only to “appeals”. The Tribunal understands that term, in fact, to refer to any application under the 2003 Act (but excluding any application, reference, review or appeal in respect of restricted patient cases.) The Tribunal strives to prioritise its workload and to ensure that all applications, appeals, reviews and references are considered timeously. The Tribunal notes that a first hearing may take place after the proposed 28 day time limit for a variety of reasons, including at the request of the patient or the named person or another party. The Tribunal recognises the importance of hearing applications, appeals, reviews and references timeously. However, the Tribunal considers that the imposition of a statutory time limit of 28 days would be unhelpful and inflexible. The Tribunal is currently considering key performance indicators for the holding of first hearings in respect of the various types of applications, appeals, reviews and references which come before it.

The Tribunal accepts recommendations 6.30 and 6.31.

The Review Group considered a suggestion that it should be possible for the President of the Tribunal to review decisions of individual tribunals and set aside decisions where there was a clear legal error. The Tribunal notes that the Review Group accepted that in certain limited circumstances, such a power “would be advantageous and would assist in disposing of decisions which are clearly wrong or incompetent at the earliest opportunity”. The Tribunal notes, however, that on balance the Review Group “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 principals should be preserved”. For that reason, the Review Group made “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”. Given that the Review Group accepted that the power sought would be advantageous in certain limited circumstances and given that it considered that the power suggested was not appropriate only “on balance”, the Tribunal is of the view that this proposal is worth further consideration, despite the fact that the Review Group did not make a recommendation. In particular, the Tribunal is keen to ensure that a clearly well-founded appeal against a decision of a tribunal should be capable of being remitted back to the Tribunal for it to be considered afresh without the need for the expense, time and effort expended on bringing the matter before a sheriff principal.

### ***The Tribunal’s view***

**The Tribunal does not support recommendation 6.28.**

**The Tribunal proposes that a section 50 application for revocation of a short-term detention certificate should require to be lodged with the Tribunal within 21 days of the making of the short-term detention certificate and that the Tribunal shall be obliged to hear that application within 7 days of receipt by the Tribunal of that application.**

**The Tribunal does not support recommendation 6.29 on the ground of its inflexibility.**

**The Tribunal supports recommendations 6.30 and 6.31.**

**Despite the fact that no recommendation was made, the Tribunal is of the view that further consideration should be given to the proposal to provide the President of the Tribunal with power to review decisions of individual tribunals and set aside decisions where there is clear legal error, referring such cases to a fresh tribunal to consider anew.**

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

#### *Review Group Limited Review Report 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.

## *Discussion*

The Tribunal notes recommendation 6.32. The Tribunal notes that a “recorded matter” specifying medical treatment, community care services, relevant services, other treatment, care or service as the Tribunal considers appropriate may be specified in a compulsory treatment order by virtue of section 64(4) of the 2003 Act. The Tribunal notes that an *interim* compulsory treatment order may only authorise such of the measures as are mentioned in section 66(1) of the 2003 Act as may be specified in it, by virtue of section 65(2) of the 2003 Act.

It appears to the Tribunal that a recorded matter may only appropriately be made where the full facts and circumstances of the compulsory treatment order application have been considered, and determined, by it. By its very nature, an *interim* compulsory treatment order is granted on a *prima facie* basis. Accordingly, it appears to the Tribunal that it would be inappropriate for a recorded matter to be made in the context of the granting of an *interim* compulsory treatment order. The Tribunal notes, however, that in making an *interim* compulsory treatment order, it is open to a tribunal, where appropriate, to make directions in terms of rule 49 of the Tribunal’s Rules and, in its Full Findings and Reasons, to make observations which may be taken on board by the appropriate mental health professionals.

The Tribunal notes recommendation 6.33. The Tribunal set up a working party on recorded matters, which has only recently reported. The Tribunal is considering that working party’s report and will determine what further action is appropriate in due course.

## *The Tribunal’s view*

**The Tribunal does not support recommendation 6.32, on the basis that it appears to the Tribunal to be inappropriate for a recorded matter to be made in the context of an *interim* compulsory treatment order.**

**The Tribunal notes recommendation 6.33. A working party on recorded matters has already reported to the Tribunal, which is considering its report. The Tribunal will determine what further action is appropriate in due course.**

## **Other recommendations**

The Tribunal notes that recommendations 6.34 to 6.65, inclusive, repeat previous recommendations.