Consultation on Implementation of Certain Sections of the Mental Health (Scotland) Act 2015 and Associated Regulations

Analysis Report

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Introduction

Part 1 of the consultation on implementation of certain aspects of the Mental Health (Scotland) Act 2015 was open between 7 March and 30 May 2016. It focused on a range of topics, including changes to provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 about named persons and advance statements and on secondary legislation regarding conflict of interests at certain medical examinations and safeguards for informal patients under the age of 16.

Part 2 of the consultation on implementation was open between 25 July and 17 October 2016. This consultation covered changes to cross-border transfer regulations, regulations related to absconding patients and proposals for savings and transitional provisions.

This report summarise the responses received for both consultations. All responses which the Scottish Government has permission to publish are available online at:

Consultation 1
https://consult.scotland.gov.uk/mental-health-law/mental-health-act/consultation/published_select_respondent

Consultation 2
https://consult.scotland.gov.uk/mental-health-law/mental-health-act-part-2/consultation/published_select_respondent

In total the first consultation received 42 responses, 10 from individuals and 32 from organisations. Of the organisations who responded, these can be categorised into seven broad types as shown in table 1.

Table 1 — Breakdown of organisational responses to consultation 1

Type of Organisation	**Number of Responses**	**Percentage**
Local Government Bodies	5	16%
Health and Social Care Partnerships	3	9%
Health Boards	1	3%
Other Statutory Organisations	5	16%
Professional Organisations	5	16%
Third Sector Organisations	6	19%
Other (including anonymous responses from organisations)	7	22%
Total	32	

In total the second consultation received 22 responses, 1 from an individual and 21 from organisations, the latter categorised as shown in table 2.

Table 2 — Breakdown of organisational responses to consultation 2

Type of Organisation	Number of Responses	Percentage
Local Government Bodies	2	10%
Health and Social Care Partnerships	4	19%
Other Statutory Organisations	2	10%
Professional Organisations	5	24%
Third Sector Organisations	3	14%
Other (including anonymous responses from organisations)	5	24%
Total	21	

It should be noted that different respondents answered different questions which will explain why there are differing numbers of responses for each question.

Short summary

For the most part, respondents were generally supportive of the principles underpinning the proposals and many supported detailed proposals.

The issues which saw the most mixed response were those related to transitional arrangements for the new provisions for named persons under the 2003 Act and those related to treatment for patients who have absconded from detention in other jurisdictions. Although the proposals were supported at least in part by most respondents, there were concerns that the proposals needed additional provisions or a different approach to ensure sufficient safeguards to realise service users' rights.

Key themes that emerged across the two consultations included:

- the importance of clear guidance and information for both practitioners and service users and their families;
- the importance of ensuring that the regulations and guidance promote and protect service users' rights;

- the importance of ensuring service users can make use of support through named persons, advance statements and advocacy.

The Scottish Government is very grateful to all those who took the time to respond to these consultations.

Consultation Part 1 - Analysis

Questions 1 and 2 asked for views on about the new limited right of appeal for the nearest relative, carer, welfare attorney or welfare guardian, known in this context as 'listed persons'.

24 respondents marked that they agreed and 3 that they disagreed with the suggestion that listed persons should have the status of relevant persons before the Mental Health Tribunal for Scotland. Of those who only commented, 7 suggested they were broadly in agreement, 1 broadly disagreed and 2 did not give a clear view either way.

The overwhelming majority of respondents agreed that listed persons should receive no or nearly no information in relation to their appeal to protect the privacy of the service user, but should be able to give evidence to the Tribunal. The suggestion that the listed person could have the status of a relevant person before the Tribunal was largely agreed with, although there were some reservations as to whether this was the most appropriate status as it could allow the listed person to receive additional information in some circumstances.

There were differing opinions as to whether the Responsible Medical Officer (RMO) should be the person who confirms to the Tribunal that the patient is incapable of appealing, and therefore the listed person has a right of appeal, or whether any Approved Medical Practitioner (AMP) should certify this. A middle way suggested was that the RMO was preferable, but that it should be possible for another AMP to confirm this if needed.

Many respondents raised the issue of clear guidance about the different roles, abilities and status of named and listed persons, and the benefits of choosing either for the individual service user. These included ensuring that a service user with no close relatives or friends is supported; ensuring that the limits to listed persons rights are well understood and guidance sets out how a listed person can act in line with the service user's will and preferences; and how service users' views about representation could be set out in advance statements.

Questions 3 and 4 asked for views about transitional provisions to move from the current law on named persons, including default named persons, to the provisions in the 2015 Act, which remove named persons appointed by default.

26 respondents marked that they agreed and 5 that they disagreed with the general approach that the final point at which the default named person should remain in their role should be the next major point of interaction with the 2003 Act. Of those who only commented, 2 suggested they were broadly in agreement and 2 broadly disagreed. 25 respondents marked that they agreed and 1 that they disagreed with the more detailed approach set out, based on this general approach. Of those who only commented, 3 suggested they were broadly in agreement, 5 broadly disagreed and 1 did not give a clear view either way.

Although most respondents indicated agreement, there were several concerns and reservations raised with this approach. Particular concerns included that some patients would be disadvantaged by continuing to have a default named person for longer than others and that discussions between care teams and service users about representation could take place at a stressful time for the service user if it is too close to a Tribunal hearing.

Question 5 asked for views on transitional provisions related to a new requirement for a named person to agree in writing to take on the role.

All respondents (31) marked that they agreed with the proposal that this requirement should only apply to new named persons, so that previous nominations would not be invalidated. Of those who only commented, all 3 suggested they were broadly in agreement.

Question 6 asked for views about the Tribunal removing an unsuitable named person.

27 respondents marked that they agreed and 3 that they disagreed with the principle that, where the Tribunal used its power to remove an unsuitable named person, no replacement named person should be appointed for patients over 16. Of those who only commented, 4 suggested they were broadly in agreement and 1 did not give a clear view either way.

Several respondents emphasised the importance of a named person being someone that the service user themself choose and also the importance of the service user being supported to make decisions about the representation that they want if their named person is removed.

Question 7 asked respondents about transitional provisions for the listed persons provisions.

27 respondents marked that they agreed and 3 that they disagreed with the proposal that transitional provisions should bring in the right of appeal for listed persons in line with the phasing out of default named persons and that existing appeal limits should apply to listed persons. Of those who only commented, 2 suggested they were broadly in agreement, 1 broadly disagreed and 1 did not give a clear view either way.

Question 8 asked for views about transitional provisions for welfare guardians and welfare attorneys receiving information about certain decisions.

27 respondents marked that they agreed and 1 that they disagreed with the proposal that these provisions should come into force in all cases on the commencement date. Several respondents noted the importance of clear guidance in relation to these provisions. Of those who only commented, 3 suggested they were broadly in agreement and 3 did not give a clear view either way.

Questions 9 to 11 asked for views on supporting service users to choose the best representation under the Act for themselves.

There was a wide range of suggestions for the guidance and information, including:

- Ensuring guidance is clear on what a named person role involves and what listed person rights are, what information a named person could receive, and what the impact of not having a named person could be.
- Suggestions on how this could relate to advance statements, e.g. encouraging people to say in their advance statement what should happen if their named person was no longer able to fulfil the role.
- Noting that real life examples could be helpful.

Question 12 asked for views regarding proposals for amending the Mental Health (Patient Representation) (Prescribed Persons) (Scotland) (No. 2) Regulations 2004.

27 respondents marked that they agreed and 3 that they disagreed with the proposal that the current list of prescribed persons able to witness the service user's choice of named person should be extended to those able to witness the named person's agreement. Of those who only commented, 5 suggested they were broadly in agreement. In addition, it was suggested that the regulations should include independent advocates and allied health professionals in the list of prescribed persons.

Question 13 asked for views regarding continuing existing provisions of the Mental Health (Conflict of Interest) (Scotland) (No 2) Regulations 2005.

23 respondents marked that they agreed and 3 that they disagreed with the proposal. Of those who only commented, 3 suggested they were broadly in agreement, 1 broadly disagreed and 5 did not give a clear view either way. In addition, it was suggested that regulations should set out that a conflict of interest exists when the doctor is a close relative of a patient made subject to an Emergency Detention Certificate.

Question 14 asked for views on whether there should be a change to what is defined as a conflict of interest where the agreement of two Approved Medical Practitioners is required.

20 respondents marked that they agreed and 6 that they disagreed with the proposal that the second medical examination coming from a doctor in a different management structure (e.g. separate clinical directorates) would be more useful than from a different hospital. Of those who only commented, 2 suggested they were broadly in agreement, 4 broadly disagreed and 3 did not give a clear view either way. Requirements for clear definitions and guidance on conflict of interest and management structure were highlighted as key to this proposal working in practice.

Questions 15 to 17 asked for views on extending conflict of interest regulations to reviews of orders, particularly in the case of those in independent hospitals.

22 respondents marked that they agreed and 3 that they disagreed with the proposal that it would be considered a conflict of interest for the RMO to extend a Compulsory Treatment Order for a patient detained in an independent hospital. Of those who only commented, 3 suggested they were broadly in agreement, 2 broadly disagreed and 3 did not give a clear view either way. Some respondents highlighted practical and cross border issues to take into account and others questioned the premise of treating independent hospitals differently.

21 respondents marked that this should also apply to those orders with additional scrutiny, such as Compulsion Orders and Compulsion Orders with Restriction Orders and 4 respondents marked that it should not. Of those who only commented, 4 suggested they were broadly in favour of this applying to these orders and 1 was broadly not in favour.

14 respondents marked that these rules would be suitable for rural health boards and 8 marked that they would not. Of those who only commented, 1 suggested they were broadly of the view that these rules would be suitable for rural health boards, 4 broadly disagreed and 5 did not give a clear view either way. Some respondents whilst generally supportive of the proposals, described practical difficulties to address.

Question 18 asked for views on changes to the Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005.

26 respondents marked that they agreed and 2 that they disagreed with proposals around the inclusion of artificial nutrition within the scope of these regulations. Of those who only commented, 3 suggested they were broadly in agreement and 4 did not give a clear view either way. The majority of respondents were supportive of the proposal, recognising the circumstances of this treatment in practice. Descriptions of how the regulations could work in practice were given by clinicians in the field.

Question 19 asked for views on the most effective best practice for Health Boards to promote support available for making an advance statement.

The majority of respondents would like a best practice approach adopted by all which would encourage discussion (at a suitable point in the patients journey of recovery when they are well enough to engage and understand matters). staff should be trained and equipped to facilitate such discussions using the relevant materials. Advance statements should also be accessible and reviewed from time to time.

There was a recognition that Health Boards are not the only ones to promote advance statements so they should also create and strengthen links with advocacy services and voluntary groups as they are also likely to support people who could

benefit from an advance statement. Information should be easily accessible and in a format which is easy to understand

There was also a call for the Scottish Government to ensure Health Boards are aware of the changes, what they have responsibility for and to ensure their staff undertake appropriate training so that they are able to talk to patients about advance statements at the appropriate time, possibly as part of the discharge process.

Question 20 asked for views and suggestions on how the implementation of the 2015 Act could encourage the uptake of advance statements.

For those who responded to this question there was a wide held view that a national campaign utilising various tools i.e. social media, printed leaflets may provide the widest reach.

A few asked whether the Mental Welfare Commission could incorporate questions surrounding the promotion of advance statements as part of their annual inspection process. There was also a suggestion that a concerted effort is made to engage with professional and support groups to promote the benefits of advance statements.

Questions 21 – 24 asked for views on how implementation of these provisions might impact on equalities, business and organisations, privacy and children.

Those who responded stated that the revised Code of Practice should have a positive impact for professional staff and will encourage transparency, regular monitoring and clarity.

However those who identified a negative impact thought that business and public sector costs could rise due to the need for additional staff training combined with the increase in resource associated with higher workloads for those seeking advance statements and advocacy services.

A few concerns were raised in relation to the changes to named persons as they felt this could lead to family tensions however others thought that the additional safeguards were a positive step.

On the impact of privacy, respondents asked for transparency, clear guidance and the inclusion of family in decision making to ensure that their rights are respected.

Question 25 asked for views on any other related issues.

Among the general points raised were the importance of awareness of rights about named persons, advance statements and advocacy; and of making sure service users understood how and when these rights were changing. Also raised was the need for more guidance about the use of force, restraint and covert medication in the Code of Practice and guidance about information sharing between organisations.

Consultation Part 2 – Analysis

Question 1 asked for views on changes related to appeals and notifications for transfers from Scotland, including a right of appeal for a named persons or listed persons and the process for reissuing warrants after an unsuccessful appeal.

Of those who commented, 10 largely agreed with the proposals, 1 largely disagreed with the proposals and 8 gave a mixed response or no clear view.

Among the points made included the importance of clear guidance for named persons and listed persons where relevant, and to ensure that these provisions respect the privacy and autonomy of patients as far as possible.

Question 2 asked for views on extending a right to appeal an order to the Tribunal in limited circumstances for those transferring to Scotland.

Of those who commented, 15 largely agreed with the proposals, and 4 gave a mixed response or no clear view.

Among the points made include the importance of clear guidance for service users setting out their rights when they transfer, including their appeal rights and their rights around support such as advocacy and advance statements.

Question 3 asked for views on amending notifications where a patient is transferring to Scotland and they have no named person.

Of those who commented, 12 largely agreed with the proposals, 4 largely disagreed with the proposals and 3 gave a mixed response or no clear view.

Among the points made were the importance of respecting the views and wishes of the patient about sharing information, particularly with the primary carer, although many acknowledged that the proposed information to be shared was very limited.

Question 4 asked about changes to the requirements for a Designated Medical Practitioner (DMP) visit for approving on-going medication for patients who have transferred to Scotland.

Of those who commented, 6 largely agreed with the proposal to change this DMP timescale to four weeks, 5 suggested the timescales should largely stay the same and 4 gave a mixed response or no clear view. Of those who commented on the need for a second DMP visit within two months, 5 largely agreed with the proposals that no second visit would be needed, 1 largely disagreed with the proposals and 3 gave a mixed response or no clear view.

Reasons for agreeing with the proposed changes included that the patient may have been on the treatment for some time before transfer. Reasons for disagreeing

included that this would be quite early in the new RMO's treatment of the patient and assessment of their requirements, as well as practicality concerns. There was also a suggestion that patients should have the option of requesting a DMP visit sooner than the statutory timescale.

Question 5 asked if respondents had any suggestions for further changes that should be made to the regulations governing reception of patients into Scotland.

Comments included bringing in a duty to inform patients transferring to Scotland about safeguards such as independent advocacy, advance statements and named persons; and giving the Commission discretion about visiting patients who have transferred, particularly if the extended appeal right proposed at question 2 is introduced or alternatively reducing that timescale to three months. There were also comments around provision of information on legislation in other EU countries when relevant and the importance of providing appropriate support to children and young people who transfer to Scotland.

Question 6 asked respondents whether they agreed with proposals to amend certain timescales for transfers of patients from Scotland to outside the UK.

Of those who commented, 15 largely agreed with the proposals, 1 largely disagreed with the proposals and 1 gave no clear view.

Alongside the general agreement to these provisions were comments noting the importance of ensuring that the patient is supported in understanding the transfer process, particularly where they decide to agree to a quicker transfer. There was also a suggestion that transfers earlier than 28 days after the effective date of the warrant should be possible where it has been demonstrated to the satisfaction of Scottish Ministers that appropriate care and treatment is available to the patient as soon as they transfer, and an early transfer is of maximum benefit to the patient.

Question 7 asked for views on transferring of patients from Scotland who are subject to suspension of detention measures.

Of those who commented, 9 were largely of the view that cross-border transfers should be permitted for patients who were subject to suspension of detention measures, 2 largely disagreed with this and 5 gave a mixed response or no clear view.

Among the comments made, it was noted that that a clearer process could be useful to those wanting to stay nearer family or support outwith Scotland or for testing out in community care that is not available in Scotland. Other comments expressed concern about how this could work with parallel legislation and with the conditions set out by the RMO that may accompany suspension of detention. The importance of patient consent to such a transfer was also noted.

Question 8 asked for views on proposals to allow quicker transfers of patients from Scotland where all parties consent and to make it easier to vary warrants in certain circumstances.

Of those who commented, 11 largely agreed with both proposals and 1 largely disagreed with both proposals. In addition, 3 largely agreed with the proposal on quicker transfers and 1 gave no clear view, and 3 largely agreed with the warrant proposals, 2 largely disagreed and 1 gave no clear view.

Among the comments made were those welcoming the suggestion that certain transfers would be able to take place more quickly, alongside those noting the importance of ensuring the patient and their relatives and carers were supported in understanding the process and setting out their views. This included their ability to withdraw their consent at any time. Also noted was the importance of ensuring that patients were clear about which hospital they were being transferred to and that it was not one with which they had negative associations; and the importance of ensuring that the destination bed was appropriate to their needs and not more restrictive.

Question 9 asked if respondents had any suggestions for further changes that should be made to the regulations governing transfer of patients from Scotland.

The comments mainly focused on the importance of supporting patients to understand and realise their rights both in relation to the transfer and in the jurisdiction to which they are moving. There were also comments in the consultation suggesting that timescales are set out for Scottish Ministers decisions on transfers and timescales for setting a Tribunal hearing for an appeal.

Question 10 asked about whether the same process for patients transferring from elsewhere in the UK should apply to patients transferring from elsewhere in Europe.

7 respondents indicated that there should be different processes or additional safeguards and conditions, 7 indicated that they considered there should be largely the same process and 5 gave a mixed response or had no clear view.

The main additional or new safeguard suggested was the ability to appeal the equivalent order decision of the RMO to the Tribunal. Respondents also commented on the need for clarity should Scotland’s status within the EU change.

Question 11 asked for any further views on cross-border transfers.

There were a limited number of comments which included reiterating the importance of good practice and guidance in supporting patients and providing information to protect patients’ rights.

Question 12 asked for views on whether regulations for treating patients who have absconded from outwith Scotland should apply where the patient consents to the treatment.

7 respondents marked that they agreed and 2 that they disagreed with the proposal. Of those who only commented, 6 suggested they were broadly in agreement with the proposal, 2 broadly disagreed and 2 did not give a clear view either way.

Comments included that if a patient was an order elsewhere and consented, then using the regulations would be less restrictive than placing the patient on a short-term detention certificate as well. There were also comments about the need to be clear as to the safeguards that would apply in these circumstances and that these may be significantly lower than those attached to a Short Term Detention Certificate (STDC).

Question 13 asked for views on whether the regulations should apply provisions related to urgent treatment to patients who have absconded from other jurisdictions.

6 respondents marked that they agreed and 2 that they disagreed with the proposal. Of those who only commented, 5 suggested they were broadly in agreement with the proposal, 5 broadly disagreed and 1 gave a mixed response.

Among the comments were some that felt this would help treat a patient so that they could be well enough to return to their home jurisdiction, and that 72 hours would be an appropriate timescale for this treatment. Others commented that there needed to be safeguards in place and that treatment should not be automatically authorised following detention.

Question 14 asked for views about if there were any other treatment circumstances that should be permitted under these regulations.

2 respondents marked that they thought there were other circumstances and 4 that there were not. Of those who only commented, 2 suggested they were broadly in agreement with there being other circumstances, 5 broadly disagreed and 3 gave a mixed response or no clear view.

Comments included that it could be of benefit to the patient to ensure treatment continued, rather than being stop-start and allow for depot treatments. Others commented that as this could be longer treatment or treatment with a long-term effect, a short-term detention certificate would be more appropriate and has clear safeguards, as well as reiterating concerns expressed at questions 12 and 13.

Question 15 asked for views on whether a timescale should be set out, either in regulations or guidance, for the length of time the regulations should apply before a short-term detention certificate should be issued.

6 respondents marked that they agreed and 2 that they disagreed with the proposal. Of those who only commented, 5 suggested they were broadly in agreement with the proposal, 3 broadly disagreed and 3 gave a mixed response or no clear view.

Comments noted either 7 days or 72 hours (the equivalent to an emergency detention certificate) could be the most appropriate timescale limit for any regulation to apply. Guidance was welcomed as important, but several respondents commented that this should be underpinned by clear regulations.

Question 16 asked for views on circumstances and safeguards related to return of patients who have absconded from other jurisdictions.

11 respondents suggested they broadly agreed there should be safeguards for the return of the patient in certain circumstances, 2 broadly suggested there were not and 2 gave a mixed response or no clear view.

Among suggested things to take into account were human rights concerns with safeguards in the original jurisdiction, the patient's views and reasons where they did not want to return and whether the patient still met detention criteria.

Question 17 asked for views about regulations allowing RMOs to specify classes of persons who may take certain absconding patients back in to custody.

13 respondents suggested they were broadly in agreement with the proposal and 4 gave a mixed response or no clear view.

Some respondents suggested that appropriate training and guidance be made available to the people who are likely to have this role, as well as ensuring that this did not lead to a rise in the use of police stations as a place of safety.

Question 18 asked for views on minor changes to notification requirements for certain absconding patients.

5 respondents marked that they agreed and 2 that they disagreed with the proposal. Of those who only commented, 7 suggested they were broadly in agreement with the proposal, 2 broadly disagreed and 1 gave no clear view.

Comments included noting instances where it would be helpful for the Commission to monitor absconding and the importance of avoiding unnecessary duplication.

Questions 19 to 22 asked for views on proposals for transitional and savings provisions.

8 respondents marked that they agreed with the proposed transitional arrangements for suspension of detention. Of those who only commented, 6 suggested they were broadly in agreement with the proposal, and 1 gave no clear view.

8 respondents marked that they agreed with the proposed general approach to transitional and savings provisions. Of those who only commented, 5 suggested they were broadly in agreement with the proposal, and 1 gave a mixed response. 6 respondents suggested they were broadly in agreement with the proposed detailed approach to individual transitional and savings provisions.

Among the comments on what would be useful for guidance was ensuring guidance was appropriate or tailored for individual professional groups and welcoming the use of case studies and flowcharts. One respondent suggested that there should be a single approach to all transitional provisions, with the new provisions only applying to any order or certificate that is made after the coming into force date.

Questions 23 to 26 asked for views on how implementation of these provisions might impact on equalities, business and organisations, privacy and children.

Amongst the comments on equalities, respondents noted the positive impact for service users from the proposals such as rights of appeal related to cross-border transfers, that patients' rights needed to be more strongly considered in the proposals and the need for certain training to ensure there was not a negative impact on service users.

Amongst the comments about the impact on business and organisations, respondents noted concerns for increased workloads for new duties and the need to provide training on changes, but also that certain provisions such as suspension of detention will be less complex.

On children's rights, comments included the importance of ensuring that cross-border transfers of children and young people are supported by consideration for other factors such as education and recreational opportunities and the importance of supporting children and young people for example through independent advocacy. On privacy, the comments focused on ensuring any new proposals to share limited information with carers are carefully considered for their impact on patient privacy.

Question 27 asked for any further views on relevant issues not raised by the consultations.

Issues raised included concerns about numbers of mental health officers, the importance of rights underpinning the implementation of the 2015 Act, that guidance should focus on ways of supporting patients to make decisions, and the importance of clear and accessible guidance.

Conclusion and Next Steps

The Scottish Government is very grateful for the time taken by respondents to complete the consultation responses, particularly in response to the very technical detail set out. We are considering all the responses and taking them into account as we move forward in developing the relevant secondary legislation, transitional and savings provisions. This includes working with members of the Implementation Reference Group. Comments and feedback will also be used to develop and shape both statutory and non-statutory guidance and information to accompany the implementation of the 2015 Act.

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