Mental Health: Legislation

Consultation on the Review of the Mental Health (Care And Treatment) (Scotland) Act 2003
Mental Health: Legislation

Consultation on the Review of the Mental Health
(Care And Treatment) (Scotland) Act 2003
Foreword by the Minister for Public Health and Sport, Shona Robison MSP

The Mental Health (Care and Treatment) (Scotland) Act 2003 is well regarded by service users and their carers in Scotland, and by mental health professionals. It is viewed internationally as being ambitious and innovative in its approach, in particular its principles based framework, with many other nations wanting to learn from our experiences.

However, perhaps as a consequence of this innovation, some issues have arisen in respect of the operation of the Act - notably in relation to named persons, advance statements and multiple hearings.

We took note of peoples’ concerns and I appointed a review group, chaired by Professor Jim McManus, in January 2008 to undertake a limited review of the Act to consider efficiency and patient experience of the Act. The Review Group reported back to me in March 2009.

This consultation paper seeks views on the recommendations made by the Review Group to enable us to make decisions about changes to the legislation.

Amendments to the Act itself will require primary legislation, which will be taken forward as part of a future legislative programme. However, there will also be some changes through practice, guidance, or amendments to the secondary legislation.

I would also draw your attention to the following research we commissioned on the operation of the Act for further background on the issues raised in the Review Group’s Report and this accompanying paper:

- An assessment of the operation of the Named Person role and its interaction with other forms of patient representation and its Findings (March 2009);

- An exploration of the early operation of the Mental Health Tribunal for Scotland and its Findings (March 2009); and

- Early Experiences Of The Mental Health Act (Care And Treatment) (Scotland) Act 2003: A Cohort Study and its Findings (May 2009).

I invite responses to this consultation paper by Friday 6th November 2009.

Shona Robison
Minister for Public Health and Sport

[date]
Part 1: Review Group recommendations

1.1 The Review Group’s Report focuses on five main areas of activity:

- Advance Statements
- Independent Advocacy
- Named Persons
- Medical Matters
- Tribunals

as well as considering some related issues. We would welcome views on the Report’s recommendations.

1.2 There are three issues on which we would particularly welcome consultees’ views – named persons, the preparation of medical reports and the issue of multiple hearings. In each of those areas the Review Group clearly identified a range of options before making their recommendations. We are keen that consultees should feel free to also give their views on any of the options discussed within the Report in relation to those issues, and we also give these some further thought in Parts 2, 3 and 4 of this paper, offering some further options for consideration where appropriate.
Part 2: Named Persons

2.1 This Part should be read in conjunction with Chapter 4 of the Review Group’s Report.

2.2 The introduction of “named persons” under the Mental Health (Care and Treatment) (Scotland) Act 2003 (‘the Act’) replaced the previous use of a person’s nearest relative who was chosen according to the statutory mechanism, thus leaving the service user no real control.

2.3 Under the 2003 Act, the named person was introduced as someone who was entitled to be notified separately of decisions proposed or having been taken, and to have the right to take part in proceedings before the Tribunal or Courts. Individuals nominate a named person, though there is a default provision within the Act to appoint a named person if no person has been appointed at all, with the person’s primary carer as their first default option.

2.4 The intention when named persons was introduced under the Act was that persons with a mental illness, learning disability or other mental disorder would benefit from the added protection of having a named person who would be kept informed of their status and who could undertake certain functions for the patient. To enable that, the named person was given similar rights to apply to the Tribunal, to appear and be represented at Tribunal hearings and to appeal; they were also entitled to be given information concerning many compulsory measures which have been taken or are being sought, where this is provided for in the Act.

2.5 However, it has become apparent to us that this particular issue is one that in practice has caused some disquiet and distress in its application.

2.6 It is an area on which the Scottish Government had commissioned research and consultees may wish to consider that report An assessment of the operation of the Named Person role and its Findings as further background to the issues arising.

2.7 We are aware in particular from reports to us of the upset that many carers have experienced when they, without warning (because they did not know that they had been nominated in person or by default) receive detailed papers on the service user, causing them either to discover things that they had not previously known about the service user or things that they had known but now have to relive. Related to this is the concern for the service user that once their named person has been appointed, that person becomes a full party to any Tribunal hearing and so receives the full paperwork including medical history.

2.8 The problems that service users experience in this regard are exacerbated by the provisions under the Act for the default appointment of a named person; it is noted too from the Scottish Government research that the majority of named persons (50 – 75%) are via the default route rather than appointment by the patient. This means that the vast majority of named persons are not chosen by the service user yet, as above, the named person has a wide ranging role and set of rights under the Act.
2.9 Whilst therefore the default named person scheme under the Act was originally provided to further protect patients, there is now a question as to whether it is in fact appropriate in the light of service users’ practical experience of the system in operation. A further and related question raised with us by service users has been the appropriate stage at which the named person should become involved under the Act when compulsory measures of treatment are in contemplation.

2.10 The Review Group made a number of recommendations (4.1 to 4.19), which including legislative change, and consultees’ views are sought on these. We would be grateful if you would incorporate these further options in any response in relation to the Chapter 4 (Named Persons) wider recommendations. If you have any other views on how the system of named persons / patient representation should be arranged in the future outwith the recommendations made in the Report then you are welcome to include those too.
3.1 This Part should be read in conjunction with Chapter 5 (Medical Matters), in particular pages 28 to 32 (medical examinations), of the Review Group’s Report.

3.2 The Act currently requires that two medical reports accompany the application made to a Tribunal by a mental health officer for a compulsory treatment order (‘CTO’). Each medical examination must be carried out by an ‘approved medical practitioner’, except that the patient’s GP is permitted to carry out the second medical examination even though not an approved medical practitioner.

3.3 In practical terms therefore, the current regime is that:

- each application for a CTO is accompanied by two medical reports, with 50% of those second reports having GP involvement; the application by the mental health officer is also accompanied by their own report, which has to state amongst other things the MHO’s own views on the mental health reports;
- where the second report is from an approved medical practitioner, that second doctor must be independent of the first;
- in the majority of cases the patient, or their representative, on receiving notice of the application for the CTO, will also instruct a third – separate / independent – medical report.

3.4 This means that for about half of all CTO applications there is currently little or no GP input. It also means that although the two required medical reports must be independent of each other, a further (third) independent medical report will still be instructed by the patient in the majority of cases.

3.5 Further, the practical reality of there being three medical reports per hearing on a CTO application, with the independent report not able to be instructed until the patient has received notice of the application, can make the process slow with resulting delays in the hearings.

3.6 Ultimately, looking at the process overall, what would seem to be desirable is:

- GP information;
- the possibility of some form of independent report; and
- a timely Tribunal to make the determination on detainability.

3.7 The issue of multiple hearings, and the role of the independent medical report which has been identified as contributing to that problem, is covered separately in Part 4 of the paper.

---

1 See page 28 of the Report – “problems identified”.

B3067724
**Review Group recommendations**

3.8 The issues raised in respect of medical examinations by the Review Group which are discussed in this Part of the paper relate to the involvement of general practitioners, and difficulties in achieving independence between the two required reports.

3.9 On the involvement of GPs, as above, the main issue highlighted is that only around 50% of second reports for CTOs are provided by a GP.

3.10 The Code of Practice that accompanies the Act currently explains that for the second examination it would be best practice for this to be carried out, wherever possible, by the patient's GP, as he/she can draw on knowledge and experience of the patient and their family, and often bring the benefit of an established, pre-existing relationship with the patient. The view has been therefore that the GP can provide an assessment of the patient's mental state which incorporates other dimensions of the patient's medical history which may not be available to an approved medical practitioner, including physical illnesses and treatments, and can offer a valuable insight into how these may interact with whatever mental health difficulties are at issue. It has also been thought that the GP is best placed to express the potential contribution of primary care services to care and treatment plans in anticipation of playing an important longer term role in contributing to the patient's rehabilitation and recovery.

3.11 The Review Group had highlighted various views of respondents on this issue\(^2\), to indicate that the low rate of involvement may due to a reluctance on the part of GPs to become involved in what may be viewed to be a specialist area, that there is a perception that they simply “rubber stamp” the psychiatrists’ report, and that the organisation of primary care services now makes it less likely that a patient has long term contact with an individual GP. It must also be recognised that, depending on the frequency with which an individual patient may visit their GP, a GP may in fact have had very little previous contact with the patient to have been able to build up the background knowledge which it has previously been assumed that he/she has to contribute.

3.12 Potential solutions identified by the Group were therefore:

- scrapping the two report system to have one report from an approved medical practitioner which simply encapsulates within it a general history and view from a GP;

- current system should remain unchanged but with increased education of GPs and support to them in providing a report;

- retain the two report system, with one report called the psychiatrists report (provided by an approved medical practitioner), and the other a GP report – in exceptional circumstances the GP report could be provided by a second approved medical practitioner.

---

\(^2\) See first four bullet points at top of page 29 of the Report.
3.13 The last solution of retaining the two report system was viewed to be the preferred solution and recommended, but that in exceptional and defined circumstances an approved medical practitioner should be able to provide the second report instead of the GP.

Further thoughts and options for consideration

3.14 It is generally considered desirable that GP information is available to the Tribunal in cases where the patient has been in contact with primary care services or where there is a clearly identifiable GP who may be involved in ongoing support to the patient. However, there might be different ways of obtaining and delivering this in practice, i.e. as a separate report, or within one of the other reports that are already commissioned such as that of the approved medical practitioner or mental health officer.

3.15 We question whether it is necessary that the GP report (where provided) should focus on detainability of the patient and whether that is actually the expertise which is being sought or offered.

3.16 We have also given consideration to the following factors:

- there is a clear and ongoing need for a full assessment of detainability under the Act by an approved medical practitioner (as is required for short term detention certificate);

- there is a need for confirmation of the approved medical practitioner assessment by an appropriate Tribunal in a timely way;

- however, it is not necessarily clear what function the second medical report where it is completed by an approved medical practitioner offers, other than independent confirmation of the first approved medical practitioner’s analysis;

- the system needs to allow for independent assessment of the patient on behalf of the patient: at the moment this is delivered by the second report as well as in most cases by the solicitor instructed independent report; in theory the Tribunal could also instruct a report.

3.17 The question then is what is the most efficient and appropriate way to ensure the availability of an independent report where one is considered desirable?

Single medical report options

3.18 The possibility of moving to a single report system for civil orders was identified by the Review Group as one of several possible solutions, but in the end discounted in favour of the Group’s recommendation to maintain the present two report system. However, we would like to give some further consideration to moving to a single report system for civil orders.
3.19 We are aware that in some more rural areas of Scotland, most notably Grampian and Highland, practitioners have experienced very real difficulties in securing a second medical report that is independent of the first. We are also aware that in urban areas such as Edinburgh, where there is only one psychiatric hospital in the health board area, the same difficulties arise.

3.20 As noted above, it is also the case that in the majority of cases a further independent report is commissioned by the patient.

3.21 We think that there are two separate possibilities within this single medical report option:

- 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; and

- 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 (see below).

3.22 In particular, therefore, we are interested in consultees’ views on the role and contribution by GPs in relation to applications for CTOs, and whether or not the benefits outweigh the problems identified by the Review Group such that the current two report system should be maintained. And, if we were to move to a single report system, whether or not information from the patient’s GP about their history and primary care needs should still be encapsulated elsewhere.

3.23 In considering this option it should be noted that the option of instructing an independent medical report would remain open to the patient; Part 4 of this paper considers separately the issues arising from the instruction of the independent medical report.

**Two medical report system - further options**

3.24 However, if carrying forward the Review Group’s recommendation that the current two report system should be maintained, we would also like to give some further consideration as to how that second report might be given.

3.25 In particular, we would like to open up for discussion whether:

- 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; or

- Option 5D: the current MHO report might be adjusted to include in future a medical history from the patient’s GP.
3.26 Please note that the proposal that the Tribunal could in future instruct the second report is separate to the consideration in Part 4 of this paper as to whether the Tribunal should have a role in relation to the independent medical report. Respondents should therefore feel free to give their views on all permutations of obtaining the two medical reports in this Part, as well as the linked independent medical report issues which is discussed in Part 4.

Summary of potential options for discussion

3.27 In summary, the potential permutations for medical report arrangements in future could be:

<table>
<thead>
<tr>
<th>1st Report - must have</th>
<th>2nd Report - could have</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMP Report</td>
<td>Yes - GP report (but in exceptional circumstances could be AMP who gives 2nd report instead) [McManus recommendation 5.1 &amp; 5.3]</td>
</tr>
<tr>
<td>AMP Report</td>
<td>None – but GP information encapsulated within AMP (1st) Report [Further option 5A above]</td>
</tr>
<tr>
<td>AMP Report</td>
<td>Yes - Tribunal instructs on receipt of application [Further option 5C above]</td>
</tr>
<tr>
<td>AMP Report</td>
<td>None – but GP information included in MHO Report [Further option 5D above]</td>
</tr>
<tr>
<td>AMP Report</td>
<td>None – no GP information [Further option 5B above]</td>
</tr>
<tr>
<td>AMP Report</td>
<td>AMP Report</td>
</tr>
</tbody>
</table>

3.28 Your views are therefore sought on all of the above thoughts and further possible options for medical examination and reporting arrangements. We would be grateful if you would incorporate these further options in any response in relation to the Chapter 5 (Medical Matters) wider recommendations. If you have any other views on how medical reports should be arranged in the future which do not fall within one of the discussed options then you are welcome to include those too.
Part 4: Tribunals – multiple hearings

4.1 This Part should be read in conjunction with Chapter 6 (Tribunals), in particular pages 42 to 51 (multiple hearings), of the Review Group’s Report.

Background

4.2 One of the main issues arising in relation to tribunals is that of multiple hearings, i.e. the large number of civil cases which require more than one hearing to reach a conclusion, with the stresses and demands that this brings on service users, their carers and indeed the mental health professionals.

4.3 This is an issue that had also been picked up in one of the three pieces of Scottish Government commissioned research An exploration of the early operation of the Mental Health Tribunal for Scotland and its Findings. That research had found, for example, that:

- in over 50% of cases more than one hearing was required to make a full decision on each application, leading to an increase in the number of Interim Compulsory Treatment Orders (ICTOs);

- while the increase in ICTOs was deemed to be an inevitable consequence of a more patient-centred system, there was a strong view that the number of ICTOs was also a function of procedural difficulties resulting from the requirement to conduct a hearing within five days of short term detention certificate expiration, and included:
  
  - the arrival of CTO applications late within the 28 day STDC period;
  
  - insufficient time in many cases to conduct an independent medical review if this was deemed necessary;
  
  - insufficient time to ensure the participation of the range of people other than panel members who may be required (or may wish) to attend a hearing; and

- there were concerns that independent medical reports may be requested as a delaying tactic, possibly for financial gain by legal representatives.

Review Group recommendations

4.4 The Review Group made a number of recommendations (6.1 to 6.9) in relation to multiple hearings, and consultees’ views are sought on these.

Further thoughts and options for consideration

4.5 We consider that each of the recommendations contained in Chapter 6 of the Report will have some effect in reducing the number of multiple hearings. What we would like to do however is to take the opportunity to explore and consult on some further possible options to reduce the number of multiple hearings in civil cases.
4.6 These include some potentially farther reaching options, keeping in mind that if we are considering changing the legislation we essentially have a fresh blank sheet as to how we might better tailor the civil provisions.

Why do multiple hearings happen?

4.7 The difficulties which arise under the current system stem to a great extent from the fact that the Tribunal receives the paperwork accompanying an application for a compulsory treatment order very late in the life cycle of the short term detention certificate (28 days). Essentially, in the majority of cases, the Tribunal now receives the paperwork at around day 26 or 27, which means that the case cannot be heard within the original 28 day period of the short term detention certificate and it requires to be extended for 5 working days under the Act’s provisions.

4.8 In almost every case therefore the Tribunal is immediately working solely within the 5 day extension period of the short term detention certificate, writing out to notify parties (including the patient) and must also hold the hearing within that 5 day window.

4.9 The effect of this is that the patient has very little time to instruct a solicitor and to get any independent medical reports that they require. If both the solicitor and the medical reports are not ready by the time of the hearing (and, as above, in the majority of cases, this is a 5 day period from notification of the application) then the Tribunal will adjourn the hearing. In deciding to adjourn the hearing to allow the participant to instruct a solicitor and obtain medical reports, the Tribunal is itself complying with relevant case law in that regard.

4.10 We therefore welcome the discussion around “Option 1” in the Review Group’s Report (pages 46-48) and their resulting recommendation 6.1 in that regard, that the time limit of five working days contained in s68(2)(a) of the 2003 Act should be increased to ten working days. We seek consultees’ views on that recommendation as part of the wider consultation.

4.11 However, we also seek views on whether that in itself would be sufficient to resolve the recognised problem of multiple hearings or whether some further measures should be considered, either in addition to or instead of this recommendation. This includes consideration by consultees of the following possible other options:

Other suggestions made to and considered by the Review Group

4.12 At page 46 of the Review Group Report, there is listed a range of suggestions which had been made to the Group as to how the number of hearings that are required might be reduced in a way that benefits the service user.

4.13 Amongst those are two suggestions: to use procedure / preliminary hearings where possible; and, that paper hearings should be used where appropriate, with the consent of the service user. These suggestions are picked up by the Review Group and discussed in further detail as part of their “Option 2” at pages 48-50.
4.14 We therefore seek further views on the remaining options highlighted by the Review Group at pages 46 to 50 and, in particular, the suggested uses of procedural hearings and/or paper hearings where appropriate.

More time to obtain legal and medical advice: shorten STDC timings?

4.15 As well as a useful focus on extending the period of time available to the Tribunal at the later stages of the short term detention certificate, we have given some consideration to whether changes could be made at the earlier stage of the process.

4.16 One option that we had considered is whether we could insert a statutory time limit in relation to applications for compulsory treatment orders where a patient is on a short term detention certificate; essentially, providing that an application for a compulsory treatment order required to be made no later than 21 days into the cycle of the short term detention certificate. However, difficulties may seem to arise with that proposal if the application for a CTO had to be made by day 21 even whilst the certificate authorising short term detention continued to run until day 28.

4.17 Alternatively, we have given consideration to reducing the length of the short term detention certificate itself, to a period of 21 days. This could then be extended as at present, for example where a CTO has been applied for.

4.18 This proposal would at the very least give the Tribunal an extra 7 days from the timescales that it currently operates under, in which to notify parties and fix the hearing. If combined with the Review Group’s recommendation that short term detention certificates be extended from 5 working days to 10 working days then essentially the Tribunal would be given a period of 2 to 3 weeks in which to notify parties and fix the hearing. In that event, the number of adjournments and ICTOs should be greatly reduced.

4.19 There are considerations for RMOs with this proposal, however, in that they would require in all cases to ensure that they had assessed the patient within the period of 21 days during which the short term detention certificate is in place.

4.20 This all therefore raises questions of competing desirability of timings:

- early consideration by the Tribunal is seen as desirable in rights terms;

- some patients will stabilise during the period of a STDC if allowed time, meaning that an application for a CTO does not need to be made. This means time for proper assessment and early treatment is desirable to reduce the number of people who go on to a long term order - which is also desirable;

- the requirement that the care plan be developed and available for the hearing creates additional work to be delivered by the time of application.

4.21 The second issue is listing and taking forward the hearing. At the moment the window is in most cases 5 working days because of when applications are received. If this window was longer then:
• there would be more time to get reports and prepare;
• the Tribunal would have more time to list hearings, increasing their ability to ‘double up’ hearings;
• the result might be to have more hearings concluded first time with the added benefit of fewer hearing days.

4.22 The current split for duration of a short term detention certificate is the initial 28 calendar days plus 5 working days extension where a CTO has been applied for. The Review Group have suggested increasing that 5 working days extension to 10 working days, which would give 42 calendar days in total for the duration of the short term detention certificate.

4.23 However, as above, what would happen if we split the process differently? For example, 21 calendar days in which to lodge an application for a CTO plus 15 working days extension of the short term detention certificate where an application has been lodged. It would give the same period of time in total but give the Tribunal – and importantly the patient – longer to prepare for the hearing after papers are lodged. It would still be open for the RMO to withdraw papers where appropriate.

4.24 We have also considered whether we could go even further: concluding that we perhaps could, but on the basis that some of the action which currently takes place before papers are lodged would need to be moved to after the papers are lodged – for example the GP report and preparation of a care plan. We question whether the Tribunal could manage the collection of these papers better or would it sit better if they continued with the MHO?

4.25 We therefore seek views on the above questions that arise in relation to this issue.

More time to obtain legal and medical advice: abolish ICTOs?

4.26 We also seek consultees’ views on a more radical potential option, and that is to abolish interim compulsory treatment orders (ICTOs) and to instead place more reliance on short term detention certificates (possibly in modified form as above), moving straight from a short term detention certificate to a CTO with no possibility of any interim order.

4.27 ICTOs were provided for in the Act to fill the gap where the Tribunal does not feel that it has enough information on which to base its decision about the full CTO; where it wishes to seek further evidence from another party or where the patient and his / her representative requires further time in which to prepare their evidence. The criteria which must be met before an ICTO can be made are very similar to the criteria for a CTO, and can authorise the same compulsory measures; the only real difference therefore is the length of time that they last (up to 28 days, and in total if consecutive ICTOs are granted, up to 56 consecutive days).
4.28 ICTOs were therefore originally provided as a safety net for what was expected to be the small number of occasions when the Tribunal could not proceed to decide on a full CTO. Instead ICTOs have in practice become almost the norm between short term detention and the full CTO.

4.29 Removal of ICTOs completely would reduce the number of additional hearings significantly. However, we would need to be certain that other mechanisms were in place to ensure that when the Tribunal comes to hear an application for a CTO it has all the facts and paperwork necessary before it to allow it to decide on the application straight away.

Preventing adjournments – Tribunal to instruct independent medical reports

4.30 In tandem with proposals to extend the timescales available to obtain independent medical reports and solicitors to be instructed, we consider that more could perhaps be done under the Act to ensure that these two aspects are assured for patients earlier in the application process.

4.31 We therefore offer a proposal that the Tribunal could be given a new role in relation to instructing independent medical reports for participants, in order to ensure that this is put into place at a much earlier stage in the proceedings. This might perhaps be by the Tribunal putting a designated medical practitioner directly in touch with the patient as opposed to an independent medical report being in any way imposed on a patient. The patient would be protected in that, although not their own free choice of medical practitioner providing the report, it would be a judicial body which makes the appointment.

SLAB review on legal aid for Tribunal

4.32 We would also highlight that the Scottish Legal Aid Board are currently reviewing the arrangements for support for legal representation at the Tribunal with a view to achieving best value while securing appropriate representation and supporting the efficient operation of the Tribunal. Progress has already been made, for example in encouraging interest in this area of practice amongst local solicitors in some of the less well-served parts of the country, with a need for training identified as an early action flowing from the review.

4.33 SLAB will be consulting widely as part of the development of options for improvement, although any subsequent changes to regulations resulting from that review would be for Ministers to consider.
Part 5: Consultation questions

Question 1: Advance Statements
Your views are sought on any or all of recommendations relating to advance statements found in Chapter 2 of the Report. If you have any separate issues in relation to advance statements which you would also like to address, you are invited to include those in your response to this question.

Question 2: Independent Advocacy
Your views are sought on any or all of recommendations relating to Independent Advocacy found in Chapter 3 of the Report. If you have any separate issues in relation to independent advocacy which you would also like to address, you are invited to include those in your response to this question.

Question 3: Named Persons
Your views are sought on any or all of recommendations relating to Named Persons found in Chapter 4 of the Report. If giving your views on any of the further thoughts relating to named persons raised in Part 2 of this paper, you are invited to provide these here in answer to this question. If you have any separate issues in relation to named persons which you would also like to address, you are also invited to include those in your response to this question.

Question 4: Medical Matters
Your views are sought on any or all of recommendations relating to Medical Matters (medical examinations / reports; medical examinations and conflict of interest; revocation of emergency detention certificates; suspension of detention requirements in relation to compulsory treatment orders; consent; and care plans) found in Chapter 5 of the Report. If giving your views on any of the other options relating to medical reports posed in Part 3 of this paper, you are invited to provide these here in answer to this question.

If you have any separate issues in relation to medical matters which you would also like to address and which are not covered in the Chapter 5 of the Report, you are also invited to include those in your response to this question.

Question 5: Tribunals
Your views are sought on any or all of recommendations relating to the Tribunal (multiple hearings; excessive formality and legality; and availability, quality and style of legal representation) found in Chapter 6 of the Report. If giving your views on any of the other options relating to multiple hearings posed in Part 4 of this paper, you are invited to provide these here in answer to this question.

If you have any separate issues in relation to Tribunals which you would also like to address and which are not covered in Chapter 6 of the Report, you are also invited to include those in your response to this question.

Question 6: Other Issues
Your views are sought on any or all of the additional points on Other Issues made in Chapter 7 of the Report; or indeed any other issues within the Group’s remit but that
are not addressed in any of the above questions you should feel free to address those in your response to this question.
Part 6 - Responding to the consultation paper

6.1 We are inviting written responses to this consultation paper by Friday 6th November 2009.

6.2 Part 5 of this paper asks a number of consultation questions on which we would welcome your views. Please respond to as many or as few of the questions as you wish, indicating in your response which questions your comments relate to. Please give reasons for your views and information from your own experience where appropriate.

6.3 If you have further comments on the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 which are outwith the remit of the consultation paper but are of concern to you, then please feel free to draw them to our attention.

6.4 Please send your response to the consultation questions along with your completed respondent information form (see “handling your response”) to:

mentalhealthlaw@scotland.gsi.gov.uk

or

Joanna Keating
Scottish Government Health Directorate
Mental Health Division
Head of Policy & Legislation Team (Branch 3)
3-ER St Andrews House
Regent Road
Edinburgh EH1 3DG

If you have any queries please contact Joanna Keating on 0131 244 2599.

6.5 This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is.

6.6 The Scottish Government now has an email alert system for consultations (SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx). This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces SG distribution lists, and is designed to allow stakeholders to keep up to date with all SG consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

6.7 We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please therefore also complete and return the respondent information form (provided
along with this consultation paper and the Report) which forms part of the consultation, as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and will treat it accordingly, subject always to any legal requirements on the Scottish Government to disclose the information.

6.8 All respondents should be aware that the Scottish Government are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under that Act for information relating to responses made to this consultation exercise.

Next steps in the process

6.9 Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library (see the attached Respondent Information Form), these will be made available to the public in the Scottish Government Library by 4th December 2009. You can make arrangements to view responses by contacting the SG Library on 0131 244 4552. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

6.10 Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on whether, and to what extent, the Mental Health (Care and Treatment) (Scotland) Act 2003 should be amended. We aim to issue our conclusions on this in 2010. If Scottish Ministers decide to proceed with amending legislation, a Bill would ultimately be required to be taken forward in the Scottish Parliament within a future legislative programme. Any changes that can be made more quickly for some issues that do not require primary legislation will be considered separately.

Comments and complaints

6.11 If you have any comments about how this consultation exercise has been conducted, please send them to Mental Health Division at the contact details shown above (under 'Responding to this consultation paper').
7.1 Consultation is an essential and important aspect of Scottish Government working methods. Given the wide-ranging areas of work of the Scottish Government, there are many varied types of consultation. However, in general, Scottish Government consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

7.2 The Scottish Government encourages consultation that is thorough, effective and appropriate to the issue under consideration and the nature of the target audience. Consultation exercises take account of a wide range of factors, and no two exercises are likely to be the same.

7.3 Typically Scottish Government consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the issue, and they are also placed on the Scottish Government web site enabling a wider audience to access the paper and submit their responses. Consultation exercises may also involve seeking views in a number of different ways, such as through public meetings, focus groups or questionnaire exercises. Copies of all the written responses received to a consultation exercise (except those where the individual or organisation requested confidentiality) are placed in the Scottish Government library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4565).

7.4 All Scottish Government consultation papers and related publications (eg, analysis of response reports) can be accessed at: Scottish Government consultations (http://www.scotland.gov.uk/consultations)

7.5 The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process, along with a range of other available information and evidence. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

7.6 Final decisions on the issues under consideration will also take account of a range of other factors, including other available information and research evidence.

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.
Annex: List of organisations being consulted

Aberdeen Bar Association
Aberdeen City Council
Aberdeenshire Council
ACPOS
Age Concern Scotland
Alzheimer Scotland
Angus Council
Argyll and Bute Council
Association of Directors of Social Work
Association of Chief Police Officers Scotland
Ayr Faculty of Solicitors
Ayrshire and Arran Health Board
Barnardo’s Scotland
Bipolar fellowship Scotland
Borders Health Board
British Association of Social Workers
British Medical Association
British Psychological Society, Scottish Division*
Campbeltown Faculty of Solicitors
Capability Scotland
Castlemilk Law and Money Advice
Central Scotland Police
Chairs of relevant cross party groups – Scottish Parliament
Citizens Advice Bureau Service in Scotland
City of Edinburgh Council
City of Glasgow Council
Clackmannanshire Council
College of Occupational Therapists (Scottish division)
Comhairle nan Eilean Siar
Common Services Agency for the Scottish Health Service
Community and District Nursing Association
Consultation and Advocacy Promotion Service
CoSLA
Crown Office and Procurator Fiscal Service
Dumfries and Galloway Council
Dumfries and Galloway Health Board
Dundee North Law Centre
Dunfermline District Society of Solicitors
Dundee City Council
Dunoon Faculty of Procurators
East Ayrshire Council
East Dunbartonshire Council
East Lothian Council
East Lothian Faculty of Procurators
East Renfrewshire Council
Edinburgh Bar Association
ENABLE Scotland
Equality and Human Rights Commission
Faculty of Advocates
Faculty of Procurators and Solicitors in Dundee
Faculty of Solicitors at Lanark and District
Faculty of Solicitors in Bute
Faculty of Solicitors in Roxburghshire
Faculty of Solicitors in Shetland
Faculty of Solicitors of Dunbartonshire
Faculty of Solicitors of Kincardine & Deeside
Faculty of Solicitors of Ross-shire and Sutherland
Faculty of Solicitors of Rutherglen
Faculty of Solicitors of the Highlands
Faculty of West Lothian Solicitors
Falkirk and District Faculty of Solicitors
Falkirk Council
Fife Constabulary
Fife Council
Fife Health Board
Forensic Network
Forth Valley Health Board
Glasgow Association for Mental Health
Glasgow Bar Association
Highland Council
Highland Users Group (HUG)
HMIE
HMIP
Independent Federation of Nursing in Scotland
Inverclyde Council
Judicial Studies Committee
Justice Committee, Scottish Parliament
Kilmarnock Faculty of Solicitors
Kirkcaldy Law Society
Lanarkshire Health Board
Law Society of Scotland
Legal Secretariat to the Advocate General
Legal Secretariat to the Lord Advocate
Legal Services Agency
Lochaber Faculty of Solicitors
Lord President
Lothian Health Board
Mental Health Aberdeen
Mental Health and Disability Law Committee of the Law Society
Mental Health Foundation (Glasgow Office)
Mental Health Nurses Forum
Mental Health Tribunal for Scotland
Mental Welfare Commission for Scotland
Midlothian Council
Moray Council
Moray Faculty of Solicitors
National Schizophrenia Fellowship (Scotland)
New Horizons Borders
NHS 24
NHS Education for Scotland
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Highland
NHS Health Scotland
NHS Quality Improvement Scotland
North Ayrshire Council
North Lanarkshire Council
Oban Faculty of Solicitors
Office of the Public Guardian
Orkney Health Board
Orkney Islands Council
Ombudsman
Paisley Law Centre
Part Time Sheriffs’ Association
Penumbra
People First (Scotland)
Perth and Kinross Council
PETAL
Renfrewshire Council
Royal College of General Practitioners (Scotland)
Royal College of Midwives
Royal College of Nursing (Scottish Board)
Royal College of Physicians
Royal College Psychiatrists (Scottish Division)
Royal College of Surgeons of Edinburgh
Royal Faculty of Procurators in Glasgow
Scottish Association for Mental Health
Scotland’s Commissioner for Children and Young People
Scottish Borders Council
Scottish Care
Scottish Child Law Centre
Scottish Commission for the Regulation of Care
Scottish Committee of the Council of Tribunals
Scottish Consortium for Learning Disability
Scottish Consumer Council
Scottish Courts Service
Scottish Government
Scottish Independent Advocacy Alliance
Scottish Law Agents’ Society
Scottish Legal Aid Board
Scottish Law Commission
Scottish Legal Complaints Commission
Scottish Prison Complaints Commissioner
Scottish Prison Service
Scottish Public Services Ombudsman
Scottish Society for Autism
Sheriff Principal Bowen QC
Sheriff Principal Dunlop QC
Sheriff Principal Kerr QC
Sheriff Principal Lockhart
Sheriff Principal Taylor
Sheriff Principal Young QC
Sheriffdom Business Managers
Sheriffs’ Association
Sheriffs Principals’ Association
Shetland Health Board
Shetland Islands Council
Society of Advocates in Aberdeen
Society of Local Authority Lawyers and Administrators in Scotland (SOLAR)
Society of Procurators and Solicitors in the City and County of Perth
Society of Procurators and Solicitors of Angus
Society of Solicitors Airdrie
Society of Solicitors and Procurators for the Eastern District of Fife
Society of Solicitors and Procurators of Stirling
Society of Solicitors in Orkney
Society of Solicitors in Peterhead and Fraserburgh
Society of Solicitors in the Shires of Selkirk and Peebles
Society of Solicitors of Banffshire
Society of Solicitors of Clackmannanshire
Society of Solicitors of Hamilton and District
Society of Solicitors to the Supreme Courts of Scotland
South Ayrshire Council
South Lanarkshire Council
SPICe, Scottish Parliament
State Hospitals Board for Scotland
Stirling Council
Tayside Health Board
University of Aberdeen
University of Abertay
University of Dundee
University of Edinburgh
University of Glasgow
University of Paisley
University of Stirling
University of Strathclyde
Victim Support Scotland
VOX
West Dunbartonshire Community Law Service
West Dunbartonshire Council
West Lothian Council
Western Isles Faculty of Solicitors
Western Isles Health Board
Wigtown District Faculty of Solicitors
WS Society
Please Note That This Form Must Be Returned With Your Response To Ensure That We Handle Your Response Appropriately

1. Name/Organisation

Organisation Name

Title Mr  Ms  Mrs  Miss  Dr  Please tick as appropriate

Surname

Forename

2. Postal Address


Postcode  Phone  Email

3. Permissions

I am responding as...

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please tick as appropriate</td>
</tr>
</tbody>
</table>

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

<table>
<thead>
<tr>
<th>yes</th>
<th>no</th>
</tr>
</thead>
</table>

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available

Yes, make my response available, but not my name and address

Yes, make my response and name available, but not my address

(c) The name and address of your organisation will be made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your response to be made available?

Please tick as appropriate

<table>
<thead>
<tr>
<th>yes</th>
<th>no</th>
</tr>
</thead>
</table>

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

Please tick as appropriate

| yes | no |