Mental Health Foundation

Mental Health (Scotland) Bill

1. About Mental Health Foundation

The Mental Health Foundation is the UK’s leading mental health research, policy and service improvement charity. The Foundation operates across four offices in London, Newport, Edinburgh and Glasgow. Just over a third of our staff are based in Scotland.

We work across all areas of mental health, from promotion and prevention activities at all levels, to supporting organisations in evaluation and development of mental health services. At our core is a belief that inequality is a critical determinant of population wellbeing, and a major inhibitor of recovery from mental illness. We are therefore committed to addressing structural inequality, poverty, discrimination and exclusion at every level, using a human right based approach to highlight the role of mental health in the cross-policy solutions to these wide ranging issues.

We bring high quality research and development skills, and experience of supporting policy at local, national and international levels. Critical to our work is supporting those with lived experience of mental ill health and inequalities to have a voice. We host VOX, the national mental health service user organisation, and additionally have on-going programmes to enable some of the most excluded populations, such as refugee and asylum seeking women to improve their mental health. We coordinate the Scottish Mental Health Arts and Film Festival, which takes place annually in October, and with SAMH we jointly manage ‘see me’, the national programme to end stigma and discrimination in mental health.

2. Comments on Specific Questions in the Consultation

Do you agree with the general policy direction set by the Bill?

In general we support the policy direction of the Bill. Though the bill is quite technical in places, we would urge the committee to bear in mind two things as the bill progresses:

- Firstly, the extent to which the provisions update mental health law in such a way as to maximise the promotion, understanding and assertion of human rights by people who are subject to the provisions. This is particularly important where provisions streamline processes to maximise efficiency.

- Secondly, the extent to which the Bill updates mental health law so as to maximise the opportunity to address inequality and failure demand both arising from and contributing to mental disorders.

To a great extent these considerations should be easily included if the Millan principles are at the front and centre of consideration of this Bill.
Along with the majority of mental health organisations, we warmly welcomed the McManus report and its recommendations. The Scottish Government’s 2010 response to the McManus review demonstrated the fact that not all of the recommendations needed primary legislation, and indeed set out the means by which many recommendations would be implemented in other ways. We would welcome an updated report which showed progress against these recommendations, including those now proposed in the Bill. That would better allow all interested parties to identify remaining gaps.

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Sections 18-20: Representation by Named Persons

We agree with the Policy Memorandum statement that that a person should only have a named person if they wish to have one. This facility provides a key point where a person can express their wish not to permit disclosure of confidential medical and personal data to third parties, consistent with the ECHR.

We continue to have concerns about whether the ‘opt-out’ system as proposed in the Bill achieves that. Having the option to formally refuse to have a named person, though welcome, is not the same thing as only having a named person if desired.

If a person does not formally opt-out of having a named person then a default named person will still be appointed under s251, even if the person they will act for does not or would not consent. We are concerned that in those circumstances, a patient may not have the agency to challenge such an appointment if it appears to them that their wishes have been overridden.

At the same time we realise that it is generally in a person’s interest to have a named person who gives informed consent to act in that capacity, and is supported to do so.

We feel therefore that all efforts must be taken to promote the benefits of having a named person, as well as to create space to enable a person to choose an appropriate named person mindful of the requirements of the role.

Equally, patients should be aware that they can change their named person at any time. This might be particularly important following first admission and default named person appointment, or in circumstances where failure to appoint led to the tribunal making an appointment.

We therefore are very supportive of proposals to ensure that named persons consent in writing to their nomination as such.

Once selected, it is critical that named persons give informed consent to serve and are offered on-going support. Ahead of this nomination it is desirable that a person who may be asked to act as a named person has appropriate,
accessible information about the role. Named Person guidance may need to take consideration of the dynamic in populations with particular hierarchies in families or social groups to consider whether a person is selecting a named person that best suits their wishes.

We note that under s19 the nominated person’s signature must be witnessed by a ‘prescribed person’. That opportunity might be a time where information and appropriate support might be offered the prospective named person.

This could be further emphasised combining a duty to support named persons with the statutory duty, as proposed by McManus, to promote advance statements.

The McManus review, and indeed the membership of VOX both picked up that having joint named persons might be desirable. We agree with this, particularly where a person may wish to nominate a person they trust and respect but who might not always be able to fulfil all the requirements of the role.

**Section 21: Advance Statements, Support and Services**

We are broadly supportive of any measures that enable people subject to the act to express their wishes in relation to their care and treatment. The ability to express wishes and see these respected at a time where detention may be considered is key to both least restrictive alternative and reciprocity principles.

Importantly, the ability to express wishes and see them respected can be important in setting out foundations for recovery, and for addressing self-stigma. We believe that advanced statements remain a key tool for achieving this, particularly with the rise in self-management strategies which could dovetail easily with advanced statements. As such we welcome the proposals to increase the usability of advance statements.

**Register of Advanced Statements**

We believe that collection of advanced statements on a central register is a good idea, provided the register of advance statements is appropriately held. Appending to health records as well as collection in a central register makes sense, and should increase the likelihood of advanced statements being consulted at key moments.

A central register could also provide good data about the number of active advanced statements in use, where now the only intelligence relates to circumstances where MWC is notified of times where advance statements are overridden. It is also possible that if basic demographic information were collected with statements that good data could be gathered about uptake of advanced statements by particular population groups, to enable targeted awareness work or support to be offered.
We have some concern that confidential personal and medical information shared in advanced statements, including details on traumatic experiences and personal preferences could be made available to a relatively large audience, potentially taking away to some extent a person’s ownership of their story. We are sympathetic to the view that the Commission should only hold basic details about the presence of a statement, its date, and where it is held. Although this might mean that an out of area professional might not be able to ascertain the wishes of a person out of hours, it would mean that only minimal information was available away from the ‘protection’ of the patient’s medical records. We would be interested to see the views of other stakeholders on this balance.

If patients, carers, and named persons aren’t sufficiently aware of the safeguards around access to advanced statement content, individuals may be inhibited from making statements for fear of their intensely personal material being widely known. At the same time, bringing advanced statements and personal stories into medical records may reassure patients that this information is subject to the highest possible level of confidentiality.

At the least, we would like to see medical records and the central register contain only the current advanced statement, meaning that previous statement versions would be purged at the time they were superseded. This would prevent any potential for the advanced statement history to be used in any assessment of a person’s health.

Section 22: Communication at Medical Examination

We welcome the requirement to meet communication needs. We assume this covers both the communication needs of people with learning difficulties and sensory impairments and the need for interpreters for those for whom English is not their first language.

Section 23: Services and Accommodation for Mothers

We very much welcome the extension of parental support to include all mental disorders. Whilst we recognise that the majority of cases would involve a mother requiring to be admitted with a baby, as primary caregiver, it is possible that fathers that are primary caregivers might also require this service. We would therefore prefer section 22 to refer to services and accommodation for parents, and section 24 of the amended Act to refer to “certain parents with a mental disorder”

Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
Not at this time
Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

The Foundation has concerns about the victim notification scheme in general. Many of our concerns were shared in consultation responses from colleagues in the Mental Welfare Commission, the Law Society of Scotland, SAMH and Support in Mind Scotland in the initial consultation on Disclosure of Information to the Victims of Mentally Disordered Offenders.

We recognise that such a scheme will be implemented, and recognise the right that all victims of crime should have to appropriate information about the circumstances and whereabouts of the offenders responsible. We welcome some of the changes to proposed scheme that have been implemented since the consultation on the draft bill, including the requirement that an MDO about whom information can be sought by a victim must have both a compulsion order and a restriction order.

We would be interested to see research on the use and uptake of the VNS for MDOs compared to that for other offenders, as we suspect that stigma around crime perpetrated by those with mental disorders might lead to a greater interest, at a lower level of severity, where the risk posed by an offender is less than some victims may perceive.

We would be interested to see in time whether victim notification around for instance the suspension of a compulsion order had an effect on the offender’s recovery and rehabilitation, or on media coverage of such important opportunities for rehabilitation.

Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

Duty to Promote Advanced Statements

We feel the Bill misses an opportunity to place a duty on appropriate public bodies to ensure that advanced statements are promoted, as proposed by McManus.

Advanced statements fit well with the movement towards integrated health and social care services and personal outcomes, and the opportunity to promote these alongside self-directed support.

At the very least, we would like to see guidance or code of practice reference to the duty of care and treatment services to promote advanced statements to people as early as possible in their experience of service use and recovery.

This would hopefully ensure that an advanced statement, and the right to assume that one would have a right to state preference for treatment and question practice that one did not want was part of any care and treatment for
new patients. This may have a substantial positive effect on both recovery and self-stigma, and may in time prevent the learned helplessness some people express at the thought of asserting their rights in inpatient settings.

**Named Persons for Children and Young People**

We note that the Bill does not take up McManus recommendation 4.16, that “a person under the age of 16 with an adequate understanding of the consequences of appointing a named person should be allowed to do so”.

In our submission to Scottish Government on the draft bill, we noted the Scottish Government’s intention to “consider the most appropriate ways in which young people might have more of a say as to the identity of their named person” and we hoped to see this developed in the Bill presented.

We would recommend consideration of the ways in which young people’s views are taken into consideration for instance in the Children’s Hearing system and in other legislation facilitating the wishes of children and young people to be heard in statutory processes affecting them.

We feel that promotion of advanced statements and understanding of named person roles could be very beneficial for young people making the transition from CAMHS to adult services.

**Medical Reports**

We welcome changes made between the draft bill and the bill as presented, regarding medical reports. We do feel however that there remains scope for a holistic report from a person’s GP, particularly where a patient’s social circumstances or their wider health has an impact on their mental disorder, or where treatment for multi-morbid conditions might be affected by their detention.

**Advocacy**

We note the extensive set of recommendations in the McManus review with regard to access to independent advocacy for people with mental health problems. As these do not require legislation to take forward, we understand why they are not included in the Bill.

We do however assume that the Bill proposed, in particular the changes in Advanced Statements and Named Persons will increase the demand for Independent Advocacy, potentially beyond the resources made available.

This demand may be from people covered by the Act but not currently detained or being considered for detention, a client group who sometimes need to wait for access where the needs of those subject to imminent or current detention are prioritised when resources are stretched.
We believe that the potential value of advanced statements and appointing a named person in terms of self-stigma and self-management is great. The window of opportunity for this where people are nervous, sceptical or only well for short periods may be short, and therefore access to advocacy when people feel sufficiently empowered and motivated to change is key.

**Do you have any other comment to make about the Bill not already covered in your answers to the questions above?**

**Duties of Local Authorities**

Sections 25-27 of the 2003 Act confer certain duties on Local Authorities with regard to the provision of services to people subject to the Act. These duties have encouraged a range of good practice in Local Authorities, and alongside with measure in Single Outcome Agreements on promoting wellbeing and addressing suicide have secured a place for mental health on Local Authority strategic agendas.

There is currently no specified monitoring structure for assessing implementation of these provisions, and we would like to see that developed, especially in the light of health and social care integration, self-directed support, and the 2011 Public Sector Equality Duty in relation to non-discrimination towards people with mental disorders, all of which have been introduced since the Act was passed and which connect with Local Authority obligations towards those with mental disorders.

We would welcome a re-visiting and updating of the guidance document ‘With Inclusion in Mind’ following the passage of this legislation.

**Use of Advance Statements to support self-management and address multi-morbidity and complexity**

We would like to see guidance recommend that advance statements explicitly invite patients to discuss ways in which their care and treatment can encourage the development/ resumption of self-management strategies as soon as practicable, for example including information about a person’s use of online peer support, WRAP plans or similar self-management strategies and their preferences around being offered these.

Equally we would prefer to see guidance cover details of process for appending other tools such as WRAP plans or SDS outcomes to advance statements.

We would like to see future guidance on advance statements recommend inclusion of sections on general health, on equality and access.

A section on general health would enable multi-morbid patients to explain their other health conditions, treatments, self-management strategies, and the effects of these treatments on their mental health. We are often told that explaining complex or rare illnesses at admission or subsequently can be
additionally stressful for patients, or that the care and treatment they need for physical illness can be hard to put in place at the start of admissions. Additionally, where patients have a strong clinical connection with a district nurse, physiotherapist or other NHS provider, an opportunity to at least notify that person so as to facilitate picking up that connection post discharge may prevent interruptions that can seriously affect a person’s ability to live independently later.

Finally, the health section of an advanced statement could also enable people to request support with health concerns, with smoking cessation or healthier eating when admitted, helping to address health inequalities and diagnostic overshadowing.

Similarly a section on equality and access would enable patients to disclose any barriers that membership of any protected characteristic groups might present that may be difficult to discuss at admission. This may be particularly helpful for patients who culturally find it difficult to address authority figures or people of the opposite gender, people with autistic spectrum disorders or learning disabilities who may find communication difficult, or transgendered people who may not want to disclose this verbally in case they are inadvertently outed.

**Ensuring Access for Underrepresented Groups**

We would like to see specific efforts concentrated on reaching underrepresented groups with promotion of advance statements and appointment of named persons, and assurance in guidance that independent advocacy is available and utilised by people with protected characteristics. This may be of particular relevance to young people, older people in isolation, BME groups and asylum seekers and refugees. Where people have access issues, such as sensory or physical impairments or language barriers, we welcome measures in the bill to improve communication but would reiterate the need to support this during care and treatment as well as at assessment.

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