The Faculty welcomes the opportunity to provide written evidence commenting on the Mental Health (Scotland) Bill, in the form it has been introduced.

We provided comments in response to the Scottish Government consultation exercise issued in December 2013, and a copy of the Faculty's response is attached for reference. We note that parts of the Bill as introduced are in much the same form as the consultation draft, but there are a number of important differences. We discuss some of those below.

Question 1: Do you agree with the general policy direction set by the Bill?
Insofar as the policy of the Bill is that set out in paragraph 15 of the Policy Memorandum, the Faculty is broadly supportive, and we are certainly supportive of the broader aim of the 2003 Act set out in paragraph 14.

Question 2: 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?
2.1 We welcome the decision not to proceed with the proposal in the consultation draft which might have resulted in patients being detained on the basis of only one medical report. For the reasons which are set out in the Faculty response to that consultation, we considered that would have been an undesirable change.

2.2 The Faculty also welcomes the more nuanced approach to the maximum period for suspension of detention proposed in section 9. While this may involve a marginal increase in effort in record-keeping, it seems to us an important safeguard for patients and may be relevant to consideration by the Mental Health Tribunal for Scotland of variation of hospital-based CTOs to community-based CTOs for patients who are able to spend substantial periods of time in the community.

2.3 We note the provisions proposed in section 1 which will double the existing extension period from 5 to 10 days for patients detained on Short Term Detention Certificates where an application for Compulsory Treatment Order has been made. This did not feature in the most recent consultation, though it was canvassed in the McManus review. We note the rationale given at paragraphs 18-20 of the Policy Memorandum, namely “ensur[ing] patients have sufficient time to prepare for hearings, even those requiring to be held at short notice, and that the Tribunal has all the information needed...” The experience of our members practising in this area is that the Mental Health Tribunal for Scotland makes strenuous efforts to facilitate hearings within the
existing timescale, though they are not in control of the production of reports and the like. It is our experience that pressure on the time of medical professionals is sometimes an issue in scheduling Tribunal business. We note that the section attempts to balance the significant extension (a Short Term Detention Certificate lasts for 28 days, so that the extension period of 10 days has to be seen in that light) by reducing the period of 6 months for which a Compulsory Treatment Order lasts by the same period. Overall, we consider that this is a reasonable way of balancing the liberty of patients and the practicalities of managing the tribunal process.

2.4 We note the provisions of sections 11 and 12, which were not in the consultation draft, and have, we assume, been brought forward by the Scottish Government following its separate consultation about section 268 of the 2003 Act in light of the decision of the UK Supreme Court in the case of M v Scottish Ministers.¹ A copy of the Faculty’s response to that consultation is attached. The Committee will no doubt be aware that case came before the courts because section 268 was enacted envisaging that patients detained other than at the State Hospital should have the same right to challenge the level of security in which they were detained, but that the coming into operation of that section required the Ministers to lay regulations before the Parliament and that had not been done. Aspects of the proposed sections 11 & 12 will require regulations too, and the Committee will no doubt wish to ascertain the Ministers’ proposed timetable for those.

2.5 The Faculty has some concerns about the proposed form of section 26. As we indicated in our response to the consultation draft, it seems to us that a requirement that the MHO consent to a transfer for treatment direction goes a good deal further than the stated policy aim of ‘involving’ the MHO in the process. More than that, however, our concern, based on the experience of members practising in this area, is that MHOs may not readily be available in the prison estate: they are skilled professionals with a large caseload. There is a risk that in some cases treatment for acutely unwell prisoners will be delayed. It might be said that the involvement of the MHO is intended as a safeguard for the prisoner/patient; while there is some truth in that, the prisoner is already subject to detention, albeit by order of the court.

**Question 3: Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?**
The Faculty has no comments on those provisions.

**Question 4: 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?**
4.1 The Faculty is of the view that in general, the scheme in Part 3 appears to strike a careful balance between the rights and interests of the various individuals involved.

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¹ M v Scottish Ministers [2012] UKSC 58; 2013 SC(UKSC) 139; 2013 SLT 57.
4.2 There is a small but potentially important practical matter which seems to us may arise under part of what is proposed in section 45, which will introduce new section 17B into the Criminal Justice (Scotland) Act 2003 about making representations. We recognise the importance of the making of representations, and equally that it may not always be practicable. It is proposed in section 17B(6) that the Scottish Ministers need not afford an opportunity to make representations if it is not reasonably practicable. That is a sensible provision, however the Ministers are not the only decision-takers mentioned in section 17B, and it seems to us that consideration should be given to extending the reasonable practicability provision to the Tribunal and to MHOs. Since the Scottish Ministers may be the first port of call for persons seeking to make representations, the public interest would be represented in the decision making process. Otherwise, it is possible to conceive of situations in which the Tribunal or an MHO might be prevented from taking a decision within a reasonable time simply because it had not proved possible to obtain representations from an affected person - that is undesirable from the point of view of certainty of decision making and the need to respect the rights of patients as much as other potentially interested persons.

**Question 5:** 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.

In our view, there is nothing from the McManus review which has not been otherwise addressed which merits primary legislation.

**Question 6:** Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

The Faculty has no other comments to make.
Appendix 1 - Faculty of Advocates response to Scottish Government consultation on draft Mental Health (Scotland) Bill

RESPONSE
by
FACULTY OF ADVOCATES
to
SCOTTISH PARLIAMENT
on
Mental Health (Scotland) Bill Consultation

The Faculty welcomes the opportunity to comment on these proposals. We have addressed the questions in turn, commenting on those of which our members have direct experience and those which appear to us to raise issues of principle or practicality.

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions? (Chapter 2)

Comment
We have no comments on the subject matter of Q1.

Question 2: Do you have any comments on the proposed amendments to the Named Person provisions? (Chapter 2)

Comment
While the Faculty understands the rationale for the proposed requirement that Named Persons obtain leave, we have a number of concerns about its scope.

As a preliminary, we would observe that the draft Bill contains no readily identifiable test for granting leave, nor is there any procedure for dealing with the refusal of leave. The former is likely to give rise to appeals, while the latter may do so.

Further it seems to us that the list of cases in draft section 19 is rather uneven. The requirement to obtain leave before making certain types of application would seem undesirable in certain circumstances. In particular we have concerns about the need to obtain leave in cases falling under section 50, which, by their very nature, require speed of action.

Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions? (Chapter 2)

Comment
The Faculty understands that there has been concern in some quarters about the proliferation of reports that can exist in some cases. We are however concerned that the effect of the changes is that some patients can be detained on the basis of one medical report. The proposal within the Bill for dispensing entirely with a second medical opinion based upon the MHO’s belief that the patient does not have a GP or that it is not practicable to obtain a second opinion subject only to a requirement to record the reasons for reaching that view does not appear to be a sufficiently robust safeguard. The requirement that there be two medical
reports has, in one form or another, been part of the landscape in this area of law for a long time, and, we suggest, for good reason. If it is to be dispensed with, the Bill should be fortified to spell out that this should be done only in truly exceptional cases.

Further, it appears to us that the observation at para 15 of the consultation that “If no GP can be identified then the patient would retain the right to instruct an independent medical report as a protection” is not really an adequate answer. That is a right which any patient ought to have, and it is no answer to a proposal which appears based on no more than expediency. The more so as it may be that patients without GP registration may - and we stress may - be drawn disproportionately from already disadvantaged groups. That ought to be explored further and a proper evidential base obtained before a proposal in this form is taken further.

Finally, it would, of course, be open to the Tribunal to instruct a report if it were not content with an application being presented on the basis of only one report. However, we suggest that reliance on this as a matter of routine rather than as an exceptional power would be undesirable for two reasons. Firstly, budgetary: the cost would be unfairly shifted to the Tribunal. Secondly, if the second medical report was, in essence provided at the instance of the Tribunal, there may be a risk that the Tribunal could be perceived as supporting the application rather than determining it. That is plainly undesirable.

Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions? (Chapter 2)

Comment

Revision of the suspension of detention provisions seems to us entirely sensible.

We note however that the draft bill departs entirely from the careful scheme recommended by the McManus review, about which there was then detailed consultation. It does not appear that any of the consultation responses has been reflected in the Government’s proposals, nor does the consultation document give any explanation of why the Government has departed from that.

The Government expressed the view that “Given the provisions within the Act for review of orders, and indeed for variation to community based orders, it is felt that the 9 month limit could now be dispensed with”. However the provisions for the review of orders and variation to community based orders had their origins in the Millan Report and were legislated for in the 2003 Act – as was the 9 month time limit for suspension of detention (which time limit did not exist before the 2003 Act). The existence of the provisions for the review of orders and variation to community based orders cannot logically be a reason for abolishing the 9 month limit now any more than it would have been a reason for not implementing the 9 month limit in the first place.
The Millan Report recognised that there was a potential for abuse (Chapter 6, paragraph 73), saying “Although we have no evidence to suggest abuse of the current arrangements, we would not wish the potential for abuse to remain, particularly when an alternative approach is available by means of a community order”. It hardly seems consistent with that approach to remove the limit entirely.

It might be viewed as inherently desirable that a patient who can, and is, spending substantial amounts of time in the community should be subject to a community-based CTO rather than being subject to a hospital-based CTO, and depending upon the discretion of the RMO for his or her liberty.

Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal? (Chapter 2)
Comment None

Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions? (Chapter 2)
Comment None

Question 7: Do you have comments on the proposed changes to the suspension of certain orders etc. provisions? (Chapter 2)
Comment None

Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions? (Chapter 2)
Comment None

Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions? (Chapter 2)
Comment As we understand matters, the Tribunal as a matter of fact acts promptly in appropriate cases and seeks to deal with all matters within a reasonable time. It is in any event part of the obligations of the Tribunal in terms of article 5(4) of the European Convention on Human Rights that cases relating to detention are reviewed speedily. The requirement for the Tribunal to “do their utmost” seems to us to add comparatively little.

Moreover, by imposing such an obligation upon the Tribunal, another procedural requirement would be imposed – a failure to comply with which would arguably be a procedural impropriety and might result in procedure before the Tribunal beyond the simple recording of why steps
were not undertaken with the utmost speed. Further, such a procedural impropriety would give rise to a right of appeal, since, quite properly, procedural impropriety is one of the enumerated grounds of appeal in section 324(2) of the 2003 Act.

There may also be an increase in the number of appeals as a consequence of the reform to timescales, though we deal with these in more detail at 18, below.

Question 10: Do you agree with the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why.
(Chapter 2)
Comment
None

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why.
(Chapter 2)
Comment
Insofar as the Bill's stated purpose of “involving” the MHO in the transfer of prisoners to hospital is concerned the Faculty would question whether the terms of the proposed legislation accurately reflects that intention.

As section 23 is currently drafted, it appears that the involvement of an MHO is mandatory and a prerequisite to transfer. That appears to go a good deal further than “involvement”, and our concern is, based on the experience of members practising in this area, that MHOs may not be readily available within the prison estate. In order to be able to provide prisoners with appropriate care in cases of urgency it might be preferable for the Scottish Ministers to retain a greater degree of discretion in the involvement of an MHO or his consent.

We have no comment in relation to the cross-border or absconding provisions.

Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?
(Chapter 3)
Comment
The provisions in relation to time limits in the criminal courts provide a helpful clarification. Otherwise we have no comment.

Question 13: Do you have any comments on the proposed amendments to the “variation of certain orders” provisions? (Chapter 3)
Comment
In light of what has been stated to be the experience of the Government in relation to these difficulties, the proposals seem entirely sensible.
We note that paragraph 62 of the consultation appears not to be addressed in any of the consultation questions. We have no comment to make on those proposals.

Question 14: Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be. (Chapter 4)

Question 15: Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer. (Chapter 4)
Comment
We have chosen to respond to these two questions and question 16 together. The Faculty is of the view that the scheme as proposed appears to strike a careful balance between the rights and the interests of the various individuals involved.

Question 16: Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to Mentally Disordered Offenders? If not, please explain why not and please outline what your preferred approach would be. (Chapter 4)
Comment
See above.

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics". (Chapter 5)
Comments:
None

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible. (Chapter 5).
Comments:
It appears to us that the possibility of granting a CTO on the evidence of one doctor may result in more appeals with a consequent increase in legal costs. It may also result in an increase in the costs to the Tribunal, as the Tribunal may be disinclined to grant a CTO on the evidence of one doctor alone and may make increased use of the power to obtain an independent report. As a result there may simply be a shifting of costs around the system.

The requirement on the Tribunal to determine cases with utmost speed might also result in an increased number of appeals and consequent costs to the Tribunal, court service and parties, for the reasons given in our answer to Q9.
Similarly, the reform of time limits may well result in an increase in legal costs. At the present juncture a large number of appeals are not instigated because the existing time limits permit a further application in comparatively early course (whether or not an application is in fact presented), and there is therefore no real practical benefit in the instigation of an appeal. By the time any appeal would be heard there could have been a new application in any event. This is particularly true in relation to cases involving restricted patients, where any appeal is heard by the Inner House of the Court of Session, which, while some progress at reducing the times involved has been made, typically takes place a number of months after the original decision.

Appendix 2 - Faculty of Advocates response to Scottish Government consultation on section 268 of the Mental Health (Care and Treatment)(Scotland) Act 2003

CONSULTATION QUESTIONS

1. Proposals for regulations

Our first proposal for legislative change is that we bring forward regulations in the following terms:

Section 268 of the 2003 Act gives a right of appeal against levels of excessive security for qualifying patients in qualifying hospitals. We propose that a qualifying patient would be -

• an individual who is subject to an order requiring them to be detained in a hospital which operates a medium level of security; and

• who has a report from an approved medical practitioner (as defined by section 22 of the 2003 Act, who is not the patient's current RMO,) which supports the view that detention of the patient in the qualifying hospital involves the patient being subject to a level of security which is excessive in the patient’s case.

A qualifying hospital would be one of the following-

• the Orchard Clinic in Edinburgh, and the regional medium secure component of Rohallion in Tayside and Rowanbank in Glasgow

Please tell us about any potential impacts, either positive or negative you feel these proposals for regulations may have.

Comments
The Faculty welcomes the opportunity to comment on these proposals. We begin with a number of general points.

We consider that section 268 and associated sections properly reflect the general scheme of the 2003 Act, and in particular that individuals should be subject to the minimum restriction on liberty necessary in the circumstances of the individual case. We suggest that it is desirable in principle that individuals who are detained in conditions of excessive security are afforded the opportunity to challenge their detention and to obtain an effective remedy, whether or not they are detained at the State Hospital.

We would also observe that affording patients at the State Hospital a right to challenge the level of security imposed upon them without affording an equivalent and effective remedy to patients at lower levels of security may amount to discriminatory treatment within the scope of Article 8 taken together with Article 14 of the ECHR.

Section 264 appears to have achieved its aims. It has been effective in moving on patients from the State Hospital who no longer require the conditions of special security there. Section 264 is perceived as being a driving force behind patients being moved from the State Hospital. Its effectiveness is not necessarily limited to the making and granting of applications. The Faculty’s view, informed by the experience of members practising in this area, is that the fact that section 264 exists is perceived as being a positive influence on moving patients to lower security levels without the need in some cases for an application to be made at all. It helps to support a culture whereby the Responsible Medical Officer requires to keep in mind the level of security at which the patient is detained.

Against that background, the effective implementation of section 268 is a welcome step.

It is perhaps stating the obvious to point out that making regulations for the purposes of section 268 would assist patients who are detained in conditions of excessive security outwith the State Hospital to move on through the mental healthcare system – which is the entire point of the excessive security provisions of the 2003 Act.

We would also observe that if there is no problem with entrapment at the level of medium secure facilities then there are unlikely to be supportive medical reports on which to base applications. In short, if there is no difficulty then the mechanism would be little used. On the other hand if there is a difficulty then those patients who are suffering as a consequence will be able to seek effective relief.

The impression of some members practising in this area is that there has been, to a certain extent, a “displacement” of the problem of excessive security from the State Hospital to hospitals with lower security levels.
There is an effective driving force for those patients detained at the State Hospital. There is no effective driving force for those patients detained in medium security.

Turning to the detail of the proposals, while the Faculty favours the proposal that a supportive report from an authorised medical practitioner should accompany an application, it is not apparent why the patient’s Responsible Medical Officer should be precluded from providing a report. Although perhaps uncommon, it is not difficult to envisage circumstances in which a patient’s Responsible Medical Officer might be of the view that a patient was perhaps detained in conditions of excessive security, but might conclude that he or she was not in a position to obtain appropriate alternative facilities. In those circumstances it would seem unnecessary to require a different authorised medical practitioner (who would almost certainly be less familiar with the patient and his or her case) to become involved and provide a report. It is possible that this would result in an overall costs saving in some cases.

Equally, it is not apparent why the proposed regulations are restricted to patients at medium secure facilities. It seems likely that any “displacement” of the issue that has happened from the State Hospital to the medium secure units is also likely to occur at lower levels. Members of Faculty have experience of patients at lower levels of security having difficulties with being detained at excessive levels of security - particularly in moving from locked wards to open wards, and from hospitals into the community. We note that the patient in the case of RM sought to move from a locked ward in a low security hospital to an open ward also in a low security hospital.

It is at least possible that limiting review of excessive security to patients in medium secure facilities will not necessarily solve the problem but merely result in a further displacement of the problem to the next lower level of security i.e. in the case of the proposed regulations to the level of low security.

2 .Our second proposal is that we do not bring forward regulations but instead repeal section 268 at the earliest opportunity. At the same time we will consider the review undertaken by the National Forensic Network of patients detained in the high, medium and low secure estates, which we hope will clarify whether there is an issue with entrapped patients held in these settings. The outcome of this could result in changes to primary legislation in early course. To take that proposal forward we seek views on the following:

• The current appeal provision in section 268 is restrictive and in particular does not allow for a change in security levels within the same hospital setting. Is there a need for a wider provision for an appeal against excessive levels of security?
First of all, we would observe that although the proposals are suggested in the alternative there is nothing to prevent the Government from implementing the regulations in terms of the first proposal and also undertaking a review to increase mobility through the secure forensic estate more generally. It is our view that this would be a desirable approach, and the Faculty would not support repeal of section 268 without a workable alternative scheme being implemented as a replacement.

We agree that, as section 268 is presently drafted, it is questionable whether patients can be transferred in-pursuance of the excessive security provisions. For example, the Rohallion clinic is composed of both a medium secure and low secure element, though both would be likely to be the same hospital in terms of the Act.

It would seem that comparatively simple amendments to the 2003 Act would permit this. If the provisions in respect of orders authorising detention could authorise detention in specified parts of a hospital rather than necessarily just a hospital and that the duty in section 268 et seq was to find an appropriate part of a hospital, where security was not excessive, then transfer within the same hospital would be possible and could be regulated by the Tribunal. Other provisions (in respect of appeals against transfer, for example) might also be so amended.

As noted above, members of Faculty have experience of patients who were detained within lower security levels who had problems with the levels of security that were imposed upon them by virtue of being in one ward rather than another (as in the case of RM). In our view, the amendments proposed would have the effect of permitting transfer from one part of the hospital to another.

Also as noted above, members of Faculty have experienced cases in which patients are considered to be suitable for community care by their hospital care team or by the Tribunal, but adequate provision is not provided by the local authority in respect of that care. At the moment the only effective mechanism to try to enforce the obligations of the local authority is by judicial review. It is a matter for consideration whether a procedure, based on section 268, might usefully be introduced to the 2003 Act for the benefit of such patients.

- If an additional appeal provision is created, do we need to provide for a preliminary review to consider the merits of the appeal before proceeding to a full hearing?

Comments

It is not entirely clear what is envisaged here. It would appear to be an unnecessary procedural step. If there were to be a precondition such as an expert report as proposed in the first option in the consultation, there would seem to be no need for a preliminary review.

- Compulsory Treatment orders, compulsion and restriction orders and transfer treatment directives are currently reviewed by the Mental Health Tribunal at least once every two years. Levels of security are not necessarily discussed at these reviews. Should there be a requirement for the Tribunal to
consider levels of security as a matter of course, with an accompanying right of appeal if the question of level of security has not been considered?

Comments

In our view, there is something to be said for the idea that there be automatic review of levels of security as a part of the periodic review of compulsory treatment orders, compulsion and restriction orders and transfer for treatment directions. In the experience of members of Faculty practising in this area, it is those patients with least capacity or those with the most profound difficulties who benefit most from the automatic review provisions. It would be unfortunate if those patients were unable to benefit from provisions for review of excessive security.

In our view, introducing automatic review of security levels would require amendment of the 2003 Act. Moreover, it would only be worthwhile if there was some sort of enforcement mechanism – there is little point in the Tribunal requiring to consider the issue of excessive security if it is unable to provide a remedy for it.

However, such automatic review does not fit with the requirement within the current proposal for regulations requiring an applicant to obtain a supportive expert medical report, nor would it seem to fit with the idea of a preliminary review (if that proposal were implemented). It also seems likely that any amendment would require to address the powers of the Tribunal dealing with the review.

• Can more effective use be made of recorded matters by the Tribunal with regard to levels of security in Compulsory Treatment Order cases?

Comments

While in general the ability for the Tribunal to make a recorded matter is a welcome facility, we would observe that in the experience of some members of Faculty, recorded matters are not seen as being an effective remedy for patients in this context, largely because there is no enforcement mechanism.

We would also observe that they are not applicable to patients subject to transfer for treatment directions, hospital orders or compulsion orders (with or without a restriction order).

• Are there other changes to the review system that you consider may help to support and develop further the effective movement of patients through the secure system?

Comments

We have little doubt that the extension of the right of appeal against excessive security to a greater number of patients would help to support and develop the flow of patients through the system. In that context the regulations proposed are a welcome step.

The extension of a scheme such as that in sections 264 and 268 to patients
who are seeking to move from hospital into the community would also assist in the flow of patients through the secure system.

Any further comments

Comments

Any provisions that require amendment of the 2003 Act, or otherwise require Parliamentary authority, might usefully be included in the forthcoming Mental Health Bill.