Royal College of Psychiatrists in Scotland

Mental Health (Scotland) Bill

1. The Faculty of Forensic Psychiatry of the Royal College of Psychiatrists in Scotland generally welcome the Mental Health Bill which mostly arises from Professor McManus’s review of the civil aspects of the Mental Health (Care and Treatment)(Scotland) Act 2003. Members of the Faculty thought that the McManus review could usefully have been extended to Forensic aspects of the 2003 Act. The Bill includes important new legislation for mentally disordered offenders but has not had the benefit of a thorough examination of the legislation.

2. Part 1 of the Bill generally has amending legislation improving certain aspects of functioning of the civil provisions of the 2003 Act. The particular area relevant to forensic practice is section 11 of the Bill which directly arises for the Supreme Courts judgement in the RM case. Appeals against excessive security were first introduced as a concept by the Millan Committee. A Faculty member, Dr Maureen Sturrock, was a member of the Millan Committee. There had been substantial policy with regards to mentally disordered offenders, not least the Scottish Office policy statement 1999MEL(5) but there had been a very disappointing implementation of that policy. Scottish Government initially withdrew the excessive security provisions of the 2003 Bill but they were put back in by the Parliamentary Health Committee as being an essential element to ensure appropriate service provision in forensic mental health care. Unusually the 2003 Act set a date for implementation of the excessive security appeals from the State Hospital at Carstairs.

A similar issue with regards to the provision of appropriate services for mentally disordered offenders occurs now. Whereas many Faculty members would identify that excessive security appeals have been important in driving forward the medium secure psychiatric estate (we now have a full national provision of medium secure units in Edinburgh, Perth and Glasgow) there is very poor development in the low secure estate. Nationally there is a need to provide low secure pre-discharge units for patients requiring complex risk management supervisory frameworks in the community - who are on extended periods of overnight testing out in the community and do not require to return to a medium secure unit meantime.

There is also a need to provide for low secure rehabilitation units where patients require day to day close behavioural management to respond to challenging behaviour. Many Health Boards are using the private sector or sending patients to England because of lack of appropriate facilities in Scotland. Many areas have well worked out proposals for providing such low secure units but in an environment of competing pressures for resources Forensic Psychiatry has yet again not been seen to be a priority. Many Faculty members therefore welcome an extension of appeals against excessive security to medium secure units as a way to drive forward low secure proposals. Unfortunately uncertainty following the RM judgement has led to something of a planning blight whilst guidance is awaited. The Faculty would encourage explicit extension of the excessive security appeals to medium secure units with a date of commencement. The worst possible outcome would be a lengthy period of time waiting for regulations, during which there would inevitably be a continuation of planning blight. The regulations will also need to take into account the different characteristics and security levels of the three medium
secure units and perhaps direction is required to harmonise certain aspects of the three units to ensure consistency with Scottish Government guidelines for medium security.

It would also be correct to say there is a sizeable number of Faculty members who would like to do away all together with excessive security appeals. Those colleagues often will come from areas where there is a better provision of low secure forensic units. As a general comment Faculty members would welcome any move to expedite excessive security Tribunals in contexts where they are very unlikely to succeed. For example, where there is no evidence being put forward that a state of excessive security exists. The success of such an application without supporting expert opinion is very remote yet considerable resources are taken up with such appeals. Overly speculative appeals, sometime encouraged by legal agents (who may raise an appeal without supporting evidence), can be very stressful for patients and damage therapeutic relations – they are not simply pointless but may do harm in contravention to the principles of the Act. Perhaps a mechanism could be put in place that such applications could first be considered by the duty MHT Convenor before proceeding to a full hearing. The Faculty is also concerned that Scottish Legal Aid Board rules enable doctors without appropriate qualifications to provide reports for such cases. The Faculty has made representations to the Scottish legal Aid Board to ask them only to approve payments to psychiatrists with relevant qualifications.

3. In terms of part 2 of the Bill on criminal cases this is mostly tidying up legislation with regards to calculation of timescales. This is welcome as there have been a number of unfortunate cases where the courts have not kept to the correct length of time. Unfortunately there has been no fundamental re-examination that the length of a Section 52D is correct at 28 days plus a week’s extension. Essentially the clinical team at the end of that 4 or 5 week period must decide whether treatability criteria exist. Faculty members welcome the proposed extension of the provisions of Section 52D for a further period of time in certain cases but 14 days appears completely arbitrary – certain members would like the ability to extend this further by a second 14 days in cases where it is difficult to establish whether 52g criteria exist.

There is also a more fundamental question about the lack of female high secure resources in Scotland and any child and adolescent forensic inpatient resources to allow for pre-trial patients to be assessed on Section 52D. This has the potential for leading to miscarriages of justice. There have been proposals before Scottish Government for at least the last 10 years about designating part of one of the secure schools as having hospital inpatient status. This would allow for children in their adolescence to be properly assessed in terms of their mental health needs prior to trial. There have been very unfortunate cases where this has not been possible or older children have been admitted to facilities such as the State Hospital at Carstairs.

There is also an issue with regards to high secure female provision. With the State Hospital at Carstairs closing a male ward there would appear the ideal opportunity to revisit the arrangement that high secure female patients are transferred to Rampton Hospital in the English East Midlands. The main problem is that remand patients on Section 52 cannot be moved outside the jurisdiction. This creates an inequity for female patients in terms of proper assessment prior to trial. It also creates a potential inequity in that high secure Scottish female patients do not have the safe guards of the 2003 Act which are generally considered to be superior to those in England.
There is a further issue with regards to jurisdictional matters with regards to the Northern Irish patients. The State Hospital is the high secure hospital for Northern Ireland. There is no ability for a Northern Ireland remand patient to be admitted to the State Hospital at Carstairs (for similar reasons to why remand child patients or female patients requiring high security cannot be moved outside of a Scottish Jurisdiction). Northern Irish patients have historically been managed at the State Hospital, Carstairs but they have the disadvantage that they may have had no period of assessment prior to final disposal from the court. There has already been one case of a patient who has successfully appealed his disposal to the court of criminal appeal in Northern Ireland. There are already cases where patients are admitted from Northern Ireland who cannot return to Northern Ireland because they now fail to meet Northern Irish detainability criteria although they continue to meet Scottish detainability criteria. That matter will get worse if the proposed new legislation in Northern Ireland is passed. The lack of the ability of admitting Northern Irish patients under Section 52 creates an inequity and it would be timely to reconsider the whole arrangement for admitting Northern Irish patients.

If of course the independence vote is passed there would need to be careful thought as to the repatriation of Scottish patients in England and the feasibility of continuing any arrangement with Northern Ireland. If the United Kingdom continues then there may be a case for considering UK wide legislation allowing remand patients to move between UK jurisdictions to allow for appropriate assessment.

The Bill creates a new requirement for MHOs to consent to Transfer for treatment Directions – prison transfers to psychiatric hospital for treatment. We have concern this measure may create unnecessary delay in transferring acutely unwell prisoners. The MHO resource is highly variable across the country and in certain cases it may be difficult to get an MHO quickly The Bill does not specify that the MHO has to see the prisoner, or that they have other statutory duties. To avoid wrangles between local authorities as to who should provide an MHO it may be worth specifying for the purpose of this aspect of the legislation is should always be the local authority in which the prison is situated who must provide an MHO. All areas have out of hours and emergency rotas but getting an MHO from another part of the country will cause delay. We question whether this particular provision is necessary and mechanism should be in place for urgent transfer without consent if required. It would be inequitable for an ill prisoner to have a delay in necessary urgent treatment because their need is to do with their mental health and not physical. Perhaps different arrangements should be in place for those prisoners who consent to psychiatric hospital treatment and those who lack capacity or object.

4. Part 3 of the Act introduces a victim notification scheme for mentally disordered offenders. Generally this is welcomed by Faculty members who have been asking for improvement in how victims are dealt with for at least the last 10 years. The current system is haphazard and lacks consistency. We welcome the appointment of the Chair of the Forensic Faculty, Dr John Crichton as convenor of the expert group to consider how this part of the Bill would be implemented. That group has been set up by Scottish Government in conjunction with the Forensic Mental Health Managed Clinical Care Network. The group has already met and a number of sub groups looking at aspects of victim notification have begun. Dr Crichton will be in a position later this year to report to the Committee the progress of the group and any particular issues with regards to the legislative proposal that has arisen through the groups’ scrutiny.
5. As previously remarked it is a matter of general regret that the McManus report was not tasked with reviewing the forensic aspect of the 2003 Act. The Bill contains very important provisions for forensic psychiatry but these have occurred because of pressures rather than a reflective review process. Although the forensic aspects of the 2003 Act are largely welcomed by Faculty members it is perhaps timely to reconsider that legislation brought in by the Scottish Parliament on its first day of sitting. On the 8th September 1999 emergency legislation was brought in because of the Noel Ruddle case. MSP Dennis Canavan made certain far sighted remarks that emergency legislation had a habit of sticking. The provisions of the 1999 Act survived intact in the 2003 Act with the serious harm test being extended to all restricted patients. The Act has been successful in terms of public safety but has not been successful in terms of appropriate placing of offenders who should not be in hospital.

As was the case in 1999 there are a small group of patients, somewhere between 5 and 10, who received a Compulsion Order and Restriction Order disposal (or its equivalent) and have subsequently been discovered to be inappropriately placed within a mental health setting. The most common reason for this is that the initial diagnosis has proved not to be correct. One proposal discussed by Faculty members would be to enable a shrieval Tribunal to review the original reasons why a CORO had been put in place and if those reasons had fundamentally changed such as the diagnostic category under which the patient belonged then there would be an ability to refer the case back to the sentencing court for a more appropriate disposal. Not only would this be welcomed by Mental Health Services who can then more appropriately target resources but it would be welcomed by patients who often find themselves stuck in a mental health system not designed for their needs. Change in this area is already occurring with that small number of patients pursuing new disposals through the courts but the process of going through the Criminal Cases Review Commission and the Criminal Court of Appeal takes a very long period of time and is costly. Committee members may be aware of the case of Alexander Reid who has eventually been transferred satisfactorily to prison but not before enormous expense and time both in terms of his inappropriate stay within a forensic mental health setting but also in terms of very lengthy court proceedings. There are a small number of other patients on the same pathway as Mr Reid and the Bill provides an opportunity to bring in primary legislation to allow a mechanism for a common sense transfer of inappropriately placed patients in mental health to a more appropriate custodial setting.

Alternatively a fairer way to consider restricted cases at Tribunal would be to harmonise the entry and exit criteria. Restriction Orders continue to be a ‘lobster pot’ – easier to get onto than off.

There is also something of an opportunity missed not to put the status of the Conditionally Discharged Restriction Order on a clearer statutory footing. There remains confusion regarding the ‘serious harm test’ and the process of derestriction with the Faculty criticising the process of derestriction as described in the Scottish Government Memorandum of Procedure for Restricted Patients. The Faculty question the conflation in current Government guidance between the ‘serious harm test’ and the ‘significant harm test’.

6. We have no further comments about the Bill.

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