Introduction

The Forensic Mental Health Services Managed Care Network welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill.

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

We support the Bill’s overarching objective to help people with a mental disorder to access effective treatment quickly and easily. The issues identified in the McManus Review regarding advance statements, named persons and multiple hearings at mental health tribunals are part of our clinical experience and therefore solutions to these issues are to be welcomed. Members of the Forensic Network have been involved in discussions regarding the victim notification scheme and we have responded to a previous consultation on this. Similarly, we have been involved in discussions regarding appeals against excessive security using our considerable clinical experience and research into this provision.

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

a) Application for a Compulsory Treatment Order

It will be helpful to patients, their carers and named persons to have 10, rather than 5, working days prior to a CTO hearing. It is noted that this will not increase the continuous period of detention as set out within the 2003 Act.

b) The new duties for the MHO to review CTO determinations in specific circumstances inserted under Section 87A fall within good practice.

c) Suspensions of orders on Emergency Detention

It is helpful that a patient subject to a community based CTO who requires an emergency detention certificate will remain subject to the giving of medical treatment in accordance with Part 16 of the 2003 Act.

d) It is helpful that patients subject to an assessment order, a treatment order, an interim compulsion order or a temporary compulsion order will no longer require the consent of Scottish Ministers for Suspension of Detention if this is to enable a patient to attend a hearing in criminal proceedings, or meet a medical or dental appointment.

e) The changes to the maximum period of suspension of detention are supported: up to 200 days in any 12 month period with the option of a 100 day extension if approved by the Tribunal following application. It is noted that the system should be simplified by not having to count any period less than 12 hours and that does not include any time overnight.
(9.00pm-8.00am) for patients subject to orders under the Criminal Law (Section 224) or under a CTO (Section 127).

f) Excessive Security
Staff within the Forensic Network have had significant experience of appeals against excessive security, both those working in high security and within local responsible NHS Board areas. See Appeals against detention in conditions of excessive security in Scotland, Journal of Forensic Psychiatry (Bennett, D.M., Skilling, G., Brown, K. & Thomson, L.D.G., (2013)). The repeal of Section 266 such that a Health Board now has a maximum period of 6 months to find a suitable alternative placement for a patient declared to be held in conditions of excessive security is supported. It is noted that appeals against excessive security are added to the list of applications in Schedule 2 to the 2003 Act which will be viewed as not having been made if withdrawn before determination. Appeals against excessive security were introduced in the knowledge that there was a significant cohort of patients unable to move on from high security. This provision has led to a significantly changed forensic estate with a much reduced State Hospital (from 240 to 140 beds) and the development of 2 new medium secure units in addition to a pre-existing medium secure unit. This has considerably alleviated the problem of entrapped patients within high security.

Appeals against excessive security are however stressful to patients. We have found that Solicitors, in we suspect a well-intentioned attempt to give clients maximum “protection”, will at times appear to “automatically” lodge an appeal against excessive security. The concern would be that the apparently easy option of withdrawing such appeals at any time before determination may result in patients finding themselves in a prolonged stressful period of always having an ongoing appeal against excessive security.

The extension of appeals against excessive security from high security alone to the medium secure estate may result in the development of further low secure units within the forensic estate. However, there is no comparison between patients entrapped in an isolated high secure hospital in Lanarkshire unable to access the community, and those treated within medium secure units where independent access to the community is entirely possible and is indeed the clinical aim. The use of legislation to precipitate service development is not without its risks. As stated before, appeals are stressful proceedings for patients and divert clinical time and resources from the direct care and treatment of patients.

g) Detention Pending Medical Treatment – Nurses holding power
The extension of the Nurses holding power to detain a patient for a maximum of 3 hours for the purpose of enabling a medical examination to be carried out is supported.
h) The reduction in the time allowed for making an appeal to the Tribunal from 12 weeks to 28 days for those patients detained in a hospital subject to a Compulsion and Restriction Order, a Hospital Direction or a Transfer for Treatment Direction, who are transferred to the State Hospital is supported.

i) The referral of cases with patients subject to a Compulsion and Restriction Order to the Tribunal for review every 2 years, including those with an ongoing reference or application under Sections 185 or 191 which has not yet been determined by the Tribunal, is supported.

j) Opt out from having a named person
The ability to opt out from having a named person has been an issue for patients across the Forensic Network. This has largely been due to the concern of patients that their named person may be distressed by receiving details of index offences and/or that they feel that their confidentiality is being breached by having this information shared if by default the patient’s primary carer becomes the named person. The amendment to Section 251 allowing a patient to make a declaration stating that their carer or relative may not become their named person is fully supported. Similarly, we have had experience of cases where a primary carer has found themselves in the role of named person and in receipt of information that they have found to be distressing without having consented formally to the role of named person. The introduction of this measure is also fully supported.

k) Registering of Advance Statements
We fully support the development of a register of advance statements to be maintained by the Commission. This is particularly useful in forensic psychiatric services where patients frequently move to units and hospitals of differing levels of security, and indeed to other health board areas.

l) The extension of regulations to include cross border transfer of patients to member states of the European Union is helpful. This is a clinical issue that has arisen.

m) Arrangements for dealing with absconding patients to include those on Interim Compulsion Orders and to cover the European Union are again sensible.

n) Agreement to transfer of prisoners
One of the major clinical issues that we deal with in forensic mental health services is the transfer of prisoners who need hospital care. This is difficult because it is often urgent, an appropriate bed may not be easily found and the patient may be placed in a prison outwith their normal geographical area of residence. There is considerable concern within forensic mental health services that a requirement for a mental health officer to agree to the making of a transfer for treatment direction
would involve considerable delay in the making of a TTD for no obvious gain to the clinical care of the patient.

In our view, it would be better to formalise the role of the MHO once transfer had occurred. At that stage, if the MHO was not in agreement with transfer, there should be an automatic appeal against hospital transfer to the Tribunal. Such a system would build in protection for the patient but without incurring delay.

Clinical experience has shown us that finding a designated MHO from the appropriate geographical service is time consuming and obtaining the services of the MHO system in the area where the prison is based is unlikely to be easy until the option of the designated geographical MHO service has been fully explored. Sadly, this will cause delays in the transfer of prisoners to hospital. The most recent audit of the transfer of prisoners in Scotland carried out by the Scottish Prison Service showed that the majority were transferred within days. These are individuals who are acutely unwell and at risk within the prison setting. It would be most unfortunate if a legislative change resulted in a deterioration in access to medical services. Further, it is not clear what ongoing responsibilities for the care and wellbeing of a prisoner are placed on a mental health officer who has refused to agree to a Transfer for Treatment Direction.

O) The extension to other legal members of the Tribunal as potential chair for proceedings relating to an application for a Compulsory Treatment Order in respect of patients subject to a TTD or an HD is sensible, as is giving notice of the application for a CTO on a patient subject to an HD or a TTD to Scottish Ministers.

3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
   a) The increase in the extension period for an Assessment Order from 7 to 14 days is helpful. The alignment of the calculation of the start of an assessment order to match criminal proceedings will hopefully prevent the confusion that has arisen to date. This likewise applies to treatment orders, interim compulsion orders, compulsion orders and hospital directions.
   b) The power to vary the appropriate hospital or hospital unit specified within an order or direction is likewise clinically helpful in ensuring that the patient is cared for within the most suitable level of security.
   c) The requirement on the MHO to prepare and submit a report to the Tribunal in cases where there is an extension of a compulsion order that requires a review of the determination of the tribunal is supported.
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?

a) Victims' Rights

There is support within the Forensic Network to extend victim notification scheme to include patients detained under a compulsion order and restriction order.

It is reasonable to inform victims if a mentally disordered offender subject to a hospital direction or a transfer for treatment direction is unlawfully at large. The information that can be given and the list of those that it can be given to are appropriate. The Network would support the right of victims to make representations in cases involving hospital directions, transfer for treatment directions or compulsion orders and restriction orders. It is noted that the means by which written and oral representations are to be made will be the subject of guidance. It would not be appropriate for victims and patients subject to these orders to be present at a Tribunal at the same time. Likewise, clinical consideration would need to be given to the appropriateness of a patient hearing a victim’s representation and a system created whereby this could be done, in appropriate cases, with clinical support.

It is noted that Section 18B provides the power to Scottish Ministers to extend the victim notification scheme to patients made subject to a compulsion order alone or where the restriction order has been revoked. We would agree that it may be appropriate in some cases to provide information to victims when a restriction order has been revoked. It remains our view, as stated in the consultation regarding the victim notification scheme, that compulsion orders alone should not be subject to this scheme. There is no time limit on compulsion orders as there is on sentences, and this would bring individuals into the victim notification scheme who would otherwise not be included had they received a sentence. Further, the Court has made a clear statement that the most appropriate place for these individuals is within the mental health system.

b) It is noted that Section 49 (4) of the Bill amends Section 224 of the 2003 Act and requires that a Responsible Medical Officer considers victims' representations before deciding what conditions should be included in any certificates suspending detentions. The system will require to be developed that ensures that the RMO has access to such representations.

5. Other

a) The information contained within the financial memorandum is helpful in outlining the resources required to enact this Bill