SAMH

Mental Health (Scotland) Bill

1. Do you agree with the general policy direction set by the Bill?
When it was introduced, the Mental Health Act put human rights and guiding principles for the treatment and care of people with mental health problems on the statute book. It was a substantial improvement on what had gone before and it was based on thoughtful research and consideration by the Millan Committee. The Millan principles upon which the Act is based are a reflection of this Committee’s firm belief in rights and liberty. We feel it is worth re-stating those principles:

- non-discrimination
- equality
- respect for diversity
- reciprocity: where society places an obligation on a person to comply with compulsory treatment, there should be an equal obligation for them to receive appropriate services
- informal care: compulsion must be used only when and to the extent that it is necessary
- participation
- respect for carers
- all treatment must be delivered in the least restrictive manner and environment compatible with the delivery of safe and effective care
- benefit: any treatment must benefit the individual in a way which cannot reasonably be achieved by any other means
- child welfare: this is paramount in any interventions imposed on a child under the Act.

SAMH was proud to be heavily involved in the creation of the 2003 Act, which we continue to believe is one of the most humane and recovery-focused pieces of mental health legislation in existence.

It has been six years since the McManus review made recommendations to improve the Mental Health (Care and Treatment) (Scotland) Act 2003. This thorough review sought the views of people with lived experience of mental ill-health, their families and carers as well as professionals from many backgrounds. It made 114 recommendations, most of which SAMH supported, and we have been anxious to see them implemented.

We appreciate that not all of the recommendations required primary legislation but note that the Scottish Government did publish a response\(^1\) to McManus. It would be very helpful for the Scottish Government to publish an update to that report, setting out which of the recommendations that did not require primary legislation have now been implemented.

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\(^1\) Scottish Government, [Response](https://www.gov.scot/​publication/​2010/05/​09/​396902/) to the Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003, 2010
We note that there have been several positive changes to the Bill since the consultation period ended earlier this year, and in particular we welcome changes to proposals on suspension of detention and medical reports. We also recognise that there are elements of the current Bill which seek to extend the rights of people with mental health problems, and we welcome those. However, there are a number of proposals which appear to restrict those rights in the interests of making the overall system run more smoothly, and we do not feel that these are in the spirit of the Millan principles.

Throughout our evidence, we express concern about people’s awareness of their rights under the Act. Evidence suggests that there is a low level of awareness of these rights and indeed considerable variation in the extent to which people feel their rights are respected by statutory services. This is supported by research with service users which we have carried out as part of preparing our evidence to the Committee. We have included some quotes from participants in this research throughout our evidence.

Research carried out for the Mental Welfare Commission reported that few participants had any recollection of their rights relating to advocacy, named persons and advance statements being explained to them. This is a serious issue, since the Act is dealing with people being deprived of their liberty. We therefore want to see meaningful discussion of rights taking place at every opportunity when the Act is applied to someone. We are aware that work is ongoing under Commitment five of the current Mental Health Strategy, which aims to increase the focus on rights in mental health, and we hope that this work will address the low awareness of rights under the Act.

The remainder of our response focuses on those sections of the Bill where we have concerns. For brevity, we offer no comment on the sections with which we are content.

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?

Measures until application determined (Sections 1-5)
At present, the Tribunal has five working days in which to organise a hearing when an application for a Compulsory Treatment Order (CTO) is made. It is not unusual for the Tribunal to have to make an interim CTO and reconvene later, due to paperwork or essential personnel not being available within the five days. The Bill therefore proposes to increase this to ten working days. This was suggested by McManus in order to reduce multiple hearings and, at the time, supported by SAMH, but did not appear in the version of the Bill that was recently consulted on.

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3 Griesbach and Gordon, Individual’s Rights in Mental Health Care, 2013
We understand that this would not lead to an overall increase in the maximum amount of time that a person can be detained, since the additional five days would be matched by a reduction of five days in the maximum length of a CTO or Short Term Detention Certificate (STDC). We also appreciate that having to go through multiple hearings is distressing for the person concerned. However, this measure would lead to an increase in the length of time for which people are held without any external scrutiny: up to 45 days in some cases. We also note that the number of interim orders is already falling, from almost 40% in 2008 down to 28% in 2013.

We remain willing to support this measure if it is still needed. But we wish to be sure that this is the case, that it will address the issue and that it will include protection from unnecessary detention.

We would like to understand what estimates the Scottish Government has made of the reduction in multiple hearings which could be expected as a result of this change, and what the average number of days detained is likely to be following its introduction. We would also suggest that the Scottish Government should consider whether measures should be introduced to allow external scrutiny of a person’s detention before a full Tribunal hearing.

Should the extension be introduced, we would strongly suggest that it is done as a sunset clause effective for a short period, perhaps 18 months, with regular reviews of its effect, to ensure that it can be revoked if it does not achieve its aims.

Information where order extended (Section 2 (2)).
This section introduces a requirement for Mental Health Officers (MHOs) to notify the Tribunal whether he/she agrees with a Responsible Medical Officer (RMO)’s proposal to extend an order, if the Tribunal will need to review the determination. The MHO must also inform the Tribunal whether he/she has interviewed the patient, notified them of their rights, helped to secure advocacy and sent a copy of their report to the patient. We welcome the introduction of this measure. However, we regret that the MHO must only notify the individual of their rights and helped them secure advocacy if it is “practicable”, particularly given that no definition of practicable is provided. Given that we know people who are detained under the Act often have a low awareness of their rights, and that there is a specific right to access advocacy for people with mental health problems, it seems to us essential that the MHO should conduct this interview.

Emergency Detention in Hospital (Section 3 (3))
This section provides that hospital managers must inform the Mental Welfare Commission when a person is detained on an Emergency Detention Certificate but removes the requirement to notify carers of the detention. Instead hospital managers “may” notify the nearest relative or named person that the person has been detained. There is no requirement for hospital managers to record the reason if they choose not to do so. We are concerned about this: if a person has been detained on an EDC, they may be in hospital for up to 72 hours, and if their carer or nearest relative is not informed, this could cause substantial distress.

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4 Mental Health Tribunal, Annual Report, 2013
Orders relating to non-state hospitals and Qualifying non-state hospitals and units (Sections 11-12)
This section responds to the Supreme Court\(^5\) case in 2012 which found that the Scottish Government had failed to make regulations to allow patients in secure hospitals other than the state hospital to appeal, if they consider that they are being held in conditions of excessive security. The original Mental Health Act had introduced the right to make such an appeal, which was to be implemented by regulation.

We do not consider that the proposals in the Bill are an improvement on the current situation: in essence, they simply repeat that the right to appeal against excessive security for people in medium-secure settings will be introduced by regulation. Given the Supreme Court’s findings, we request detail on when these regulations will be made and seek assurances that it will happen quickly.
We are concerned that there is no intention to introduce a right for people to appeal against excessive security in low secure facilities.

Paragraph 62 of the Bill’s Policy Memorandum states that the Scottish Government does not consider there to be a problem with patients being held in excessive security in low secure settings. We understand that the Government’s view is that an appeal against low security is essentially an appeal against detention, since the next step is a community setting. However, we note that the patient who brought the Supreme Court case (RM) was himself being held in a low secure setting, and that, given the existence of community-based CTOs, it is possible to achieve a reduction in security while still remaining on an order. We therefore believe that the Scottish Government should reconsider this position.

We note that paragraph 62 of the Policy Memorandum states that the right to appeal will apply only to patients who are subject to a compulsion and restriction order, a hospital direction or a transfer for treatment direction. However we do not think that is the effect of the Bill as it is currently drafted and would welcome clarification on this matter. Our view is that the right to appeal should apply as broadly as possible, as this appears to have been the policy intention when the original Act was passed.

More generally, we have concerns about whether sufficient low secure facilities are available, particularly for female patients. We would like to understand what analysis has been undertaken of the forensic estate to ensure that there is sufficient low security provision for both men and women, and what improvements are planned.

Detention pending medical examination (Section 14)
The Bill proposes to extend the power of a registered mental nurse to detain a person for the purposes of examination, from two to three hours, and to allow this to happen even when a doctor is immediately available.

We oppose this on two grounds. Firstly, no justification for the extension has been provided. Secondly, section 299 (4) of the Act already provides that the holding period can be extended by one hour if the examiner does not arrive within the first hour. Therefore a three-hour period is already available if it is required.

\(^5\) RM vs the Scottish Ministers, 2012, UKSC 58
Appeal on hospital transfer (Section 15)
Currently, a person has 12 weeks to appeal against an order to transfer them to the state hospital. The Bill proposes to reduce this to 28 days on the grounds that a lengthy appeal process can delay treatment.

However, section 220 (4) (b) of the Act states that the Tribunal can order the transfer of a patient pending an appeal. Therefore this appears to be a substantial reduction in rights without proper justification, to which we are opposed.

Named persons (Sections 18-20)
At present, if a person has not appointed a named person, their primary carer or nearest relative is appointed by default. They will receive substantial information about the person and have full rights to participate in Tribunal hearings. Due to the privacy and human rights implications of this, McManus recommended that default named persons be abolished. While this Bill does make positive changes to named persons, it retains the default role, proposing that people must opt out from having a Named Person. If they do not, and they have not specifically chosen a Named Person, then the provisions in Section 251 of the Act will still apply and a default named person – the primary carer or nearest relative – will be appointed.

Paragraph 90 of the Policy Memorandum states that

“The Scottish Government considers than an individual should only have a named person if they chose to have one”.

SAMH agrees but this is not the effect of the Bill as it is currently drafted. We would like to see McManus’ recommendations implemented in full and believe that the role of default named person should be entirely abolished. In order to ensure this does not diminish the support provided to service users, it will be vital to implement McManus’ wider recommendations on this area, including the widespread promotion of the role of named persons, the introduction of limited automatic rights for carers and the provision of support to them.

“I think that should be made very clear … that there is that choice [regarding appointment of a named person], that opportunity, if you didn’t want the next of kin to be the people to be supporting you mainly, and you’d like somebody else to be your named person, I think that should be made very clear. It never ever was made clear to me, ever, ever, never in our discussion, never”.

SAMH research participant

We would also like to see the implementation of McManus’ recommendation 4.15, that a Mental Health Officer (MHO) should have a duty to consult with the Named Person on the proposed care plan. McManus further recommended that Named Persons should be notified when a person is taken to a place of safety – again, we would like to see this enacted.

Advance statements (Section 21)
Anyone can make an advance statement, setting out what treatments they do or do not want in the event of being treated under the Act. If the advance statement is overruled, the Commission must be notified. The Bill introduces a register of
advance statements, to be held by the Commission, and sets out who can view the register.

We welcome the introduction of such a register but we are aware that some service users have concerns about privacy. Advance statements can contain highly personal information, often rooted in deeply traumatic experiences. We propose that the Commission’s register should simply note that a specific person has made an advance statement, the date it was last updated and where it is kept. We feel that this would be sufficient for the Commission to take an overview of the use of Advance Statements and, where required, to ensure they are acted on, but would not require the disclosure of highly personal information to people not directly involved in a person’s care.

If our proposal is not accepted, we would strongly urge that the definitions of who can access the register be tightened up. The Bill proposes that the power to inspect an advance statement be held by the person who made it, anyone acting on the person’s behalf, the person’s MHO and Responsible Medical Officer (RMO), and the responsible Health Board. Clearly the MHO, RMO and person who made the statement should have such access, but we are concerned that the remaining two categories are too broad.

We are aware that awareness of advance statements generally is low and consider that this should be addressed: advance statements are an excellent tool, allowing the service user to make their voice heard even when they are deeply unwell.

“I think they [clinical staff] were thinking about using xxxxx (name of drug) on me, and they looked at my statement and they saw I’d written it down and I wasn’t given it, so it was really good”.

“This is the first time I’m hearing about this [advance statements], and I’ve been for the past 19 years in and out of hospital. Why is the mental health team not telling you about this? How can I ask if I don’t know it’s there?”

**SAMH research participants**

We note that, in its response to the McManus review, the Scottish Government undertook to place a statutory duty on NHS Boards and local authorities to promote advance statements, and we would welcome the introduction of such a duty.

We further propose that the forms required to nominate a named person and make an advance statement should be simplified and combined.

**Dealing with absconding patients (Section 25)**

The Bill proposes to allow patients who have absconded from detention elsewhere in the UK to receive medical treatment in Scotland as if on a Scottish order, until they are returned.

As we outlined in our response to the initial consultation, we are opposed to this proposal. Section 243 of the current Act already allows for emergency treatment to be provided and the Scottish Government has not provided any justification for an extension to this. The consequences of these powers being extended could be the
approval of quite invasive treatment without the individual’s consent, something which may be required in their home jurisdiction. The additional treatment could have an impact on the individual’s treatment programme; the individual may not be well enough to have the rights to advocacy and other support explained and provided to them, which would be discriminatory; and this could have a long term impact on how the individual responds to acute mental health care and treatment, regardless of which jurisdiction they are in. Any treatment beyond emergency care requires a proper assessment of whether the individual meets the criteria for compulsory treatment in Scotland: it cannot be assumed that they would do so, simply because they meet the criteria elsewhere.

3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

Periods for assessment orders (Section 29)
Currently, an Assessment Order made in respect of someone in the criminal justice system can be extended once, for seven days. The Bill proposes that to extend this to fourteen days. We are opposed to this on the grounds that no justification has been provided. We are aware of concerns within the judiciary regarding the quality and timely arrival of reports on the mental health of offenders. We speculate that it is these concerns that have driven the introduction of this extension. However, the arguments for such an extension need to be explicitly stated in order that they can be debated. Furthermore, if there are problems with the quality of reports being provided, it does not follow that these will be solved by having more time to produce them, on top of the existing 35 days that are available. If there are issues relating to staff capacity, training or ability, then these should be addressed.

Variation of interim compulsion orders (Section 34)
We note that paragraph 124 of the Policy Memorandum explains that this section of the Bill is intended to give an RMO the power to recommend to a court that a person being held on an interim compulsion order be moved to a different hospital in order to ensure that they receive the correct treatment. We support this change but suggest that the Bill should make clear that the court should only do so on the basis of an RMO’s recommendation, to ensure that such transfers only take place when it is clinically required.

Transfer of patient to suitable hospital (Section 35)
This section allows an RMO to transfer a person on an Assessment Order, Treatment Order or Interim Compulsion Order to a different hospital within the first seven days of the order, if it becomes apparent that the hospital is not suitable. We suggest that the person’s named person, if there is one, should be added to the list of people whom the RMO must notify of such a transfer.

Information on extension of compulsion order (Section 41)
This section introduces a duty on MHOs when an RMO intends to extend a Compulsion Order, in a similar manner to that introduced by section 2 in relation to civil orders. Our comments on section 2 also apply here: we wish to ensure that, wherever possible, the MHO interviews the person and advises them of their rights.
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?

This section introduces new rights for victims of Mentally Disordered Offenders (MDO) to make representations about an MDO’s release or temporary release and to be told about their likely date of release. It is our understanding that this is intended to ensure all victims have the same rights, and that it will only apply to people who are detained for eighteen months or longer.

We support the principle of equality for victims but have two areas of concern.

Firstly, we are conscious that, while the length of a prisoner’s sentence can be taken as an indication of the severity of their offence, the length and type of an MDO’s detention is reflective of the severity and duration of their illness and not reflective of their offence. We would welcome some clarification on whether this scheme will ensure that those who have committed only minor offences, which would not lead to the victim having a right of representation if committed by a non-MDO, will not be affected by these provisions. We hope that the Scottish Government can provide some analysis of the offences committed by existing MDOs on the relevant orders, to allow this comparison to take place. We note that most MDOs have Multi-Agency Public Protection Arrangements (MAPPA) involvement in their case who already take into account the concerns of victims.

Secondly, we are concerned about the level of Ministerial power to vary this section contained within the Bill. Section 48 of the Bill gives Ministers the ability to vary the circumstances under which victims can make representations and the types of MDOs affected. We seek an explanation of the need for these powers.

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.

Medical reports
We note that proposals to change the system of medical reports have been removed. While we were strongly opposed to the proposals made in the consultation to allow detention on the basis of one medical report, we have seen no evidence to suggest that the problems identified by McManus about medical reports have been addressed and we remain supportive of his recommendation to introduce a holistic GP’s second report. We note that a number of respondents during the recent consultation period expressed the view that where GPs have strong links with an individual, they could provide important information. We request that the Committee explores with the Scottish Government the reasons for making no proposals in this area.

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Scottish Government analysis of responses to proposals for a Mental Health (Scotland) Bill, July 2014
Certificates granted under Part 16 of the Act
We note that McManus recommended that expiry dates should be introduced for certificates granted under Part 16 of the Act, authorising specific treatments. It is our understanding that this has not yet happened and we believe that it should.

Mental health law
McManus made a number of recommendations intended to address the lack of appropriately qualified and experienced solicitors available to represent people who are the subject of applications to the Tribunal. In particular he recommended that new undergraduate or short postgraduate courses in mental health law should be set up, and that further in-service training should be offered. We recognise that these are not matters for primary legislation but strongly believe that this issue is affecting the quality of legal representation available and should be addressed.

Advocacy
The McManus Review of aspects of the 2003 Act reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland. Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. We note that the existing Act contains a right to advocacy for everyone with a mental health problem, but would suggest that the problems outlined by McManus have not been resolved. We understand that the Scottish Independent Advocacy Alliance intends to propose solutions in its evidence to Committee and we believe these should be carefully considered.

‘I’ve been offered nothing! Absolutely nothing. But maybe because my husband’s been my carer, maybe they’ve not felt there’s a need for any kind of advocacy, you know … There’s a lot of lack of communication and it needs to be sorted out.’

SAMH research participant

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

Sections 25-27
Sections 25-27 of the current Act place obligations on local authorities in relation to people who have a mental disorder and are not currently in hospital, requiring them to provide care and support services, and services which promote wellbeing and social development. For some time, SAMH has been raising the issue that no-one has responsibility for monitoring local authority compliance with sections 25-27. As the largest mental health social care provider in Scotland, SAMH has had direct experience of the impact of substantial funding cuts on the provision of such services. We would suggest that now, more than at any other time since the introduction of the Act, it is particularly important that local authorities’

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implementation of these duties is monitored. We suggest that such a responsibility be built into existing care inspection regimes such as those operated by the Care Inspectorate.

**Mental Health Officers**

The Bill introduces new duties on MHOs: for example they will be required to give consent for prison to hospital transfers and to send a report to the Tribunal when a orders are to be extended. We welcome these new duties but are concerned about the capacity of MHOs to deal with them and believe that action is needed to increase the number of MHOs. In his review, McManus noted the shortage of qualified MHOs willing to practice as a matter of concern and reminded local authorities of their statutory duty (Section 32 (1) of the Act) in this regard.

Alarmingly, the number of trainee MHOs has decreased from 59 in March 2012 to 33 in December 2012: the lowest number since the survey began, and a substantial decrease from the 105 trainee MHOs recorded in 2008. The high proportion of current MHOs who are above the age of 50 completes this extremely worrying picture.

We need action to recruit, train and retain MHOs, in order to reduce the evident pressure on the current workforce. This is particularly the case since MHOs often act as Care Managers and as service leads on areas such as drug and alcohol addictions or learning disabilities, in addition to their duties under the Act. We suggest that the Scottish Government should, as part of its workforce planning, reviewing the duties, conditions and incentives of MHOs.

**Conclusion**

We thank the Committee for the opportunity to put forward our evidence and hope to have the chance to discuss it with members.

**SAMH**

**August 2014**