October 2005, whilst also
acknowledging that the Mental Health (Care and Treatment) (Scotland) Act
2003 has greatly changed the way in which law and practice in mental health
has been delivered to the benefit of the service users.

Given this we would support the general policy direction set by the Bill.

In some areas the Bill proposes further duties and responsibilities for Mental
Health Officers. The increase in duties is accepted as appropriate and
provide for good practice. However this needs to be considered alongside
national MHO workforce and capacity. Local Authorities need to ensure that
they are sufficiently resourced to enable them to meet their statutory duties
and responsibilities in this area. A review of MHOs in Scotland should be
undertaken particularly in relation to recruitment and retention. Additional
payments for MHOs vary across the country and in some Authorities there is
no remuneration for qualifying as an MHO. A review of this is vital if we are to
encourage and recruit a new and vibrant MHO workforce.

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.

Most of the changes proposed in Part 1 of the Bill are viewed as positive and
promote further the interests of service users in line with the Principles of the
Act.

The proposed changes to the emergency and short term provisions are
viewed as very positive in the main. However there is a concern regarding the
exercise of a Hospital Managers’ discretion. It was felt that this needed to be
informed by the RMO /GP in relation to any information that may be of a
sensitive nature before exercising discretion.

We have no concern regarding notification of the granting of the order to
relevant parties, but we did note concern in relation to the circulation of full
papers to named person, carers etc. and did not feel that this was necessary
or appropriate. Concern is to be noted in relation to this if default Named
Person is being retained, particularly where there may be information of a
sensitive nature. Even with the proposed changes to the Named Person there
would still be a default position when the service user is very unwell, has no
named person and at point of detention is not capable of nominating a named
person. In this case, named person would fall to the default position until
service user was well enough to consent to default being named person or able to nominate another person of his/her choosing.

The other proposed changes to Named person were welcomed and viewed as positive i.e., opt out system and named person’s consent to undertaking the role. Repealing the power of the Tribunal to appoint a Named Person on application where no such person exists and retention of Tribunal power to remove a Named person is felt to be positive.

The suggestion of establishing a register for Named Person was put forward, as is proposed for Advance Statement, and that these could possibly be incorporated.

The proposed amendments to the Advance Statements are welcomed and are seen as potentially assisting with increasing the number of Advance Statements completed. The statements would require to be updated regularly with any changes and previous statements revoked. There should be clear procedures and clarity as to where the Advance Statement should be forwarded to within Health Boards and who will be responsible for the administration of this. Having a register held by the Mental Welfare Commission is really positive, but Health Boards need to keep them informed of changes, updated statements etc. in order that the register is kept up to date.

We also note that there may need to be guidance on who should be able to access the register and how this can be accessed, when necessary, out of hours. We would also suggest that copies of Advance Statements should be forwarded to MHOs.

In relation to Short term detentions we view the extension of the 5 working days to 10 as very positive and of clear benefit to the Mental Health Tribunal’s administration processes together with benefit to service users, carers, and named person. This could have been viewed as a restriction on service users’ liberty, but the provision to ensure that the proposed extension will not increase the continuous period of detention of 56 days, nor the 6 month period for Section 64 would appear to offer a balance to this. It will be interesting to have service users’ views on this.

The extension of the Nurse’s holding power from 2 to 3 hours is a positive change as it can often be difficult to access an AMP/RMO within the two hours. However it would be helpful if MHO and AMP/RMO are notified at start of Nurse’s holding power or as soon as possible afterwards in order for them to attend as soon as is possible. There is some slight concern about the use of this within the context of pressurised RMO resources and the impact of this on the least restrictive principle for service users if the full 3 hours was frequently used.

Extending the list of specified measures in Section 36(2) to include a reference to Section 113 (5) is viewed as appropriate and as an omission in the current Act.
The proposed amendments to Section 87 are viewed as good practice. MHOs locally regularly complete Section 86 extension and variation reports for the Tribunal and the RMO as standard practice. We currently use a prescribed proforma which records information as outlined in Section 87 A (4) (d) of the proposed amendments. We are of course not legally obliged to prepare a record at present, which allows us to dispense with the report if the workload capacity of MHOs is particularly high at any time. This will not be possible with the proposed amendments.

Demand for CTOs may be lower locally than for other larger areas however this is proportionate to the per head of population qualified MHOs workforce. CTO proposals may have an impact on workload for MHOs over and above SCR completion in terms of the number of reports required.

We would like to comment on the proposed changes which involve further duties on MHOs around notification in this area i.e., sending copies of reports to patient, RMO’s, Named Persons, Mental Welfare Commission etc. We are of the view that the Mental Health Tribunal is best placed to do this when the report is forwarded to them or perhaps this is a role for medical records.

It is important for RMOs to notify and discuss plans to extend a CTO with the MHO in a timely manner.

We assume that these arrangements would also apply to Compulsion Orders but this is not specifically stated.

The proposal to place a duty on the MHO to notify the Mental Welfare Commission when applying for a removal order is viewed as appropriate.

In relation to suspension of orders when someone is subject to a community based order, and their condition deteriorates, they can be made subject to an emergency or short term detention and admitted to hospital. We think it is appropriate that Sections 43 and 56 within the Act are amended as per Section 7 of the Bill to include those subject to a compulsion order and interim compulsory treatment order.

The current provision for suspension of detentions for those subject to a Compulsory Treatment Order has been viewed as potentially bureaucratic and complicated. The proposed amendments to this would be welcomed. The 200 day i.e. 6 month limit would be viewed as less restrictive for service user as the RMO should consider varying an order to a community based order or revocation of the order altogether before reaching this limit.

We are of the view that it is appropriate that any extension to this i.e. 100 days should be approved by the Mental Health Tribunal. We are of the opinion that these extensions would only be requested in exceptional circumstances i.e., someone who is undergoing a long phased return to the community after a lengthy spell in hospital to assess risk etc.
In relation to restricted patients, whereby suspension periods are granted by RMOs with consent of Scottish Ministers, MHOs are largely in agreement with two specific circumstances that prior consent of Scottish Ministers not required i.e. to enable a patient to attend Court, or necessary medical or dental appointment. MHOs would wish to maintain informing of Scottish Ministers to ensure that necessary information is communicated with regard to patient safety in the community.

The removal of the restriction for the Convener of the Tribunal Panel to be either a Tribunal President or to be selected from the Shrieval Panel is viewed as a positive step which would reduce administration and running costs and allow for more flexibility when scheduling Hearings.

Involving the MHO in the process of Transfer for Treatment applications, Secton 136, would offer another level of scrutiny for the service users, ensuring that their rights etc. are upheld within the process. There would need to be clarity as to which Local Authority would respond to the request from the Prison Service for an MHO in these circumstances. It would likely be the Local Authority where the service user last resided that would pick this up. A contingency plan may need to be in operation in that an MHO from the Host Authority would be available should an MHO from the relevant Authority be unable to respond within the specified timeframes.

The amendments to Section 268 of the 2003 Act by Sections 11 &12 of the Bill, are viewed as appropriate, which would offer more service users the right to appeal against excessive security.

The change whereby service users will be able to move to lower security settings within the same hospital could be viewed both positively and negatively. On the one hand it would afford the service user an opportunity for further rehabilitation at a lower level to take place in a familiar environment. But, on the other, moving to another hospital gives the service user an opportunity to learn to cope with change and to become familiar with a different environment which could possibly result in an easier transition to the community.

In relation to proposed amendments to services and accommodation for mothers i.e., Section 24 of the Act, this is viewed positively. It is felt to be less discriminatory and more inclusive of mothers who are admitted to hospital for treatment for other mental disorders and not just for post natal depression.

Changing the existing provisions re help with communication at medical examinations is very welcome.

There were no concerns raised in relation to proposals to extend cross border transfer to include patients from outwith the U.K. from other EU countries.
3. **Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?**
Amendments in relation to assessment orders, treatment orders, interim compulsion orders, compulsion orders, hospital direction orders, appear to be minor and appropriate and would appear to come into line with other computation periods in the criminal courts generally.

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?**
We would agree in principle with extending the Criminal Justice victim notification scheme to include victims or the relatives of mentally disordered offenders. There would be concern if this were to include those service users subject to a compulsion order, who may have committed only a minor offence and this should be discussed on a case to case basis.

There is a requirement for clear and consistent guidelines around this and clarification of roles and responsibilities, boundaries and accountability. We were of the view that MAPPA could be key in this process as Police have access to wider information and may make other suggestions.

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.**
No other pressing issues identified.

6. **Do you have any other comment to make about the Bill not already covered in your answers to questions above?**
In general it was felt that most of the proposals were positive and will help to improve the efficiency of the mental health system i.e. scheduling of hearings, administration of calculating suspension etc. It also helps to improve rights and interests of service users, carers in line with the Principles of the Act.

We felt that the changes overall tried to reflect the views within the consultation process and in the McManus Report.

As stated in the introduction, the changes do give rise to additional duties and responsibilities on the MHO workforce. Any additional costs arising from these duties would require to be resourced. Workforce planning is required in relation to the MHO staff group at a national level.

**East Renfrewshire Community Health and Care Partnership**
**August 2014**