Glasgow City Council Social Work Services

Mental Health (Scotland) Bill

It disagrees with some of the proposals in the Bill which it thinks undermine the rights of individuals and seem designed to deal with administrative and organisational failings. It disagrees with the transfer and increase on functions and duties to MHOs and the increased costs to local authorities.

These include the increase in the length of detention before someone appears at tribunal (subsequent reduction in detention doesn’t properly mitigate this), changes to the rules and organisations of medical reports and the changes around “named persons”.

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

In terms of the general policy direction set by the Bill, we largely agree with the March 2014 ADSW response to the consultation on draft proposals for a Mental Health (Scotland) Bill, in that there are elements of the Bill which are seen to be positive in that they address existing gaps with the Mental Health Act.

While the positive elements with the Bill reflect current good practice, there are elements of the Bill which raise questions and concerns about the practical application of the proposed amendments and the potential impact that these may have on service user’s rights and the resources of local authorities (where there is proposal to transfer or increase duties of Mental Health Officers).

The propositions to further increase the duties and responsibilities of Mental Health Officers (MHO), as well as the proposed transfer of some duties currently within the remit of Responsible Medical Officers (RMO) continues to raise concerns, particularly around the current capacity of the MHO workforce and the cost implications to local authorities.

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?

The proposed amendments to the Advance Statement are welcomed, although we would reiterate the ADSW request that consideration be given to the introduction of a recommended pro-forma incorporating an advisory note to the effect that it requires to be submitted within a specified timeframe following completion to be effective and will require to be reviewed annually (or where there is a change in circumstances) and that it revokes any previous statement. The inclusion of a requirement to forward a copy of the statement to the Commission is welcome; however there are still questions about the potential need for 24 hour access to submitted statements for those parties that require it.
Whilst we broadly welcome the proposed changes in respect of the Named Person, in particular the right to opt in/out for those service users who have capacity, we have concerns about the rights of those service users who do not have capacity and may be discriminated against as they may be left with no Named Person who would be able to appeal on their behalf. We are of the strong opinion that the final bill has to ensure that there is clear protection and safeguarding of those service users who do not have a Named Person.

Regarding the suspension of orders, we are of the view that the proposed changes make no reference to MHO involvement and/or consent in the RMO application to extend suspension. This is specific to the MHO role, and we highlight that any suspension arrangements should be part of care plan.

In addition, we feel that clarity is required regarding the upper limit of suspension timeframes before extension, as the Bill and associated Policy memorandum appear to indicate that a ‘day’ in the 200 day upper limit must include overnight. It was felt that this may make the upper limit redundant in a circumstance where a service user is out every day returning to the hospital at night. We feel that a more practical application of the upper limit within suspension orders would be to discount any suspension time that was formal and supervised (i.e. spent with the clinical team), and count all informal and unsupervised time towards the upper limit with a day counted in 4, 8 or 12 hour blocks rather than an overnight stipulation.

We also noted that, if an extension to the suspension of an order was being sought after the 200 days upper limit had been reached, then a variation of order should be sought – or some other hearing – with MHO involvement.

We have concerns about the proposed changes to the procedure for Compulsory Treatment Orders, specifically the proposal to change the automatic period of extension beyond the date that the short term detention certificate is due to expire from 5 working days to 10 working days. We have two issues with this. Firstly, the proposal states that any extension to the period of detention in these circumstances would not increase the continuous period of detention. This implies that time would be removed from the end of the detention period. We had concern that this not only implies that the detention period is viewed as a “sentence” where time can be “given back”. The only criteria for reducing a detention period should be that of service user safety with a robust care plan in place.

Secondly, the Bill and the supporting Policy Memorandum strongly imply that the driver for this proposed change is to enable more effective administration process. We find it difficult to support a change that would have an impact on service user’s rights when the driver appears to be one of administrative efficacy.

Furthermore to this, we would question whether the proposed change will alleviate the issue outlined in the Policy Memorandum, as there would remain a risk that RMOs would continue to submit relevant reports “at the wire” We
feel that making the system better (rather than adjusting potential periods of detention would be a more pragmatic and effective approach.

We fully agree with the previous ADSW response in relation to the proposed amendment requiring an MHO to submit a written report to the Mental Health Tribunal when considering a requested extension to a CTO.

In addition to the above, it was noted that the proposed transfer of responsibilities from Health Boards and RMOs to Local Authorities and MHOs in respect of medical examinations, which was part of the consultation responded to by the ADSW in March 2014 is not included in the draft Bill presented here, however we would like it noted that we support the ADSW response to this previous proposal.

We agreed with the principle of the proposals in relation to Orders regarding level of security, and noted that the 6 month timescale is more realistic to identify a suitable hospital on which the Heath Board and Ministers agree than the 3 month timescale currently in place.

We had mixed views on the amendment to the arrangements to transfer of prisoners, and the proposed requirement to bring MHO involvement to the ‘front end’ of the process. The Bill and Policy Memorandum imply that the driver for this amendment is one of consistency, and we were not convinced that this is a sufficient reason.

We also had concerns about the implications on MHO resources, and noted the complex arrangements that would need to be in place where the host and placing authority were not the same.

Equally, we recognised that MHO role is already involved in this process at the “back-end”, and noted that bringing this forward would be reasonable in terms of strengthening the checks and balances to safeguard the service user. We would anticipate further clarity and consultation on the application of this proposal that recognises the potential complexity and impact upon Local Authorities and the MHO resources.

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

We had no comments in respect of Part 2 of the Bill.

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 recognised that the introduction of a Victim Notification Scheme in respect of mentally disordered offenders is a complex area, however we agreed that is right to tackle this.

As is outlined in the Policy Memorandum, we agree that the rights of the victim and the offender have to be carefully balanced where the offender is themselves vulnerable.
We feel that the proposed amendments don’t provide for adequate mechanisms for managing feedback from offenders where they are able to do so.

We also feel that the proposed amendments in their current form offer less protection to mentally disordered offenders with learning disabilities, and are concerned that that there may be potential consequences for not having greater clarity about the protection for vulnerable offenders and offenders with no mechanism to articulate their views (e.g. destabilising supervising arrangements).

In this respect, we felt that high risk people, with minimal control over their behaviours, are better protected by the proposed amendments than those who have undergone rehabilitation.

We feel that, in terms of the inclusion of mentally disordered offenders in the Victim Notification Scheme that lessons could be learned from the existing protocols for offenders subject to Multi Agency Public Protection Arrangements and that best practice should be informed by victim support involvement.

Is there anything from the MacManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

We are of the view that the Bill does not, in its current form, reiterate the ten Millan principles about which the McManus Report notes that “there should be a clearer statement of the need for the principles to be observed in all matters relating to mental health, and not only in those governed by the Act (2003)”.

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

We agree with the previous ADSW response that, while generally positive, there are concerns that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.

Again, we would seek to highlight that proposed further increases to the duties and responsibilities of MHO services need to be viewed in the context of MHO workforce and workload capacity not being matched by any increase in the MHO infrastructure. This will incur further costs to local authorities which need to be considered by Scottish Government.

Glasgow City Council Social Work Services
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