I am a Forensic Mental Health Advocate working in Rowanbank Clinic and Leverndale hospital. I have read the consultation document and provide below my response and opinions pertaining to this document.

The consultation document and the Mental Welfare Commission report suggest that there is no evidence of entrapped patients, this is simply not true in my opinion and experience. As there is no low secure facility in the local area for female patients, many have been discharged into the community from medium secure. It seems ridiculous to think that the individual needs to be in a medium secure setting when they are considered such a low risk they are being granted accommodation in the community. This same reasoning applies to male patients being discharged directly from medium secure due to the lack of beds in low secure, of which there have been a number of cases recently. RMO's have admitted they are trying to move more people on into the community from medium secure due to the lack of availability in low secure. Furthermore, I have encountered a number of cases of patients in low secure that have been there for a number of years due to lack of suitable accommodation and could be considered entrapped. I will now detail some specific cases on entrapment from my caseload.

- Patient A has been in low secure ward for a number of years. He has an acquired brain injury and suffers from Polydipsia, a compulsive need to drink water. Due to this and his brain injury, he needs constant supervision to ensure he does not drink excessively and hurt himself. At his most recent tribunal, it was his position that he did not require hospital care and was seeking conditional discharge. The RMO was of the position that he could be cared for in the community if suitable accommodation could be found, but this had not been found so far. The process of looking for housing has gone on for a number of years and continues to this day. If appeals against excessive security were enforced, patient A would be able to appeal and if successful place a statuary duty on the authority to find a place within a certain timescale, rather than the patient be continually told that the MDT is still looking and being held in low secure.
- Patient B has been in low secure for a number of years and is working towards discharge. He cannot progress until a housing assessment has been completed and housing identified. His MHO has missed a number of meetings, has failed to complete an assessment and is not responding to communication from Advocacy and members of the MDT. This patient can be considered entrapped as he does not need the level of security he is currently in as he is considered suitable for community accommodation and he cannot progress due to circumstances outwith his control. Additionally, this patient had previously be referred to an open ward, further showing he does not need the security he is in now, but this attempt was abandoned due to lack of beds.

These are by no means the only cases, and my colleagues at Circles Network have seen a number of cases over the years that clearly demonstrate entrapment and cases where patients would have benefited from appeals against excessive security. Indeed, in the past year, I have been approached by a number of patients that have asked if they can appeal against excessive security.

The suggestion to repealing the whole section of the act would be grossly unfair, as this was an intended power of the act and there is an issue with patients in medium and low being entrapped. This is not a suitable or appropriate response for the Government to make. The section was included in the Mental Health (Care and Treatment) (Scotland) Act 2003 by the Milan committee for a reason, because they realised there was a clear and present problem with entrapment within security levels other than the state hospital. Removing the whole section directly contravenes the principle of the least restrictive option which is central to the Mental Health Act.

The report cites as a problem the extra time and pressure section 268 appeals would cause for psychiatrists. While I appreciate this concern and understand the workload and pressure they are under, I do not think this would be a problem due to the small number of patients that would be eligible and want to appeal. Also, this to me does not seem to be a patient centred focus. The idea of the new Mental Health Act was to put the patient at the centre of the process, and denying them an option of an appeal on the basis that RMO's don't want more to do seems to directly conflict with a patient centred focus.

The suggestion of needing a supportive preliminary hearing seems unfair and unsuitable. This is not the case for other tribunals that appeal against the order, and therefore I would consider this to be a discriminatory practise and possibly infringing the right to a fair trial. Additionally, due to the way legal aid is funded, the patient would not be able to receive legal aid until the full tribunal was convened and would therefore have to pay on a means tested basis for all work up to and including the preliminary hearing. This further demonstrates how this would be a discriminatory practise.

I do not think recorded matters can deal with the issue of security adequately, recorded matters only make recommendations and cannot enforce an action. Additionally, these are only available for civil cases, which would therefore not deal with the issue of security for those on CO or COROs. This again I believe would be an unfair and a discriminatory practise.

Using two year reviews more to deal with security issues is also not appropriate. Firstly, patients would have to wait for two years for security to be looked at which seems discriminatory. It would also seem to suggest that it is perfectly acceptable to hold someone in conditions of excessive security for up to two years, this can simply not be acceptable. Two year reviews also only happen if patients have not appealed within this period, and would discriminate against patients wanting to appeal against their order and deal with security issues.

Many patients at Rowanbank are being considered for community placements instead of going to low secure. If patients are considered suitable to be conditionally discharged into the community, then surely they d not need the security restrictions of medium secure until the day of discharge. Additionally, the reason that many patients are referred from Rowanbank to the community is that there are no beds available in low secure, which is due at least in part to the fact that many in Low secure are awaiting accommodation being identified, and could therefore also be considered to be held in conditions of excessive security. I think if section 268 is activated, it is essential that qualifying hospitals and patients include those in low secure as well as

medium or the result will be a bottle necking of patients in low secure, further increasing the pressure on these services and resulting in more patients held in conditions of excessive security in medium and low secure settings. Furthermore, I believe that it is also important for section 268 to include movement between different wards in the same hospital as patients are also entrapped in this way.

To conclude, there is clearly a problem of entrapment in medium and low secure settings which needs addressed in some way. The suggestions of recorded matters, preliminary hearings and two year reviews being used instead of section 268 are not appropriate and would discriminate a number of patient groups. I believe section 268 needs to be enacted for appealing in medium and low secure settings, as well as allowing for movement between wards.