These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

MENTAL HEALTH (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Mental Health (Scotland) Bill introduced in the Scottish Parliament on 16 September 2002:
   • Explanatory Notes;
   • a Financial Memorandum;
   • an Executive Statement on legislative competence; and
   • the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 64–PM.
INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

REFERENCES AND KEY TERMS

4. Throughout the notes, certain expressions are used either as convenient abbreviations or as having the particular meaning given to them by section 228 of the Bill, or in other sections in relation to particular Parts or sections of the Bill. Apart from “mental disorder”, which is discussed in paragraph 27 below, the most important of these expressions are as follows:

(a) “the Bill” means the Mental Health (Scotland) Bill 2002;
(b) “the 1984 Act” means the Mental Health (Scotland) Act 1984;
(c) “the 1995 Act” means the Criminal Procedure (Scotland) Act 1995;
(d) “the 2000 Act” means the Adults with Incapacity (Scotland) Act 2000;
(e) “approved medical practitioner”: a doctor certified by a Health Board as having special expertise in the diagnosis and treatment of mental disorder;
(f) “the Commission”: the Mental Welfare Commission for Scotland, continued in existence by Part 2 of the Bill;
(g) “designated medical practitioner”: a doctor authorised by the Mental Welfare Commission to give second medical opinions for certain medical treatments under Part 13;
(h) “mental health officer”: a qualified social worker appointed by the local authority with responsibilities including consent to emergency and short-term detention and making application for compulsory treatment orders;
(i) “named person”: A person who is entitled to protect the interests of the patient in relation to compulsory measures. The procedure for appointment is set out in Part 14;
(j) “patient”: a person who has, or appears to have, a mental disorder (who need not be in hospital);
(k) “responsible medical officer”: The doctor with primary responsibility for a patient's medical treatment;
(l) “the Tribunal”: the Mental Health Tribunal for Scotland established under Part 3 of the Bill.
SUMMARY AND BACKGROUND

5. The Bill makes provision for the following matters concerning the care and welfare of people with mental disorders:
   - compulsory care and treatment;
   - the powers and duties of the Mental Welfare Commission for Scotland;
   - arrangements for the care and treatment of mentally disordered offenders;
   - protection from neglect and abuse;
   - the duties of local authorities to provide care services;
   - the rights of mental health services users and their carers.


7. The major changes are in the provisions for compulsory care and treatment. These include the introduction of a new judicial body, the Tribunal, to oversee detention and compulsory treatment; new criteria which must be met before compulsory care and treatment may be applied; and the introduction of a flexible form of compulsory treatment order. The Bill also makes significant changes to the arrangements for dealing with mentally disordered offenders who are subject to special restrictions. The Bill updates the duties on local authorities to provide care services for people with mental disorders, and introduces a new duty on local authorities and the NHS to secure advocacy services.

OVERVIEW

8. Part 1 sets out principles which should be applied in relation to the exercise of certain functions under the Bill.

9. Part 2 and schedule 1 make provision for the constitution and general functions of the Mental Welfare Commission for Scotland.

10. Part 3 and schedule 2 establish the Mental Health Tribunal for Scotland.

11. Part 4 sets out various local authority and NHS functions

   - Chapter 1 sets out the duty of Health Boards to maintain a list of ‘approved medical practitioners’, who have various responsibilities under the Bill in relation to compulsory care.
• Chapter 2 sets out the duties on local authorities to secure a range of care and support services for people with mental disorders, the duty of local authorities to provide mental health officers, and sets out the responsibilities and powers of local authorities and mental health officers to make enquiries and to take protective measures when it appears that a mentally disordered person in the community may be at risk.

12. Part 5 contains procedures allowing medical practitioners to initiate detention in hospital for up to 72 hours in cases of emergency.

13. Part 6 sets out procedures and safeguards in respect of short-term (up to 28 days) detention.

14. Part 7 contains the detailed provisions concerning long term compulsion under civil procedure. It creates a new order, the compulsory treatment order.

• Chapter 1 sets out the procedures for making an application to the mental health Tribunal for a compulsory treatment order, the powers of the Tribunal on receiving an application, and the measures that may be authorised under a compulsory treatment order.
• Chapter 2 sets out the arrangements for review of compulsory treatment orders. It also sets out the rights of patients and named persons to seek variation or termination of a compulsory treatment order.
• Chapter 3 contains the procedures for temporary suspension of the order and sets out the effect of non-compliance with a community based order. It also contains provisions allowing temporary suspension of compulsory treatment orders, and for the transfer of detained patients between hospitals.

15. Part 8 contains provisions concerning mental health disposals in the criminal justice system.

• Chapter 1 deals with persons in the criminal justice system who have not received a final disposal. It creates 2 new disposals where an accused person appears to be mentally disordered: the assessment order and the treatment order. It also establishes an interim compulsion order, replacing the current interim hospital order.
• Chapter 2 deals with mental health court disposals for convicted persons. It replaces the current hospital order with a compulsion order.
• Chapter 3 sets out procedures under which a prisoner serving a sentence may be transferred to hospital for treatment for mental disorder.

16. Part 9 sets out the effect of a compulsion order (without restrictions) imposed on a mentally disordered offender.
• Chapter 1 provides for the appointment of a responsible medical officer and for steps to be taken by the mental health officer on the making of a compulsion order.
• Chapter 2 sets out arrangements for the initial review of compulsion orders.
• Chapter 3 sets out arrangements for further reviews of compulsion orders.
• Chapter 4 provides for the transfer between hospitals of patients subject to compulsion orders.

17. Part 10 sets out the effect of a compulsion order with a restriction order imposed on a mentally disordered offender.

• Chapter 1 provides for the appointment of a responsible medical officer and for steps to be taken by the mental health officer on the making of the order.
• Chapter 2 sets out procedures for review.
• Chapter 3 contains provision concerning the recall to hospital of a patient who has been conditionally discharged.
• Chapter 4 provides for transfers of restricted patients between hospitals.
• Chapter 5 deals with temporary release from detention (generally called leave of absence).

18. Part 11 contains provisions regarding the effect of a hospital direction, which provides for an offender given a prison sentence to be initially admitted to hospital.

19. Part 12 sets out the effect of a transfer for treatment direction, which operates to transfer a person serving a prison sentence to hospital.

20. Part 13 deals with medical treatment. It sets out the responsibilities of the Mental Welfare Commission to appoint designated medical practitioners and the authority of the responsible medical officer to provide treatment to persons liable to be treated compulsorily. It also contains additional safeguards for particular treatments.

21. Part 14 contains measures for patient representation and support, through duties to support advocacy, and by the creation of the named person, who has rights to appeal against and oppose compulsory measures.

22. Part 15 contains a range of miscellaneous provisions about a Code of Practice; the duties to provide accessible information to patients; rights of patients to make advance statements; regulation of security measures in hospital; the powers of the police and nurses to detain mentally disordered persons for short periods in an emergency; and a power for the Tribunal to intervene when an informal patient may be unlawfully detained.

23. Part 16 deals with the arrangements under which a person who is absent without leave from detention or certain compulsory treatment orders may be recalled.
24. Part 17 contains offences directed at sexual abuse or ill-treatment of mentally disordered persons, as well as an offence of obstruction.

25. Part 18 sets out the procedure for and grounds of appeals from the Mental Health Tribunal to the sheriff principal and the Court of Session.

26. Part 19 makes general provision for prescribed forms, regulations and directions, interpretation, and consequential and transitional provisions.

"Mental disorder"

27. The expression “mental disorder” is used throughout the Bill. Mental disorder is defined in section 227 as being divided into three categories: mental illness, personality disorder and learning disability, however caused or manifested.

Table of compulsory measures

28. The table below lists the principal compulsory measures which are provided for in the Bill and the nearest comparable provision in the 1984 Act or, in some cases, the 1995 Act.

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| **Interim compulsion order**: Section 93: allows an offender to be assessed in hospital prior to sentencing, particularly relevant for high risk offenders. | Section 53 of 1995 Act (interim hospital order) |
| **Compulsion order**: Section 95 and Part 9: on conviction the court may sentence the offender to receive compulsory treatment. | Section 60 (effect of hospital orders), 58 1995 Act (making of hospital orders) |
| **Restriction order**: Part 10: granted in conjunction with a compulsion order – for those who require additional scrutiny as they progress through the mental health system. | Section 62 (effect of restriction orders), 59 1995 Act (making of restriction orders) |
| **Hospital direction**: Part 11: on conviction the court may sentence the offender to a prison term but with a requirement to commence that term in hospital. | Section 62A (effect of hospital directions), section 59A of 1995 Act (making of hospital direction) |
| **Transfer for treatment directions**: Sections 97-99 and Part 12: enables convicted prisoners to move from prison to hospital. May include a restriction direction. | 71 (transfer direction), 72 (restriction direction) |

**COMMENTARY**

**PART 1 – INTRODUCTORY**

**Section 1: General principles applicable to the discharge of certain functions**

29. This section sets out a series of principles which must be considered by persons and organisations with responsibilities under the Bill.

30. Subsections (1) to (3) require Ministers, Health Boards, NHS trusts, hospital managers and local authorities, doctors, nurses and mental health officers to discharge functions under the Bill in a manner which encourages equal opportunities and the observance of the equal opportunities requirements. These requirements include the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disability Discrimination Act 1995. “Equal opportunities” has the same meaning as in the Scotland Act, being “the prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions”.

31. Subsections (6) to (9) apply to any situation where a person is discharging functions in relation to Parts 4 to 7 of the Bill (which relate to functions of Health Boards and local authorities, emergency and short-term detention and compulsory treatment orders). Subsections (6) to (8) and (10) apply to any decision under the Bill about medical treatment. Amongst the situations where these provisions would require to be applied would be where any doctor or mental health officer is taking a decision concerning emergency or short-term detention, or applying for, renewing, or seeking to vary compulsory powers. They would also apply to
individual decisions by a responsible medical officer or designated medical practitioner about particular medical treatment which might be authorised under Part 13 of the Bill.

32. The matters which fall to be considered can be summarised as:
   - the present and past wishes of the patient;
   - the views of named persons, primary carers, guardians and welfare attorneys;
   - the range of options available; and
   - what is the approach which affords the least interference with the patient.

PART 2 – THE MENTAL WELFARE COMMISSION FOR SCOTLAND

33. Sections 2 to 17 replace sections 2 to 6 of the 1984 Act, and set out the general functions of the Mental Welfare Commission.

Continued existence of Commission

Section 2: The Mental Welfare Commission for Scotland

34. The section continues the existence of the Mental Welfare Commission for Scotland which was originally established by the Mental Health (Scotland) Act 1960. Schedule 1 contains provisions as to the membership, organisation and general powers of the Commission.

General duties

Section 3: Duty to monitor operation of Act and promote best practice

Section 4: Reporting on operation of Act

35. Section 3 makes provision for the monitoring of the operation of the Bill and the promotion of best practice by the Commission, and section 4 allows it to inform the Scottish Ministers of any matter relating to the operation of the Act. The specific duty to monitor the operation of the Act is new. The general duty in the 1984 Act was ‘to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests’.

Particular functions

Section 5: Duty to bring matters generally to attention of Scottish Ministers and others

Section 6: Duty to bring specific matters to attention of Scottish Ministers and others etc.

36. The sections together create duties on the Commission to bring matters as respects the welfare of any persons who have a mental disorder to the attention of the appropriate organisations and persons. They replace sections 3(2)(d) and 3(2)(f) of the 1984 Act. Section 5 is directed at general matters of policy and practice, and section 6 allows the Commission to make recommendations when the Commission believes that an organisation or person has the ability to prevent or remedy certain circumstances. The circumstances are outlined in section 9(2) of the Bill and include unlawful or improper detention, ill-treatment, neglect or a deficiency
in the care or treatment of a person with mental disorder, loss or damage to a person’s property and when a person is living alone and is unable to manage their affairs.

Section 7: Duty to give advice

37. The section establishes a duty on the Commission to provide advice when the Scottish Ministers, a local authority, a Health Board or the Scottish Public Services Ombudsman has referred a matter regarding the Bill to them and the Commission has agreed to provide such advice. It replaces section 3(2)(e) of the 1984 Act. The Scottish Public Services Ombudsman has been added to the list. Prior to the passing of the Scottish Public Services Ombudsman Act 2002, the Health Service Commissioner could not investigate matters within the Commission's remit. This will no longer be the case.

Section 8: Publishing information, guidance etc.

38. The section allows the Commission to publish general information and guidance with regard to its functions and also more specific information and guidance following an inquiry under section 9(1) of the Bill or visits to persons who have mental disorder under section 10(1) of the Bill. By virtue of section 17, such advice attracts qualified protection from legal proceedings for defamation.

39. Subsection (2) provides that the Commission may also publish the advice it has given under section 7 of the Bill if the relevant party has agreed to its publication.

Section 9: Investigations

40. The section provides the Commission with the ability to inquire and make recommendations into any case where a person may have a mental disorder and if the circumstances outlined in subsection (2) apply. It replaces section 3(2)(a) of the 1984 Act.

41. The circumstances include: the unlawful detention, ill-treatment, neglect or a deficiency in the care or treatment of the person, the actual or risk of loss or damage to a person’s property and when a person is living alone and is unable to manage their affairs. Sub paragraphs (c) to (e) overlap with the duties of local authorities under sections 28-30 to inquire into cases where the welfare of a mentally disordered person in the community is at risk. The local authority is intended to have the lead role in taking action in such cases, through its powers to provide services and through the powers and responsibilities given to mental health officers. The functions of the Commission are directed towards it having a secondary and investigative role.

Section 10: Investigations: further provisions

42. The section provides powers for the Commission to hold a formal inquiry when it carries out an investigation under section 9(1) of the Bill. It replaces section 4 of the 1984 Act. The Commission can require the attendance of persons, and has the ability to examine witnesses under oath. The proceedings of an inquiry will have the privileges of proceedings in a court.
Section 11: Visits in relation to patients

43. The section gives the Commission a duty to visit persons who are subject to compulsory measures under the Bill or the 1995 Act, or subject to an intervention order or guardianship order or who have granted a welfare power of attorney under the 2000 Act. The section does not specify how often visits must take place, which is at the discretion of the Commission. The duty applies whether the persons concerned are in hospital or the community.

44. In addition to the duty to visit patients subject to formal measures, the Commission may visit hospitals, community mental health facilities and prisons, both to inspect the facilities and to meet service users. The Commission does not, however, act as a regulatory body in respect of care facilities. For community care services, that is primarily the function of the Care Commission, established under the Regulation of Care (Scotland) Act 2001.

45. Subsection (6) allows the Commission to make unannounced visits.

46. This section replaces sub-section 3(2)(b) of the 1984 Act and sub-section 9(1)(e) of the 2000 Act.

Section 12: Interviews

47. The section provides a power for the Commission to interview mentally disordered persons or other appropriate persons in private, in the exercise of its functions (for example as part of a visit or an investigation). It also requires the Commission, when carrying out visits under section 11, to give patients the opportunity of a private interview.

Section 13: Medical examination and inspection etc. of records

48. The section provides that a person authorised by the Commission may carry out a private medical examination of a mentally disordered person, require the production of medical or other records of the person and inspect those records. It replaces section 3 (5) and (6) of the 1984 Act.

49. Subsection (2) provides that the authorised person must be a medical commissioner or a member of staff of the Commission with the relevant qualifications, training and experience as will be prescribed by regulations. Medical commissioners are appointed in terms of Schedule 1, paragraph 3 (1) (b).

Section 14: Duties of Scottish Ministers, local authorities and others as respects the Commission

50. The section details organisations or persons who must provide facilities for the Commission to carry out its functions. It replaces and extends section 5 of the 1984 Act.
Section 15: Annual report

Section 16: Statistical information

51. Section 15 contains a duty to publish an annual report and section 16 a duty to provide and publish statistical information. Statistical information is likely to be compiled from the information which must be submitted to the Commission under the Bill in connection with measures of compulsory care and treatment.

Section 17: Protection from actions of defamation

52. This provision is new and protects the Commission from actions of defamation unless it can be shown to be acting maliciously. It would apply, for example, to any report published by the Commission as a result of an investigation into deficiencies in the care of a mentally disordered person.

PART 3 – THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Section 18: The Mental Health Tribunal for Scotland

53. The section establishes the new Mental Health Tribunal for Scotland. The Tribunal will act as a judicial body which will authorise compulsory treatment orders and deal with appeals against and reviews of compulsory treatment orders, short-term detention, compulsion orders and other mental health disposals affecting mentally disordered offenders. The Tribunal substantially replaces the role of the sheriff in mental health legislation. The composition of the Tribunal and its organisation and procedures are detailed in schedule 2 to this Bill. Appeals from the Tribunal to the sheriff principal and the Court of Session are dealt with at Part 18.

PART 4 – LOCAL AUTHORITY AND HEALTH BOARD FUNCTIONS

Chapter 1: Health board duty

Section 19: Approved medical practitioners

54. The section places a duty on Health Boards to maintain a list of medical practitioners approved as having special experience in the diagnosis or treatment of mental disorder. An approved medical practitioner has a number of statutory functions under the Bill. At least one of the medical recommendations for a compulsory treatment order must be from an approved medical practitioner, and short-term detention may only be initiated by an approved medical practitioner.

Chapter 2: Local authority functions

Provision of services

55. Sections 20 to 27 replace sections 7 to 11 of the 1984 Act.
These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

Section 20: Care and support services etc.

56. The section places a duty on local authorities to provide, or secure the provision of, services that provide care and support for persons in their area who have, or have had a mental disorder and who are not in hospital. The kind of services which might be provided in implementation of this duty would include services providing practical and emotional support in a crisis, assistance with daily tasks, and accommodation with appropriate levels of support.

Section 21: Services designed to promote well-being and social development

57. The section places a duty on local authorities to provide, or secure the provision of, services that are designed to promote the well-being and social development of those persons in their area who have, or have had a mental disorder and who are not in hospital. It replaces and extends section 11 of the 1984 Act, which is restricted to persons with mental handicap.

58. Examples of services which could be provided in fulfilment of this duty could include training in vocational and social skills, adult education, and access to leisure opportunities.

Section 22: Assistance with travel

59. The section places a duty on local authorities to provide, or secure the provision of, transport for persons to attend or participate in those services outlined in sections 20 and 21.

Section 23: Services under sections 20 to 22: charging

60. The section details amendments to section 87 of the Social Work (Scotland) Act 1968 and sections 2 and 22(1) of the Community Care and Health (Scotland) Act 2002. The amendments have the general effect that:

- a local authority providing a service under sections 20 – 22 of this Bill may recover such charge (if any) for it as they consider reasonable;
- if a person utilises a service provided under these sections and satisfies the authority that they cannot afford to pay the charge for the service provided, the authority must only charge what the person can practically afford; and
- Ministers may by regulations exclude certain services from any charging regime.

Section 24: Relationship between duties under sections 20-22 and general duties under 1968 and 1995 Acts

61. The section makes it clear that the duties established under this Part of the Bill are in addition to the basic social work duties set out in section 12(1) of the Social Work (Scotland) Act 1968 (the general duty to promote social welfare) and section 22(1) of the Children (Scotland) Act 1995, (a duty to provide an appropriate range and level of services to safeguard and promote the welfare of children in need).
Co-operation and assistance

Section 25: Co-operation with Health Boards and others

62. The section establishes a duty on local authorities who provide, or secure services, under this Part of the Bill to co-operate with Health Boards and NHS trusts, and voluntary organisations who have an interest in the provision of those services or a power or duty in relation to the provision of services generally to the person. It replaces and extends the effect of section 8(2) of the 1984 Act.

Section 26: Assistance from Health Boards and National Health Service trusts

63. This section allows local authorities to request that Health Boards and NHS trusts assist them in the provision of care and support services and services for well-being and social development. These NHS bodies are required to co-operate if to do so is compatible with their own responsibilities.

64. Subsection (3) makes it clear that the section does not interfere with, and is in addition to, provisions having similar effect in section 21 of the Children (Scotland) Act 1995.

Appointment of mental health officers

Section 27: Appointment of mental health officers

65. Mental health officers have various functions under the Bill, including consenting to short-term and emergency detention, and making applications for compulsory treatment orders. Although appointed by the local authority, mental health officers exercise an independent professional discretion in relation to their functions under the Bill.

66. This section places a duty on local authorities to appoint sufficient mental health officers for their area. It replaces section 9 of the 1984 Act.

67. The section allows Ministers to specify qualifying requirements for mental health officers. Current directions require that mental health officers should have a professional qualification in social work and have completed an approved training course. It is intended to retain similar requirements. The Bill adds a new duty on local authorities to secure appropriate training for mental health officers.

Duty to inquire into individual cases

Sections 28-30: Duty to inquire

68. Section 28 creates a duty on local authorities to enquire into situations where a person with a mental disorder may be at risk in the community. The creation of this duty implements, in respect of persons with mental disorder, a recommendation of the Scottish Law Commission’s report on Vulnerable Adults (Scot Law Com No 158). Under section 29, local authorities may seek the co-operation of Health Boards and NHS trusts, the Mental Welfare Commission or the Scottish Commission for the Regulation of Care in carrying out such inquiries.
69. The duty to enquire may be satisfied without exercising further statutory powers under the Bill. In situations where this is not possible, section 30 allows a mental health officer appointed by the local authority to seek a warrant from a sheriff or a justice of a peace to obtain access to the person and, if necessary, arrange for a medical examination. Such an examination may be a preliminary to emergency detention or short-term detention under Parts 5 and 6 respectively.

70. The powers vested in mental health officers replace those in section 117 of the 1984 Act.

PARTS 5 TO 7: COMPULSORY TREATMENT

Introduction to compulsory treatment for civil patients

71. Parts 5-7 of the Bill deal with the conditions under which a patient may be compulsorily admitted to hospital for emergency or short-term detention or may be made subject to compulsory treatment in hospital or in the community. The Bill retains the basic framework in the 1984 Act of emergency detention for up to 72 hours, short-term detention for up to 28 days, and long term compulsory measures authorised by a judicial body, initially for up to 6 months. In contrast with the 1984 Act, a patient may be admitted directly to short-term detention. Tribunal approval will be required for long term compulsory treatment orders under Part 7, which supersede both detention and community care orders under Part V of the 1984 Act.

PART 5 – EMERGENCY DETENTION

Section 31: Emergency detention in hospital

The emergency detention certificate

72. In an emergency, the time required for the procedures leading to short-term detention or long-term compulsion may involve an unacceptable delay in view of the need for immediate admission and treatment. Section 31 of the Bill therefore provides an emergency procedure under which a patient may be removed to hospital and detained for up to 72 hours on the strength of a certificate granted by a medical practitioner. This section replaces sections 24 and 25(1) of the 1984 Act.

73. Any registered medical practitioner may grant an emergency detention certificate: it is not necessary for the doctor to be an approved medical practitioner. The doctor granting the certificate must, however, have personally examined the patient on the day on which the certificate is signed or within the previous four hours, whichever provides the greater time.

74. The effect of subsection (2) is that emergency detention may not follow immediately upon an earlier emergency detention or short-term detention.

Consent of mental health officer

75. Subsections (3)(c) and (d) provide that, where it is practicable to do so, the medical practitioner must obtain the consent of a mental health officer about the proposed certificate.
Criteria for emergency detention

76. The grounds which must be met before emergency detention may be granted are set out in section 31(4) and (5). The certifying doctor must be satisfied that the conditions in subsection (5) are met, but need only consider it likely that the conditions in subsection (4) are met. Some of the grounds are similar to those for a compulsory treatment orders (presence of mental disorder, impairment of decision making ability and risk to patient or others). However, they are in modified form to reflect the nature of an emergency situation. Section 31(5)(c) also requires the doctor to be satisfied that, in the circumstances, it would take too long to initiate a short-term detention or seek a compulsory treatment order.

Removal to hospital

77. An emergency detention certificate is sufficient authority to remove the patient to hospital within the period of 72 hours from the time on which the certificate was granted and to detain the patient in hospital for up to 72 hours. The arrangements for the care of the patient prior to removal and for the removal of the patient will, by the very nature of emergencies, vary from case to case.

Patients already in hospital

78. An emergency detention certificate may be granted in respect of the patient who is already in hospital on an informal basis, whether or not the hospital is one in which treatment for mental disorder is normally given for compulsorily detained patients. The procedure for granting an emergency detention certificate is the same as for patients detained from the community.

Sections 32 to 34: Actions following emergency detention

Persons to be notified of emergency detention

79. Section 33 places the managers of the hospital under a duty to inform, within twelve hours of the period of emergency detention commencing, the nearest relative or some other person who normally resides with the patient, and the patient’s named person (where known). If no mental health officer consented to the detention the local authority must also be informed of the detention.

80. Section 32 requires that, within seven days beginning with the granting of the certificate, the medical practitioner who granted the certificate is obliged to inform the hospital managers, the Mental Welfare Commission and, where no consent was obtained from a mental health officer, the local authority of the reasons for granting the certificate, detailing any mental health officer involvement. Under section 34, the Commission must also be informed by the patient’s responsible medical officer of any urgent compulsory treatment administered to the patient (under the provisions of section 171) within seven days of that treatment having been first administered to the patient.

Medical assessment and treatment during emergency detention

81. The hospital managers are required by section 33 to appoint a responsible medical officer and to arrange a medical examination by an approved medical practitioner, who must revoke the
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certificate if not satisfied that the criteria for emergency detention are met. This serves two purposes. Emergency detention may be authorised by a doctor who does not have special expertise in psychiatry, and this provides for an early specialist examination. It also allows, where appropriate, emergency detention to be quickly superseded by short-term detention.

82. Emergency detention, unlike short-term detention, does not give general authority to provide compulsory medical treatment under Part 13 of the Bill. Treatment during emergency detention will normally require either the consent of the patient, authority under the 2000 Act or, in the case of a child, the consent of a person with authority in terms of the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995. Urgent treatment may, however, be administered under section 171.

Absence without leave

83. General provisions relating to absence without leave are to be found in Part 16. They are applied to patients subject to emergency detention by virtue of section 204(1)(c).

PART 6 – SHORT-TERM DETENTION

Sections 35 to 44: Short-term detention in hospital

84. A patient may be detained in hospital for a period of 28 days for the purposes of assessment or treatment of his mental condition where an approved medical practitioner has granted a short-term detention certificate. Unlike the 1984 Act, it is not necessary for the patient to have previously been admitted under emergency detention.

85. This Part replaces sections 26 and 26A of the 1984 Act.

Procedure for initiating short-term detention

86. Under section 35, short-term detention is initiated by an approved medical practitioner, who has examined the patient, determined that the criteria for short-term detention are met, and obtained the consent of a mental health officer. Section 36 provides that, on being asked to consent to short-term detention, the mental health officer must, if possible, interview the patient.

Criteria for short-term detention

87. The criteria are set out in section 35(4). They contain similar criteria to compulsory treatment orders in respect of the presence of mental disorder, impaired decision making ability, risk and the necessity of the order. However, because short-term detention may be required when the nature and effect of the patient’s mental disorder is not clear, it is not necessary to demonstrate that medical treatment is available which would benefit the patient. Instead, the approved medical practitioner must be satisfied that it is necessary to detain the patient either to determine what treatment should be given or to provide medical treatment.

Effect of granting of short-term detention certificate

88. By virtue of section 35(5), a certificate granted by an approved medical practitioner grants authority (where the patient is not already in hospital) for removal to hospital, and
detention for up to 28 days. A patient subject to short-term detention may be given compulsory medical treatment under Part 13 of the Bill. The managers of the hospital where the patient is detained must take steps under section 37 to notify interested parties.

89. Where a patient has been made subject to short-term detention, the mental health officer is under a duty by virtue of section 38 to consider making a social circumstances report. This report is provided to the responsible medical officer and Commission, but plays no formal role in proceedings relating to detention or compulsion. The purpose of this provision is to ensure that there is full investigation by care agencies of the situation of a person who has experienced short-term detention, in order to inform future care planning.

Revocation of detention

90. Throughout the 28 day period, the responsible medical officer is under a duty under section 39 to keep the patient’s situation under review and to revoke the detention if it is no longer required. The patient or named person may appeal to the Tribunal under section 40 for the detention to be revoked. Short-term detention will also come to an end if replaced by a compulsory treatment order.

Extension of short-term detention

91. At the end of the 28 days, the patient may be detained for a further three working days if his condition suddenly deteriorates, in order to enable the responsible medical officer to prepare an application for long-term compulsion. Provisions for this 3 day extension are contained in section 41. The responsible medical officer must be satisfied that: the short-term detention criteria continue to be met; an application for a compulsory treatment order should be made; and it is not reasonably practicable to submit an application to the Tribunal before the expiry of the 28 day period. Where practicable, the mental health officer should be consulted and, where consulted, his consent is mandatory. Section 42 specifies that the patient, the named person, the Tribunal and any guardian should be notified of the extension and related matters.

92. Under section 56, where an application for a compulsory treatment order is submitted to the Tribunal before the expiry of short-term detention, the patient may be further detained for a period of five days beginning with the day on which such application is made. The purpose of this extension is to enable the Tribunal to hold at least a preliminary hearing prior to the expiry of detention.

Effect of subsequent orders

93. Sections 43 and 44 provide respectively that the granting of a short-term detention certificate supersedes an emergency detention, and a compulsory treatment order supersedes a short-term detention.

94. Section 35(2) provides that a patient may not be re-detained under short-term detention immediately following the expiry of an earlier period of short-term detention.
Leave of absence

95. A patient may be granted leave of absence under section 90 from short-term detention at the discretion of the responsible medical officer.

Absence without leave

96. General provisions relating to absence without leave are to be found in Part 16. A patient who is absent without leave from short-term detention is liable to be re-admitted while the 28 detention period lasts, by virtue of section 204(1)(a).

PART 7 – COMPULSORY TREATMENT ORDERS

97. Part 7 of the Bill sets out the procedures for making and the effect of compulsory treatment orders. These are orders made by the Tribunal which authorise various compulsory measures. The order can only be sought by a mental health officer, who is required to apply on receiving medical reports. A compulsory treatment order lasts for 6 months, unless revoked before then, but may be renewed by the responsible medical officer for a further 6 months, then annually. The measures authorised are specified by the Tribunal. They may subsequently be varied by the Tribunal. The responsible medical officer has powers to suspend the effect of the order for temporary periods, or to revoke it. Patients and named persons have rights to apply periodically to the Tribunal for revocation or variation of the order.

Chapter 1: Application for, and making of, orders

Pre-application procedures

Sections 45-46: Medical examinations and mental health reports

98. Applications for compulsory treatment orders may only be made by a mental health officer. The mental health officer is under a duty to make such an application on receiving two ‘mental health reports’. One of the reports must be by an approved medical practitioner and the other may be by an approved medical practitioner or the patient’s GP.

99. The doctor’s reports must:

- include a statement as to the form(s) of mental disorder from which the patient is suffering, being mental illness, personality disorder or learning disability, and the symptoms and effects of such disorder;
- include a statement that the patient meets the criteria for long term compulsion, as set out at section 45(3);
- set out the compulsory measures which the doctor believes should be authorised;
- be given by a medical practitioner who has personally examined the patient and specify the date of the examination. (The examinations may be made at the same time if the patient or the patient’s named person, guardian or welfare attorney consents. If the examinations are made separately, the interval between the days on which they are made must not be more than 5 days).
100. Both reports must agree on the form of mental disorder (or at least on one such form), and the compulsory measures which are considered appropriate.

**Sections 47 to 51: duties and powers of mental health officer on receiving reports**

101. On receipt of the mental health reports, the mental health officer is required to interview the patient (section 50), take steps to identify the named person (section 47), co-ordinate the preparation of a care plan (section 51), and prepare a report and application to the Tribunal (section 52 and section 45).

102. The application must be submitted to the Tribunal within 14 days of the later of the two medical examinations (section 45(6)).

103. Before making an application, the mental health officer must, under section 48, inform the patient and the named person. Advance notice to the patient need not be given if one of the mental health reports from an approved medical practitioner has indicated that it is not desirable to do so. This does not, however, act to remove the mental health officer’s duty to inform the patient of the application and about advocacy services, at the point at which the mental health officer is preparing the report required under section 50.

104. Section 49 provides that the mental health officer may require that the local authority carry out a community care assessment under the Social Work (Scotland) Act 1968 or a children’s assessment under the Children (Scotland) Act 1995. Such assessments would, by virtue of section 51(4)(b), inform the care plan submitted with the application.

105. The mental health officer’s report must contain the information specified at section 50(3). This includes general background information, confirmation that the patient has been made aware of his rights, and the views of the mental health officer on the mental health reports. The mental health officer is required by section 45 to submit an application whether or not he or she considers the powers sought are appropriate but may express views on the mental health reports under section 50(3). Any difference in views between the mental health officer and the medical practitioners will be a matter for the Tribunal to consider. The report must also give details of any advance statement by the patient (see sections 187-188).

106. Section 51 requires that the care plan must be prepared by the mental health officer in conjunction with the doctors who provided the mental health reports and in consultation with other persons or agencies who will be providing treatment or care to the patient. It must contain information about the needs of the patient, the care and treatment to be provided to meet those needs, and the compulsory measures which are sought. It must also set out any services which are essential to the package of care which the compulsory powers are intended to support.
Application for order

Sections 52 and 53: Consideration by tribunal

107. Section 52 provides that the mental health officer must submit an application to the Tribunal together with the mental health reports, the care plan and the mental health officer’s report.

108. On receipt of an application from the mental health officer, the Tribunal must make arrangements under section 53 to consider it. Section 53(2) and (3) require the Tribunal to afford various persons including the mental health officer, the relevant doctors, the patient and the patient’s named person an opportunity to make representations. Tribunal rules made under schedule 2 to the Bill will set out further procedural requirements, as to notice etc. It is intended to make rules which require a curator ad litem to be appointed to represent the patient’s interests if the patient is unable to instruct representation.

109. The patient and named person will be entitled to be legally represented, and it is intended that legal aid will be available under the Assistance by Way of Representation scheme.

110. The Tribunal will be required to consider whether the patient meets the criteria for making a compulsory treatment order. These are set out in section 53(5) and can be summarised as:

- presence of mental disorder;
- treatment is available which will benefit the patient;
- without such treatment there would be a significant risk to the patient or others;
- the mental disorder means that the patient’s ability to make decisions about treatment is significantly impaired;
- making a compulsory treatment order is necessary.

111. If satisfied that the criteria are met, the Tribunal must also consider what specific measures are appropriate, from the list set out in section 54(1).

112. In determining both of these questions, the Tribunal must have regard to the principles of the Bill set out in section 1(6) to (9), and must take account of all the information before it, including the care plan. The care plan does not form part of the order made by the Tribunal but provides the Tribunal with information to assist in determining whether and what compulsory measures may be necessary.

113. In addition to specifying particular measures which may be authorised, the Tribunal may, if it wishes, specify in the order services which it is necessary for the patient to receive. In doing so, the Tribunal will be informed but not bound by the proposed measures set out in the care plan under section 51(4)(g).
Sections 54 and 55: Measures that may be authorised by a compulsory treatment order

114. The measures which may be authorised by a compulsory treatment order include removal to and detention in hospital or any of a range of measures listed at section 54(1)(c), designed to allow care and treatment to be delivered in the community. Whether or not the patient is in hospital or in the community, the order may or may not specify that the patient is liable to be given compulsory medical treatment in accordance with Part 13 of the Bill. The Scottish Ministers may extend the list of measures which may be imposed by regulation.

115. The initial period for which the compulsory measures are authorised is 6 months. For provisions regarding renewal, see Chapter 2.

Sections 57 to 59: Actions following the making of a compulsory treatment order

116. If a compulsory treatment order is made, a responsible medical officer should be appointed by the hospital managers, the care plan should be placed in the patient’s medical records, and the mental health officer should prepare a social circumstances report. Section 59 has the same effect upon the making of a compulsory treatment order as section 38 does upon a patient being subject to short-term detention. In situations where a compulsory treatment order follows upon short-term detention, the mental health officer may under the discretion afforded by section 59(3) determine that a further report would serve no practical purpose. The social circumstances report need not be submitted to the Tribunal.

Chapter 2: Review of orders

Sections 60 to 63: review of orders by responsible medical officer

117. Unless renewed, a compulsory treatment order will expire after 6 months. If renewed, the order lasts for a further 6 months and must then be renewed annually. Renewal is at the initiative of the responsible medical officer. Sections 60 and 61 require the responsible medical officer, in the two months before the order is due to expire, to:

- carry out or initiate a medical examination of the patient;
- consult the mental health officer and other persons with responsibilities for the care of the patient;
- consider whether it is appropriate that the order be renewed; and
- if the responsible medical officer considers that the order should be renewed, consider whether it would be appropriate to seek a variation of the order from the Tribunal (see section 68(2)).

118. In addition to the duty in the immediately preceding sections to review the order prior to its expiry, section 62 (read alongside section 71) places the responsible medical officer under a duty to consider on an ongoing basis whether the patient still meets the criteria for a compulsory treatment order and, if so, whether the order might require to be varied in any respect.
Sections 64 and 65: Responsible medical officer’s duty to revoke order

119. If, following a review initiated in consequence of any of sections 60-62, the responsible medical officer is not satisfied that the criteria for the making of a compulsory treatment order continue to apply, he or she is required to revoke the compulsory treatment order and to notify the persons listed at section 65(2). Revocation by the responsible medical officer does not require the approval of the Tribunal or any other person, and is not subject to appeal.

Sections 66 and 67: extension of order by responsible medical officer

120. If, following a review prior to the expiry of an order, the responsible medical officer considers that the order should continue to apply in the same form, a duty is placed on him or her to make a determination. This determination has the effect of continuing the order for 6 months (in the case of a review after the initial 6 months of the order) or 12 months (at any other review), subject to the Tribunal’s powers of review, set out in section 77.

121. A record of the determination must be sent to the Tribunal, including reasons and information about the views of the mental health officer. Copies must be sent to the parties listed at section 67(2)(c), subject to provisions allowing notice to the patient to be withheld. The responsibilities of the Tribunal on receiving such a record are set out at section 77.

Sections 68 to 70: Extension and variation of order: application by responsible medical officer

122. The responsible medical officer may decide, on reviewing the order prior to its expiry, that it is still appropriate to have a compulsory treatment order, but that different compulsory powers are appropriate, or that there should be a change to any services recorded in the order as necessary. In that event, section 68 provides that responsible medical officer must, before the expiry of the order, apply to the Tribunal for an order extending the compulsory treatment order in an amended form.

123. This duty, linked to the expiry of the order, is separate from the responsibility of the responsible medical officer under section 71 to seek a variation of the order at any time, if he or she considers that its terms require amendment.

124. Section 70 sets out the information that must be provided in such an application, and section 69 provides similar notice requirements as for an extension of the order under section 67.

Sections 71 to 73: Variation of order: application by responsible medical officer

125. These sections make provision for the responsible medical officer to seek a variation of the order at times other than the date on which the order must expire or be renewed.

126. If at any time the responsible medical officer is satisfied that the terms of a compulsory treatment order require to be varied, there is a duty under section 71 to apply to the Tribunal seeking such variation. The variation may be to the specific powers authorised by the order or to the services recorded in the order as necessary. This may happen, for example, where the
These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

responsible medical officer considers that a deterioration in the patient’s condition means it is no longer appropriate to provide compulsory treatment in the community and hospital detention is required.

127. On making an application, notification must be given to the parties listed at section 72(1), subject to the discretion of the responsible medical officer not to give notice to the patient. Section 73 sets out the information that must be contained in the application.

128. The powers of the Tribunal on receiving such an application are set out at section 79.

Section 74: Mental health officer: duties as respects patient

129. This section imposes duties on the mental health officer, on being notified by the responsible medical officer that the compulsory treatment order has been renewed or that the responsible medical officer is seeking a variation of the order. The mental health officer must interview the patient and give information about the patient’s rights, and about advocacy services.

Sections 75 and 76: Applications by patients etc for revocation or modification

130. The patient and the patient’s named person, and the Commission, may apply periodically to the Tribunal to have the order revoked or varied. This is not possible in the first three months following the Tribunal’s making of the compulsory treatment order. The patient, named person and Commission may apply to the Tribunal when an order is renewed by the responsible medical officer. Each party may also apply twice in the first six months of the order or in any subsequent period for which the order is extended. The powers of the Tribunal on such an application being made are set out in section 79.

Sections 77 to 82: Review of order by Tribunal

131. Section 77 provides that the Tribunal must review the order on an application being made under the foregoing sections. Also, when the order is due to expire, if the responsible medical officer determines that the order should be extended, that determination must be considered by the Tribunal in the circumstances set out in section 77(2). These are that the mental health officer opposes the renewal, or that, at the date of expiry, the order would have been in force for 2 years without having been considered by the Tribunal.

132. Where an application has been made by the responsible medical officer to extend and vary the compulsory treatment order, and there will not be time to determine the application before the order is due to expire, the Tribunal may, under section 78, extend the compulsory treatment order for a period of up to 28 days.

133. Sections 79-81 set out the powers of the Tribunal. At any time when the order is under consideration by the Tribunal, it may revoke, continue or vary the order, provided it has allowed interested parties, including the patient, the named person, the responsible medical officer and the mental health officer, the opportunity to make representations. The Tribunal may also call for
supplementary information, as set out in section 81, and may amend the description of the necessary services specified in the order.

Chapter 3: Miscellaneous

Section 83: Suspension of order

134. This section deals with situations where the responsible medical officer feels that a patient subject to a compulsory treatment order should be given the opportunity of demonstrating that the order might safely be revoked. The responsible medical officer may issue a certificate suspending the effect of the order for up to three months at a time. This provision is entirely at the discretion of the responsible medical officer and can neither be imposed or removed by the Tribunal or any other party. While suspension is in effect, the patient is not obliged to comply with the compulsory measures authorised by the order.

135. This section also deals with the situation where a patient has agreed to be admitted to hospital. This may be for reasons unrelated to the mental disorder. Where a patient is subject to a community based compulsory treatment order and is admitted to hospital, it may be impossible for the patient to comply with the terms of the order (for example to attend certain specified places). In these circumstances, suspension will remove the effect of those conditions which cannot be met while in hospital.

Sections 84 to 86: Non-compliance with compulsory treatment order

136. These sections set out possible steps which may be taken if a patient is not detained in hospital, and does not comply with the terms of a compulsory treatment order.

137. Section 84 applies specifically to a breach of a requirement that the patient attend at specified places for the purpose of receiving medical treatment. The responsible medical officer, with the consent of the mental health officer, may make arrangements to ensure that the person is admitted to hospital or taken to the specified place to receive the treatment. If the compulsory treatment order also authorises compulsory medical treatment under section 54(1)(b), the treatment may then be given under the terms of Part 13 of the Bill.

138. More generally, if a patient does not comply with the terms of the order, and the responsible medical officer considers that there is a significant risk of deterioration in the patient’s mental health, section 85 provides that the responsible medical officer may arrange for the patient to be admitted to hospital. The consent of a mental health officer must be obtained. Except in cases of urgency, reasonable steps must first have been taken to communicate with the patient and give the patient a reasonable opportunity to comply.

139. On admission to hospital, a medical examination must be carried out. Following such examination, the responsible medical officer may grant a certificate under section 86 detaining the patient in hospital for up to 28 days. This is to allow consideration of whether an application should be made to the Tribunal modifying the order to authorise detention in hospital. The named person should be consulted, if practicable, and a mental health officer should be notified.
The mental health officer should seek to interview the patient and the hospital managers should formally notify the patient, the named person and the Mental Welfare Commission.

140. The effect of the certificate by the responsible medical officer is similar to short-term detention under Part 6. It should be revoked by the responsible medical officer if the conditions set out at section 86(1) are no longer met. The patient and the patient’s named person may apply to the Tribunal for the certificate to be revoked. The effect of such revocation would be to reinstate the terms of the existing compulsory treatment order.

Sections 87 to 89: Transfer between hospitals

141. Section 87 specifies the procedure whereby a patient detained under a compulsory treatment order may be transferred from one hospital to another. It replaces section 29 of the 1984 Act. (Patients subject to emergency or short-term detention may be transferred administratively).

Notice of transfer

142. Section 87 provides that the patient should be given seven days notice of transfer except where either it is impracticable or the patient consents to the transfer. The patient's named person and the patient's primary carer should also be given notice of the transfer.

Effect of transfer between hospitals

143. Where a patient is transferred in accordance with section 87, the provisions of the Act apply as if the original compulsory treatment order had specified the receiving hospital. The authority to detain the patient thus passes to the managers of the receiving hospital as if the patient had been admitted to that hospital at the time when he was originally admitted to the hospital specified in the compulsory treatment order. The transfer does not affect the duration of the patient's compulsory treatment order, which will expire at the same time as it would have expired if the patient had not been transferred.

Appeal against transfer

144. Under the 1984 Act, there is no appeal right against transfer, except for patients transferred to the State Hospital. Section 88 provides that a patient may appeal to the Tribunal against the transfer, at any time between being given notice of the transfer and 28 days after the transfer has occurred. In the case of transfer to the State Hospital, the patient may appeal under section 89 up to 10 weeks from the date of transfer.

Criteria for transfer to the State hospital

145. There are no specific criteria for transferring patients between hospitals in Scotland, with the exception of transfers to the State hospital. The criteria which the tribunal must apply on appeal are set out in section 89(5). They replace criteria at section 29(4) of the 1984 Act: ‘that the patient, on account of his dangerous, violent or criminal propensities, requires treatment under conditions of special security, and cannot suitably be cared for in a hospital other than a State hospital’.
Sections 90 and 91: Suspension or variation of detention

146. These sections replace the provisions in section 27 of the 1984 Act concerning ‘leave of absence’. They provide for authorisation for a temporary removal of a requirement to be detained in hospital. The responsible medical officer may suspend or vary the detention requirement and may, under section 90(5), set conditions where he or she considers it necessary in the interests of the patient or for the protection of others. The responsible medical officer may direct that the patient remain in custody during his absence and retains a wide discretion to impose conditions. The responsible medical officer may, for example, require the patient to live in a specified place under the care of a specified person, or to accept visits from doctors or social workers, or to attend at a day hospital or outpatient clinic.

Duration of suspension or variation

147. Section 90(3) provides that the suspension or variation of the detention requirement may be granted for any specified period of not more than six months. (Under the 1984 Act, the maximum period is twelve months.) Authority may be granted for further periods without recalling the patient provided that the total amount of time spent away from hospital under this authority in any twelve months does not exceed nine months. Where a patient might, under the 1984 Act, have been granted leave of absence for a longer period, it is open to the responsible medical officer to apply to the Tribunal to vary the order or, if appropriate, the responsible medical officer may revoke the order.

148. Where a suspension or variation of detention is proposed for a period of over 28 days, the responsible medical officer must consult the patient's general practitioner and the mental health officer prior to granting authority. The Mental Welfare Commission must also be notified of periods of leave of suspension or variation.

Commencement of, and termination of the suspension or variation

149. The RMO may, under section 91, recall the patient before the expiry of the period for which authority has been granted. Extensions to, and recall from leave of absence must be notified to the patient in writing. The RMO may recall the patient where he believes that it is necessary in the interests of the patient or for the protection of other persons. Failure to comply with the terms of the recall would make the patient absent without leave, for which see Part 16. If the compulsory treatment order expires without renewal whilst the patient is absent from hospital, then the patient is discharged from the order and may not be recalled.

PART 8 – MENTALLY DISORDERED PERSONS: CRIMINAL PROCEEDINGS

Chapter 1: Pre-sentence mental health orders

Assessment order and treatment order

Section 92: Mentally disordered persons subject to criminal proceedings: assessment and treatment

150. Section 92 replaces provisions contained in:

(a) section 52 of the 1995 Act; and
Assessment order: sections 52A – 52H

151. Sections 52A and 52B provide that where it appears to the prosecutor (at the pre-conviction stage in the proceedings) or the Scottish Ministers (if the person is in custody) that a person who is subject to criminal proceedings may have a mental disorder an application may be made to the court for an assessment order in respect of that person. Section 52D provides that a court may also make an assessment order on its own initiative without an application being made if it appears to it that the person may have a mental disorder.

152. Section 52C sets out the matters on which the court must be satisfied before it can make an assessment order. The court may make an assessment order if it is satisfied on the evidence of a medical practitioner that:

- there are reasonable grounds for believing that the person has a mental disorder, that detention in hospital is necessary to assess the person’s need for medical treatment and that there would be a significant risk of harm to the person or others if the order was not made; and
- a hospital is available for the person’s admission within 7 days of the making of the order and is suitable for their detention and assessment.

The court must also be satisfied that the order is appropriate in all the circumstances and having regard to any alternative means of dealing with the person.

153. Subsection (6) of section 52C sets out the measures authorised by the assessment order, these being:

- the removal of the person to the specified hospital within 7 days of the making of the order by an authorised person;
- the detention of the person in the specified hospital; and
- the giving of compulsory treatment as set out in sections 170 and 171 of the Bill.

154. Subsection (7) of section 52C details the conditions that form the basis of the assessment and report by the responsible medical officer. The conditions are:

- the person has a mental disorder;
- that medical treatment which is likely to:
  - prevent the mental disorder worsening; or
  - alleviate the symptoms or effects of the mental disorder; is available, and
- if the person were not provided with medical treatment there would be a significant risk of harm to the health, safety, or welfare of the person or the safety of any other person.
155. Subsection (9) of section 52C provides that on the making of an assessment order in respect of a person who is in custody, then a restriction order must also be made by the court at the same time. The court has discretion on the making of a restriction order for any other person in addition to making of the assessment order. The practical effect of the making of a restriction order is that the granting of leave of absence would require the consent of the Scottish Ministers. The intention is that this provides additional scrutiny of those persons who may be a significant risk to public safety.

156. Section 52E provides that if it is not practicable by reason of emergency or other special circumstances to admit the person to the hospital specified in the order, the court and the Scottish Ministers (for those persons in custody) may direct that the person be admitted to another hospital.

157. Subsections (1) to (3) of section 52F provide that the responsible medical officer must report back to the court within 28 days of the assessment order being made on the results of the assessment undertaken. At that time the court can proceed with the case as it sees fit. If it receives the appropriate evidence and reports, the court may make a treatment order continuing the person’s detention in hospital.

158. Subsections (4) to (6) of section 52F provide that if, during the 28 days, there has been a change of circumstances that requires a variation of the order since the order was made, the responsible medical officer can submit a written report to the court. The court may then either confirm, vary or revoke the order. A variation allows the transfer of the person to another hospital. If the court revokes the order, it may take action including committing the person to prison or some other institution.

159. Section 52G sets out the circumstances when an assessment order would cease to have effect due to reasons other than as set out in section 52F. The circumstances are:

- the making of a treatment order;
- the making of a final disposal as defined in section 52A(3); and
- the making of an order as set out in subsection (3) or the imposition of any other sentence.

160. Section 52H sets out the powers of the court to commit a person who was subject to an assessment order to prison or other institution or deal with them as they consider appropriate when an assessment order ceases to have effect. The power does not apply to those situations dealt with under section 52G.

Treatment order: sections 52J – 52S

161. Sections 52J and 52K provide that where it appears to the prosecutor (at the pre-conviction stage in the proceedings) or Scottish Ministers (if the person is in custody) that a person who is subject to criminal proceedings may have a mental disorder, an application may be made to the court for a treatment order in respect of that person. Section 52M provides that a court may make a treatment order on its own initiative without an application being made.
162. Section 52L sets out the matters on which the court must be satisfied before it can make a treatment order and the measures that such a treatment order authorises. Subsections (2), (3) and (4) provide that the court may make a treatment order only if it is satisfied on the evidence of two medical practitioners, one of whom must be an approved medical practitioner, that the conditions as set out in section 52C(7) are met and that there is a suitable hospital available for the admission of the offender within 7 days of the order being made. The court must also be satisfied that the order is appropriate in all the circumstances and having regard to any alternative means of dealing with the person.

163. Subsection (6) of section 52L sets out the measures authorised by the assessment order, these being:

- the removal of the person to the specified hospital within 7 days of the making of the order;
- the detention of the person in the specified hospital; and
- the giving of compulsory treatment as set out in sections 170 and 171 of the Bill.

164. Subsection (8) of section 52L provides that on the making of a treatment order in respect of a person who is in custody, then a restriction order must also be made by the court at the same time. The court has discretion on the making of a restriction order for any other person in addition to the making of the treatment order. The practical effect of the making of a restriction order is that the granting of leave of absence would require the consent of the Scottish Ministers. The intention is that this provides additional scrutiny of those persons who may be a significant risk to public safety.

165. Section 52N provides that if it is not practicable by reason of emergency or special circumstances to admit the person to the hospital specified in the order, the court and (for persons in custody and those persons subject to an assessment order who were in custody prior to that assessment order being made) the Scottish Ministers may direct that the person be admitted to another hospital.

166. Subsection (1) of section 52P provides that the responsible medical officer must submit a report in writing to the court if satisfied that the criteria for the order set out in section 52C(7) (see paragraph 154) are no longer met, or there has been a change of circumstances since the order was made that requires the revocation of the order.

167. Subsection (2) of section 52P provides that if the court are satisfied on the evidence of the responsible medical officer that the matters outlined in section 52C(7) are no longer met or there has been a change of circumstances the court must revoke the treatment order and commit the person to prison or other institution or otherwise deal with the person as they consider appropriate. If the court is satisfied that the person should be subject to the treatment order it must confirm, vary or revoke the order.
168. Section 52R provides that, unless revoked earlier by the Court, a treatment order remains in effect until the case is disposed of or final disposal (as defined in section 52A(3) of the Bill), the making of an order listed in subsection (3) or the imposition of any other sentence.

169. Section 52S sets out the powers of the court to commit a person who was subject to a treatment order to prison or other institution or deal with them as they consider appropriate when the treatment order ceases to have effect. The power does not apply to those situations dealt with under section 52R.

Interim compulsion order

Section 93: Mentally disordered offenders: interim compulsion orders

170. Section 93 replaces section 53 of the Criminal Procedure (Scotland) Act 1995 with new sections 53 – 53E.

171. An interim compulsion order may be made to allow a substantial period for assessment of the offender’s mental disorder, their needs and the risk they may pose to themselves or others, in order to inform the sentencing decision of the court. The order may be made if a court thinks that a sentence of a compulsion order with a restriction order or a hospital direction may be in prospect. The offender has a right of appeal against the order being made under section 60 of the 1995 Act.

172. Subsection (1) of section 53 sets out which persons are eligible for an interim compulsion order, namely:

- those convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or
- those remitted to the High Court from the sheriff court for sentence for an offence punishable by imprisonment.

173. Subsections (2) to (7) of section 53 set out the matters on which the court must be satisfied before it can make an interim compulsion order. Subsection (2) provides that the court must be satisfied on the evidence of two medical practitioners, one of whom is an approved medical practitioner, that the offender has a mental disorder and the matters in subsection (3) are met and it is appropriate having regard to the matters outlined in subsection (4). The matters in subsection (3) are:

- there are reasonable grounds for believing that the conditions outlined in subsection (5) are met;
- there are reasonable grounds for believing that it would be appropriate to make a compulsion order with a restriction order, or a hospital direction as provided for in subsection (6);
- a hospital is available and is suitable to assess the offender within 7 days of the order being made,
• if the hospital is to be a state hospital the court must be satisfied that the criteria as outlined in subsection (7) are also met (see paragraph 174 below);

• it would not be reasonably practicable for the assessment to be made without an interim compulsion order.

174. Subsection (7) provides that the person may be admitted to a state hospital if the court is satisfied that the assessment can only be carried out in conditions of special security and that such conditions of special security can only be provided in a state hospital.

175. Subsection (8) sets out the measures that are authorised when an interim compulsion order is made. These are:

• the removal of the offender to the hospital specified in the order within 7 days of it being made by persons authorised to do so;

• detention in the hospital specified in the order for up to 12 weeks;

• the giving of medical treatment in accordance with Part 13 of the Bill.

176. Section 53A provides that if it is not practicable by reason of emergency or other special circumstances to admit the person to the hospital specified in the order, the court or the Scottish Ministers may direct that the person be admitted to another hospital.

177. Section 53B provides that should a person who has been made subject to an interim compulsion order abscond, a constable has the authority to arrest the person without a warrant. The court can then revoke the order or deal with the offender in any way in which it could have dealt with them if the order had not been made.

178. Subsections (1) to (7) of section 53C set out the provisions for the review and extension of an interim compulsion order after the initial period of up to 12 weeks. Before the expiry of the 12-week period, the court will receive a report from the responsible medical officer with the results of the assessment undertaken to that point and any recommendation as to further renewal for continued assessment or on the appropriate disposal. The interim compulsion order can be extended by a court for further periods of up to 12 weeks, subject to an overall maximum of 12 months. The renewal of an interim compulsion order may be effected without the offender being brought before the court if their counsel or solicitor, who are given the opportunity of being heard, represents them.

179. Subsection (8) of section 53C provides that on receiving the report from the responsible medical officer under subsection (1) and if satisfied that it is appropriate, the court can revoke the order and either make one of the disposals mentioned in section 53(6) or deal with the offender in any way in which it could have originally have dealt with him, except that it cannot make a fresh interim compulsion order.
180. Section 53D sets out that an interim compulsion order will cease to have effect of the court unless either a compulsion order or a hospital direction in relation to the offender, or the offender is dealt with in some other way.

181. Section 53E provides that if an interim compulsion order ceases to have effect, other than in the circumstances provided for in section 53D, then the court can deal with the offender in any way (except it cannot make another interim compulsion order).

Remand for inquiry into mental condition

Section 94: Remand for inquiry into mental condition: time limit for appeals

182. This section amends section 200(9) of the 1995 Act by removing the time limit within which a person may appeal against their committal to hospital under 200(2)(b) of the 1995 Act.

Chapter 2: Mental health disposals

Compulsion order

Section 95: Mentally disordered offenders: compulsion orders

183. Sections 57A to 57C below replace the hospital order provisions of section 58 of the Criminal Procedure (Scotland) Act 1995. The effect of a compulsion order is similar to that of a compulsory treatment order made under Part 7 of the Bill.

184. Subsection (1) of section 57A set out which persons are eligible for a compulsion order, namely:

- those convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or
- those remitted to the High Court from the sheriff court for sentence for an offence punishable by imprisonment.

185. Subsections (2) to (6) of section 57A set out the matters on which the court must be satisfied before it can make a compulsion order.

186. Subsection (2) of section 57A provides that the court must be satisfied on the evidence of two medical practitioners, one of whom is an approved medical practitioner, that the conditions in subsection (3) are met and that the order is appropriate after consideration of the matters in subsection (4).

187. The conditions in subsection (3) of section 57A are:

- that the person has a mental disorder;
- that medical treatment which is likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the mental disorder is available;
• if the person were not provided with medical treatment there would be significant risk to the health, safety or welfare of the person or the safety of any other person; and
• that the making of a compulsion order is necessary.

188. The matters to be considered in subsection (4) of section 57A in the determination of whether the order is appropriate are:

• the mental health officer’s report; and
• all the circumstances (including the nature of the offence with which the person is charged or convicted and the antecedents of the person) and having regard to any alternative means of dealing with the person.

189. Subsection (6) of section 57A provides that the person may be admitted to and detained in a state hospital only if both the medical practitioners who gave evidence under subsection (2) satisfy the court that the medical treatment proposed can only be carried out under conditions of special security and that such conditions of special security can only be provided in a state hospital.

190. Subsection (7) of section 57A sets out the measures that can be authorised when a compulsion order is made. A compulsion order can authorise detention in hospital or community based treatment in the same way as a compulsory treatment order, as provided for in section 54 of this Bill. Unlike a compulsory treatment order there is no provision for a court to record details of services which are considered to be necessary to enable the patient to comply with the proposed measures (see paragraph 113).

191. Subsection (8) of section 57A provides that the descriptions of the person’s mental disorder given by both the medical practitioners in relation to subsection (3) must be the same.

192. Subsection (12) of section 57A provides that the court may also make the person subject to a restriction order at the same time as the compulsion order if the offender has previously been subject to an interim compulsion order or if they are satisfied that the making of an interim compulsion order is not required before the making of a restriction order. The criteria for the making of a restriction order are set out in section 59 of the 1995 Act, as follows: having regard to the nature of the offence with which he is charged; the antecedents of the person; the risk that as a result of his mental disorder he would commit offences if set at large, and that it is necessary for the protection of the public from serious harm. The effects of restriction orders are outlined in Part 11 below.

193. Section 57B provides for the mental health officer, where directed by the court, to interview the person and to prepare a report setting out information relative to the making of the appropriate disposal, including the mental health officer’s views on the medical reports provided under section 57A(2).
194. Section 57C provides that if it is not practicable by reason of emergency or special circumstances to admit the person to a hospital specified in the order, the court or the Scottish Ministers may direct that the person be admitted to another hospital.

Probation with a condition of treatment

Section 96: Amendment of 1995 Act: probation for treatment of mental disorder

195. Section 96(a) amends section 230 of the 1995 Act by removing the 12-month maximum time limit on a requirement of treatment for mental condition. This has the effect that such a treatment requirement can now last for up to the 3-year maximum duration of a probation order.

196. Section 96(b) replaces subsection (3) of section 230 of the 1995 Act with a new subsection (3). The new subsection (3) has the effect that before imposing a requirement of treatment specifying that the offender attend a particular service the court should be satisfied on the evidence from those who provide the service that the service is available.

Chapter 3: Mentally disordered prisoners

Section 97: Transfer of prisoners for treatment for mental disorder

197. Section 97 provides for the transfer of persons from prison to hospital for treatment for mental disorder. Further provisions regarding the effect of such transfers are at Part 12.

198. Subsections (2) to (4) provide that the Scottish Ministers may make a transfer for treatment direction if they are satisfied on the evidence of two medical practitioners, one of whom is an approved medical practitioner, that the following conditions are met:

- the prisoner has a mental disorder;
- that provision of medical treatment which is likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the mental disorder is available
- if the prisoner were not provided with the medical treatment proposed there would be significant risk:
  - of harm to the health, safety, or welfare of the prisoner; or
  - to the safety of any other person;
- that the making of the order is necessary; and
- a hospital is available for admission within 7 days of an order being made and is suitable for the medical treatment of the prisoner.

199. Subsection (5) provides that the person may be admitted to a state hospital only if the Scottish Ministers are satisfied that the medical treatment proposed can only be carried out under conditions of special security and that such conditions of special security can only be provided in a state hospital.
200. Subsection (6) sets out the measures a transfer for treatment direction authorises in relation to the prisoner. This includes the giving of medical treatment under Part 13.

Section 98: Transfer for treatment direction: supplementary

201. The section provides that if it is not reasonably practicable by reason of emergency or other special circumstances to admit the prisoner to a hospital specified in the order, the Scottish Ministers may direct that the prisoner be admitted to another hospital.

Section 99: Restriction direction

202. The Scottish Ministers may also make a restriction direction in conjunction with a transfer direction. Patients subject to a transfer for treatment direction and a restriction direction are subject to the same regime as those patients subject to a hospital direction under Part 11 of the Bill.

PART 9 – PATIENTS SUBJECT TO COMPULSION ORDER

Chapter 1: Preliminary

Section 100: Application of Part

Section 101: Appointment of patient’s responsible medical officer

Section 102: Mental health officer’s duty to prepare social circumstances report

Section 103: Mental health officer’s duty to identify named person

203. These sections together provide that when a compulsion order without a restriction order is made then a responsible medical officer must be appointed (section 101), the mental health officer must normally prepare a social circumstances report within 21 days of the order being made (section 102) and the mental health officer must take reasonable steps to identify the patient’s named person (section 103). They are similar to duties for patients subject to civil compulsory treatment orders (as set out in sections 47, 57 and 59).

Chapter 2: First mandatory review of compulsion order

204. A compulsion order falls to be renewed at regular intervals in a similar manner to a compulsory treatment order. However, unlike a compulsory treatment order, the compulsion order must be reviewed by the Tribunal at the expiry of the initial 6 month period, if it is to be further extended.

First mandatory review

Section 104: First review of compulsion order

205. Unless renewed, a compulsion order will expire after 6 months (see section 57(A)(7)(b) introduced by section 95). If renewed, the order lasts for a further 6 months. Renewal is at the
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initiative of the responsible medical officer. This section requires the responsible medical officer, in the two months before the order is due to expire, to:

- carry out or initiate a medical examination of the patient;
- consult the mental health officer and other persons with responsibilities for the care of the patient; and
- consider whether it is appropriate that the order be renewed.

206. This duty exists alongside the ongoing duty on the responsible medical officer in section 114 to keep the need for the order under regular review.

Consequences of first mandatory review

Section 105: Responsible medical officer’s duty to revoke order

207. The section provides that if, as a result of the review initiated in consequence of section 104, the responsible medical officer is not satisfied that the conditions for the making of a compulsion order continue to apply, he or she is required to revoke the compulsion order and to notify the persons listed under section 65. Revocation by the responsible medical officer does not require the approval of the Tribunal or any other person, and is not subject to appeal.

Section 106: Responsible medical officer’s duty to extend order

208. If, following a review under section 104, the responsible medical officer considers that the order should continue to apply in the same form, a duty is placed on him or her to make a determination. This determination has the effect of continuing the order for 6 months, subject to the Tribunal’s powers of review, set out in section 111. A record of the determination must be sent to the Tribunal. Copies must be sent to the parties listed at section 67(2)(c), subject to provisions allowing notice to the patient to be withheld.

Section 107: Responsible medical officer’s duty to apply for extension and variation of order

209. The section provides that the responsible medical officer may decide, on first reviewing the order prior to its expiry, that it is appropriate to extend the compulsion order for a further 6 months, but that the order should be varied by modifying the measures authorised by it. The responsible medical officer must then, before the expiry of the order, apply to the Tribunal for an order extending the compulsion order in an amended form.

210. Subsection (5) provides that the responsible medical officer must give notice to those persons listed in section 69(1) when an application is made under this section.

Section 108: Application to Tribunal

211. The section sets out the information that must be included in an application by the responsible medical officer to the Tribunal for an order extending and varying a compulsion order.
Proceedings before Tribunal on first mandatory review

Section 109: Extension of compulsion order pending decision of Tribunal

212. The section provides that if the Tribunal considers that they are not able to come to a decision before the compulsion order would cease to have effect and it is appropriate to extend the order, then the order can be extended for up to 28 days.

Section 110: Review by Tribunal of responsible medical officer’s determination under section 106

213. This section requires the Tribunal to hold a hearing and review the responsible medical officer’s determination renewing the order after six months. The Tribunal, may revoke, continue or vary the order, provided it has allowed those persons listed in subsection (5) the opportunity to make representations and give evidence.

Section 111: Powers of Tribunal on application under section 108

214. The section provides that the Tribunal may:

- grant the application that has been made under section 108 of this Bill which has the effect of extending the order for 6 months and vary the order by modification of the measures specified;
- grant the application that has been made under section 108 of this Bill but only to the extent of extending the order for 6 months;
- refuse the application; or
- refuse the application and revoke the order.

Chapter 3: Further mandatory review of compulsion order

Further mandatory review

Section 112: Further review of compulsion order

215. If extended beyond 6 months from the date it was first made, the order must be extended again at the first anniversary and annually thereafter, or it will lapse. Within the last 2 months before the expiry date, the responsible medical officer must take the same steps to review the continuing need for the order as section 104 sets out for the initial 6 month review.

Consequences of further mandatory review

Section 113: Application of sections 63 to 70

216. This section applies sections 63-70 to a review of a compulsion order. The general effect is that, on review, the responsible medical officer must revoke the order, make a determination extending the order, or apply to the Tribunal for the order to be extended and varied. Extension has the effect of continuing the order for a further 12 months.
Unlike a compulsory treatment order, the Tribunal cannot record details of services which are considered necessary to enable the patient to comply with the compulsory measures.

**Duty generally to keep compulsion order under review**

**Section 114: Application of sections 62 and 71 to 73**

In addition to the duty to review the order prior to its expiry, section 114 places the responsible medical officer under a duty to consider on an ongoing basis whether the patient still meets the criteria for a compulsion order and, if so, whether the order might require to be varied in any respect.

If the responsible medical officer decides that the conditions for a compulsion order no longer apply there is a duty to revoke the order. There is no appeal against a decision of the responsible medical officer to revoke (or not to revoke) a compulsion order. If the responsible medical officer decides that the order should be varied, there is a duty to apply to the Tribunal seeking a variation.

**Mental health officer’s duty to interview patient**

**Section 115: Mental health officer: duties as respects patient**

This section imposes duties on the mental health officer on being notified by the responsible medical officer that the compulsion order has been renewed or that the responsible medical officer is seeking a variation of the order. The mental health officer must interview the patient and give information about the patient’s rights and the availability of advocacy services.

**Applications by patient etc.**

**Section 116: Application of sections 75 and 76**

The section has the effect that the patient, the patient’s named person and the Commission may apply periodically to the Tribunal to have the order revoked or varied. This is not possible in the first 6 months following a court’s making of a compulsion order. The patient and named person may each apply twice in any period for which the order is extended after the first 6 months following the making of the order.

**Review by Tribunal of determination extending order**

**Section 117: Application of section 77**

This section has the effect that if, when the order is due to expire, the responsible medical officer determines that the order should be extended, that determination must be considered by the Tribunal in the circumstances set out in section 77(2). These are that the mental health officer opposes the renewal, or that, at the date of renewal, the order will have been in force for 2 years without having been considered by the Tribunal.
Proceedings before Tribunal on further mandatory review

Section 118: Application of sections 78 to 81

223. This section has the effect that where an application has been made by the responsible medical officer to extend and vary the compulsory treatment order, and there will not be time to determine the application before the order is due to expire, the Tribunal may extend the compulsory treatment order for a period of up to 28 days.

224. At any time when the order is under consideration by the Tribunal, it may revoke, continue or vary the order, provided it has allowed interested parties, including the patient, the named person, the responsible medical officer and the mental health officer, the opportunity to make representations. The Tribunal may also call for supplementary information.

Breach of order

Section 120: Non-compliance with compulsion order

225. This applies to compulsion orders the provisions of section 84 relating to breach of a community based compulsory treatment order (see paragraph 137).

Chapter 4: Transfer between hospitals etc.

Section 121: Transfer of patients subject to compulsion order

226. This section applies the provisions of sections 87 to 89 to the transfer of patients subject to a compulsion order.

PART 10 – PATIENTS SUBJECT TO COMPULSION ORDER AND RESTRICTION ORDER

227. Part 10 forms the framework for the effect of compulsion orders when combined with a restriction order. It replaces sections 62 to 68 of the Mental Health (Scotland) Act 1984.

Chapter 1: Preliminary

Section 123: Appointment of restricted patient’s responsible medical officer

Section 124: Mental health officer’s duty to identify named person

228. These sections together provide that when a compulsion order with a restriction order is made, a responsible medical officer must be appointed (section 123) and the mental health officer must take steps to identify the patient’s named person (section 124).
Chapter 2: Review of orders

First mandatory review

Section 125: First review of compulsion order and restriction order

229. The section provides that the responsible medical officer must carry out a review of the restricted patient before the end of the 12 months starting from the day on which the compulsion order and restriction order was made.

Section 126: Further mandatory review of compulsion order and restriction order

230. The section provides that the responsible medical officer must carry out further reviews every 12 months after the first review. The reviews must conform to the requirements set out in section 125(2) and report on the matters outlined in subsection 125(3).

Consequences of mandatory review

Section 127: Responsible medical officer’s report and recommendation following review of compulsion order and restriction order

231. The section sets out the process following the mandatory reviews under sections 125 and 126. The responsible medical officer submits a report on the review to the Scottish Ministers, including views on whether the compulsion order should be revoked, the restriction order should be revoked, the restriction order should be revoked and the compulsion order varied so that the patient is no longer detained in hospital, or the restricted patient should be discharged subject to conditions.

Section 128: Duty of Scottish Ministers on receiving report and recommendation from responsible medical officer

232. The section provides that where the report submitted under section 127 contains recommendations favouring a change to the status of the restricted patient, the Scottish Ministers must make an application to the Tribunal under section 131 of the Bill.

General duty of Scottish Ministers to review orders

Section 129: Duty of Scottish Ministers to review compulsion order and restriction order from time to time

233. The section provides that the Scottish Ministers are under a duty to keep the compulsion order and restriction order to which the restricted patient is subject under review, and may ask the responsible medical officer to undertake a review as under section 125(2) at any time. If the Scottish Ministers are not satisfied that:

- the compulsion order remains appropriate, then they must apply to the Tribunal for an order under section 133 to revoke the compulsion order;
- the restriction order remains appropriate, then they must apply to the Tribunal for an order under section 133 to revoke the restriction order;
These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

- although a compulsion order and restriction order remains appropriate it is not necessary for the restricted patient to be detained in hospital, then they must apply to the Tribunal for an order under section 133 to conditionally discharge the patient.

234. Where the Scottish Ministers apply to the Tribunal under section 133 for an order to revoke the restriction order but not the compulsion order, they may also apply to the Tribunal for an order to remove any authorisation for the detention of the patient in hospital.

Section 130: Application by Scottish Ministers: notification

235. The section provides that where the Scottish Ministers are to make an application to the Tribunal under section 131 of the Bill they must notify the persons listed in subsection (1). If they do not notify the patient they must give reasons for that decision.

Section 131: Application to Tribunal

236. This section sets out the information and documentation which must be provided by the Scottish Ministers when applying to the Tribunal for an order under section 133.

Application by patient etc.

Section 132: Application by restricted patient and named person for discharge

237. The section provides that a restricted patient or the patient’s named person can apply to the Tribunal for any of the following orders:

- the restricted patient should no longer be subject to a compulsion order;
- the restriction order should be revoked;
- the restriction order should be revoked and the compulsion order varied to a community based compulsion order; or
- the restricted patient, if currently detained in hospital, should be discharged subject to conditions.

238. The restricted patient and the patient’s named person can each apply:

- once in the period beginning with the day 6 months after the compulsion order was made and ending on the anniversary of the order; and
- once in any subsequent period of twelve months.

239. The named person must give notice to the restricted patient if they make an application under this section.
Proceedings before Tribunal

Section 133: Power of Tribunal on applications under section 131 or 132

240. The section provides that following an application under sections 131 or 132 of this Bill the Tribunal may make certain orders altering the restricted patient’s status. It must hold a hearing and shall allow the persons listed in subsection (9) the opportunity to make representations and give evidence. The section details a series of questions that the Tribunal will be required to determine and which have particular consequences:

241. Subsection (2). Is the Tribunal satisfied that the restricted patient has a mental disorder and that the effect of the mental disorder makes it necessary in order to protect others from serious harm that the patient continues to be detained in hospital whether, for treatment or not? If the Tribunal is so satisfied, it shall refuse the application.

242. Subsections (3) and (4). Is the Tribunal satisfied that the restricted patient has a mental disorder or that the conditions in section 125(3)(b)-(d) and (f) continue to apply? If the Tribunal is not satisfied, it shall revoke the compulsion order.

243. Subsection (5). Is the Tribunal satisfied that neither the conditions in section 125(3)(e) nor (f) of the Bill apply? If the Tribunal is so satisfied, it shall revoke the restriction order.

244. Subsection (6). Is the Tribunal satisfied that it is necessary to continue the compulsion order and restriction order, but that the matter in section 125(3)(f) does not apply and that it is not necessary to detain the patient in hospital? If the Tribunal is so satisfied, it shall conditionally discharge the patient.

245. Subsection (7). If the Tribunal revokes the restriction order but not the compulsion order, it may also vary the compulsion order to remove the authorisation for the detention of the patient in hospital.

Section 134: Tribunal’s powers when varying compulsion order

246. The section provides that if, under section 133(7), the Tribunal has removed the restriction order, the Tribunal may vary or modify the compulsion order, but it must allow those with an interest in the case as listed in 133(9) the chance to make representations and give evidence before it does so.

Section 135: Deferral of conditional discharge

247. Where the Tribunal considers that a compulsion order and a restriction order is still appropriate but orders the conditional discharge of the restricted patient, the discharge may be deferred to allow the necessary arrangements to be made to provide suitable medical treatment in the community.
Effect of modification or revocation of orders

Section 136: General effect of orders under section 133

248. The section provides that where the Tribunal makes any of the orders listed on subsection (1), those orders shall not take effect with the occurrence of the earliest of certain events. The events are:

- the expiry of the appeal period (to be specified in regulations), if no appeal has been lodged;
- the receipt by both the Court of Session and the managers of the hospital in which the patient is detained of notice from the Scottish Ministers that they do not intend to move the Court of Session to make an order to continue the patient’s detention until the appeal has been concluded;
- the refusal by the Court of Session to make an order continuing the patient’s detention;
- the recall of any such order or the expiry of its effect.

Section 137: Effect of revocation of restriction order

249. The section provides that when the Tribunal revokes a restriction order but not the compulsion order then the patient is treated as if the compulsion order the patient is subject to was made without a restriction order. The effects are the same as those after a confirmation by the Tribunal under section 110(3) of the Bill of a determination by the responsible medical officer.

Section 138: Meaning of “modify”

250. The section makes it clear that any modifications made by the Tribunal to the compulsion order under this Part of the Bill are to be read as if they were the original measures specified in the order.

Chapter 3: Recall from conditional discharge

Section 139: Recall of restricted patients from conditional discharge

251. The Scottish Ministers can by warrant recall a restricted patient on conditional discharge to hospital if they are satisfied that the patient still meets the conditions set out in section 125(3)(a) to (e) and it is necessary for the patient to be detained in hospital. The intention is that the Scottish Ministers can recall restricted patients from conditional discharge if:

- breach of one, some or all of the conditions and/or a deterioration in the patient’s mental condition indicates the need for recall;
- the medical treatment which the patient requires can be provided only by way of detention in hospital; and
suitable arrangements cannot be made for the patient so that the patient can be safely managed in the community.

Section 141: Appeal to Tribunal against recall from conditional discharge

252. The section provides that should the Scottish Ministers recall a patient to hospital from conditional discharge then the Scottish Ministers must refer the patient’s case to the Tribunal for review within 28 days of the recall taking effect.

Chapter 4: Transfer between hospitals

Section 142: Transfer of restricted patients

253. The section provides that the Scottish Ministers may transfer a restricted patient detained in hospital to another hospital after giving notice of the transfer to those persons specified in subsection (4) at least 7 days before the proposed transfer, including the patient and their named person, unless it is an emergency or the patient has consented to the notice being dispensed with.

Section 143: Transfer of restricted patient to hospital other than state hospital: appeal to Tribunal

254. The section provides that a restricted patient and their named person may appeal to the Tribunal against the transfer to a hospital other than a state hospital within 28 days of notice being given or from the date of the transfer itself if no such notice was given.

Section 144: Transfer of restricted patient to state hospital: appeal to Tribunal

255. The section provides that a restricted patient and their named person may appeal to the Tribunal against the transfer to a state hospital within 10 weeks of notice being given or from the date of the transfer itself if no such notice was given.

Chapter 5: Temporary release from detention

Section 145: Temporary release from detention

256. The section provides that a restricted patient may be temporarily released from detention by the responsible medical officer, with the consent of the Scottish Ministers:

- for specified occasions; or
- for specified periods up to maximum of 3 months at a time, provided the total does not exceed 9 months in any twelve-month period,

subject to conditions considered necessary and which are in the interests of the patient or the protection of other persons.
257. If the temporary release is to last for more than 28 days then those persons listed in subsection (7) must be notified.

258. Subsection (8) provides that the Scottish Ministers and the responsible medical officer can recall a restricted patient if either are satisfied that it is necessary in the interests of the patient or for the protection of other persons.

PART 11 – PATIENTS SUBJECT TO HOSPITAL DIRECTIONS

259. This Part principally provides for the review of a hospital direction in a similar way to the review process for a compulsion order and restriction order under Part 10 of this Bill. However, important differences are:

- a patient subject to a hospital direction cannot be conditionally discharged; and
- the Scottish Ministers are under a duty, in certain circumstances, to revoke a hospital direction and return the patient to prison without the requirement to apply to the Tribunal.

Preliminary

Section 146: Application of Part

260. Section 146 introduces the term “offender patient” for those patients who are subject to hospital directions. This term is used as the hospital direction is made following conviction of an offence punishable by imprisonment.

Section 147: Appointment of offender patient’s responsible medical officer

Section 148: Mental health officer’s duty to identify named person

261. These sections provide that, when a hospital direction is made under section 59A of the 1995 Act, then a responsible medical officer must be appointed (section 147) and the mental health officer must take reasonable steps to identify the offender patient’s named person (section 148). They mirror the provisions for compulsion orders at sections 100, 101 and 103 and for compulsion orders and restriction orders at sections 122-124.

Mandatory reviews

Section 149: First review of hospital direction

Section 150: Further review of hospital direction

262. These sections provide a duty on the responsible medical officer to carry out a review before the end of the 12 months, starting from the day on which the hospital direction was made, and then to repeat the review every 12 months thereafter, in the same manner as for restricted patients under sections 125 and 126. Section 149 imposes a duty on the responsible medical officer to consult, in addition to the mental health officer, such other persons as he considers appropriate.
Consequences of review: revocation of hospital direction

Section 151: Responsible medical officer’s report and recommendation following review of hospital direction

263. As with section 127 in respect of restricted patients, section 151 sets out the process which follows the mandatory reviews above. The responsible medical officer will submit a report to the Scottish Ministers which must include a view on whether or not the hospital direction should be revoked.

Section 152: Revocation by Scottish Ministers of hospital direction

264. Section 152 provides that the Scottish Ministers are under a duty to revoke the hospital direction where they receive the report from the responsible medical officer recommending that the hospital direction be revoked. This is an important difference in the role of the Scottish Ministers under section 128 as no referral to the Tribunal is required. The Scottish Ministers, on revoking the direction, must then return the offender patient to prison or other institution and the direction will cease to have effect on the date the offender patient is so returned.

General duty of Scottish Ministers to review directions: revocation

Section 153: Duty of Scottish Ministers to review hospital directions from time to time

265. This section places a general duty on the Scottish Ministers to keep the hospital direction under review. It also allows them to require the responsible medical officer to undertake a review at any time of the offender patient in the same manner as for restricted patients under section 129. Unlike section 129, however, the Scottish Ministers are not required to make an application to the Tribunal but are under a duty to revoke the direction under certain circumstances.

266. Section 153 further provides that, where the Scottish Ministers revoke the hospital direction, then section 152(3) and (4) have effect so that the offender patient must be returned to prison or other institution and the hospital direction will cease to have effect once the offender is admitted to that prison or other institution.

Application by offender patient etc.

Section 154: Revocation of hospital direction on application by offender patient and named person

267. This section provides the offender patient and their named person with the right to apply to the Tribunal for revocation of the hospital direction. The Tribunal has the power to direct that the hospital direction be revoked by the Scottish Ministers. Unlike compulsion orders and restriction orders there is no power to release the offender patient on conditional discharge. The Scottish Ministers are placed under a duty to revoke the hospital direction where directed to do so by the Tribunal. As with section 153 above, where the hospital direction is revoked section 152(3) and (4) apply so that the offender patient is returned to prison and the direction ceases to have effect on admission to prison.

268. The offender patient and offender patient’s named person can each apply:
These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

- once in the 12 month period beginning with the day after the hospital direction was made and ending on the anniversary of the order; and
- once in any subsequent period of twelve months.

**Termination of direction on release of patient**

**Section 155: Termination of hospital direction on release of offender patient**

269. This section provides that the hospital direction ceases to have effect when the underlying sentence of imprisonment to which the patient is subject comes to an end under the terms of Part I of the Prisoners and Criminal Proceedings (Scotland) Act 1993. In broad terms, the 1993 Act provides that persons serving a prison sentence of four years or less are entitled to be released after one-half of the sentence has been served. Prisoners serving longer terms may be released after one half of the sentence if the Parole Board so recommends, and must be released after two-thirds of the sentence has been served. Prisoners serving life sentences will be released when the Parole Board so directs.

**Transfer of offender patients**

**Section 156: Transfer of offender patients between hospitals etc.**

270. This section provides for transfers of prisoners subject to hospital directions between hospitals and mirrors section 142 for restricted patients. One important difference, however, is that there is no right of appeal to the Tribunal against the transfer decision.

**PART 12 – PATIENTS SUBJECT TO TRANSFER FOR TREATMENT DIRECTIONS**

271. This Part provides for the effects and review of prisoners subject to transfer for treatment directions, including those patients who are also subject to a restriction direction.

272. Those patients subject to a transfer for treatment direction without restrictions are subject to the same regime as those patients subject to a compulsion order under Part 9 of the Bill.

273. Those patients subject to a transfer for treatment direction and a restriction direction are subject to the same regime as those patients subject to a hospital direction under Part 11 of the Bill.

**PART 13 – MEDICAL TREATMENT**

274. Sections 161 to 175 replace Part X (sections 96 to 103) of the 1984 Act. They set out provisions concerning medical treatment for mental disorder affecting those who are liable to be treated compulsorily. Sections 162 to 164 also apply to patients who are being treated informally.

275. Treatment is given a broad definition in section 228, which is of similar effect to the definition of medical treatment in section 125 of the 1984 Act.
276. Patients who are subject to certain orders are automatically liable to be given medical treatment compulsorily. This applies to patients subject to short-term detention, and various orders imposed by the criminal courts, including compulsion orders with restrictions, treatment orders and interim compulsion orders. A patient subject to a compulsory treatment order is liable to be given medical treatment compulsorily only if the Tribunal has authorised this under section 53. In the case of a patient made subject to a compulsion order without restrictions, the sentencing court must specify whether the order authorises compulsory treatment, and this may be varied, at a later review, by the Tribunal. For emergency detention, see paragraphs 81-82.

277. In addition to the specific requirements set out in this Part, any doctor giving treatment must have regard to the principles set out in section 1, and to any advance statement made by the patient (see sections 187-188).

278. Part 5 of the Adults with Incapacity (Scotland) Act 2000 deals with medical treatment for adults who are incapable of giving consent as a result of incapacity, including incapacity caused by mental disorder. For patients not liable to compulsory treatment under the Bill, the provisions of Part 5 may still apply, except in respect of neurosurgery for mental disorder and any other treatments specified in regulations made under section 162. Even where a patient is being given medical treatment compulsorily under the Bill, Part 5 of the 2000 Act may still apply to medical treatment for physical problems not related to the mental disorder.

Designated medical practitioners

Section 161: Designated medical practitioners

279. This Part of the Bill includes provisions requiring that certain treatments be authorised by an independent expert doctor. The Mental Welfare Commission is given the responsibility under this section to maintain a list of such doctors, known as designated medical practitioners. A new duty is placed on designated medical practitioners to undergo training if required to do so by the Commission.

280. The Commission is required to include on the list medical practitioners with expertise in child and adolescent psychiatry. Part 13 requires that such a specialist should be involved in certain treatment decisions about a child or young person which attract special safeguards (see sections 163(6), 164(6), 166(3), 167(2)(b), 169(3)(b)).

281. Subsection (4) confers certain powers on designated medical practitioners to allow them to perform the functions given to them under this part of the Bill, namely powers to:

- interview the patient in private;
- carry out a medical examination of the patient in private;
- require those holding the relevant medical records to produce them; and
- inspect the records produced.
Medical treatments to which safeguards apply

Section 162: Certain surgical operations etc.

282. The section specifies the treatments given to any patient, whether or not they are subject to compulsion under the Bill, that require the special safeguards as set out in sections 163 and 164 of the Bill. It specifies only one type, any surgical operation that destroys brain tissue or the functioning of brain tissue (generally known as neurosurgery for mental disorder). The section provides that Scottish Ministers can, in regulations and after consultation, specify other types of medical treatment that will attract the same special safeguards.

283. Currently, similar safeguards are imposed by section 97 of the 1984 Act. That section only applies to detained patients. However, by agreement between the Mental Welfare Commission and the Scottish Executive, the same procedures have been operated in respect of informal patients who have been referred for neurosurgery for mental disorder. The Bill formalises that practice.

284. Currently, there is one other treatment specified as subject to the special protections in section 97 of the 1984 Act: hormone treatment for the purposes of reducing male sexual drive (see Mental Health (Specified Treatments, Guardianship Duties etc.) (Scotland) Regulations 1984 S.I. 1984 No 1494). No such treatment has been performed in recent years. It is intended, however, to continue to provide in regulations that this treatment should be covered by these safeguards.

Section 163: Treatment mentioned in section 162(2): patients capable of consenting

285. The section sets out the conditions and requirements that must be met before neurosurgery for mental disorder or other treatments specified in regulations under section 162 may lawfully be given to patients who are capable of consenting.

286. The patient must consent in writing to the treatment, and two lay persons appointed by the Mental Welfare Commission must certify that the patient is able to consent and has done so. In addition, a designated medical practitioner must confirm both that the patient has consented and that the treatment is in the patient’s best interests.

287. This replicates the procedure in section 97(2) and (3) of the 1984 Act. The annual reports of the Mental Welfare Commission give details of the operation of these provisions. See, for example, Mental Welfare Commission Annual Report 2000-2001, pages 65-66.

288. The patient can withdraw consent to the treatment at any time. The remainder of the treatment or any future treatment of the same type would be treated as a separate form of treatment which could not be given on the basis of the earlier consent.

289. Where the patient is aged under 16, either the responsible medical officer in charge of the treatment, or the designated medical practitioner who approves the treatment, must be a specialist in child and adolescent psychiatry.
Section 164: Treatment mentioned in section 162(2): patients incapable of consenting

290. The section sets out the conditions and requirements that must be met before neurosurgery for mental disorder or other treatments specified in regulations under section 162 can be given to patients who are incapable of consenting.

291. No person who opposes the treatment – either by stating opposition or by resisting treatment, may be given such treatments. This section applies to patients who do not object to receiving the treatment, but are too incapacitated by mental disorder to give a legally valid consent. An independent designated medical practitioner must certify that this is the case and that the treatment is in the patient’s best interests. Two lay persons appointed by the Mental Welfare Commission must certify that the patient does not object to the treatment. In addition, the responsible medical officer must apply to the Court of Session, which may only authorise the treatment if satisfied that it is in the best interests of the patient, and the patient does not object.

292. If the patient does not meet the conditions at any point, for example if they resist any part of the treatment, then the treatment cannot continue.

293. Where the patient is aged under 16, either the responsible medical officer in charge of the treatment, or the designated medical practitioner who approves the treatment, must be a specialist in child and adolescent psychiatry.

Section 165: Electro-convulsive therapy etc.

294. The section specifies the treatments that require the special safeguards as set out in sections 166 and 167 of the Bill, when given to patients liable to be treated compulsorily. It specifies only one type, electro-convulsive therapy (ECT). It is not currently proposed to add further treatments by regulation.

295. The effect of this section, read alongside sections 166, 167 and 171, is that, apart from emergencies, ECT may only be given to a patient who is subject to compulsion if:

- the patient can and does consent, or
- the patient is incapable of consenting and the treatment is authorised by a designated medical practitioner.

It will not be possible, except in emergencies, to give ECT to a patient who is able to take a treatment decision and refuses the treatment.

Section 166: Treatments mentioned in sections 165(3) and 168(3): patients capable of consenting

296. This sets out provisions for treatments given under section 165 (ECT) and section 168 (medication given for more than 2 months and other treatments specified by regulations), in cases where a patient liable to compulsory medical treatment can and does consent. The patient must consent in writing and either the responsible medical officer or a designated medical
practitioner must certify that this consent has been given and that the treatment is in the patient’s best interests.

297. Where the patient is aged under 16, either the responsible medical officer in charge of the treatment, or the designated medical practitioner who approves the treatment, must be a specialist in child and adolescent psychiatry.

298. The patient can withdraw consent to the treatment at any time. Any further treatment would not be authorised on the basis of the earlier consent.

Section 167: Treatment mentioned in section 165(3): patients incapable of consenting

299. The section sets out the conditions and requirements that must be met before ECT or any treatment specified by regulations under section 165 can be given to patients liable to compulsory treatment who are incapable of consenting.

300. An independent designated medical practitioner must certify that the patient is incapable of making a decision and that the treatment is in the patient’s best interests.

301. Where the patient is aged under 16, either the responsible medical officer in charge of the treatment, or the designated medical practitioner who approves the treatment, must be a specialist in child and adolescent psychiatry.

Section 168: Treatments given over a period of time etc.

302. The section specifies the treatments that require the special safeguards as set out in sections 166 and 169 of the Bill. It specifies only one type, drug treatment for mental disorder after 2 months of compulsory treatment have elapsed. The section provides that Scottish Ministers can, in regulations and after consultation, specify other types of medical treatment that will attract these safeguards. The section also provides that Scottish Ministers can also by order vary the length of time specified in subsection (3).

303. Subject to further consultation, it is proposed to provide in regulations that the following treatments will be covered by these provisions:

- treatment with drugs for the purpose of reducing sex drive;
- compelling a patient to eat or be given nutrition by artificial means against the will of the patient;
- medication for mental disorder which exceeds normally recommended dosages or is for a purpose other than the medication’s recommended purpose.

304. The effect of this Part of the Bill is that a patient liable to compulsory treatment may only be given any of the specified treatments in one of the following situations:

- the patient can and does consent;
• the patient does not consent but the treatment is authorised by an independent designated medical practitioner;
• the patient is incapable of consenting and the treatment is authorised by an independent designated medical practitioner; or
• the treatment is required in an emergency.

305. This is a similar effect to treatment which currently requires consent or a second opinion under section 98 of the 1984 Act. That section currently applies to medication for mental disorder given for more than 3 months, and ECT.

Section 169: Treatment mentioned in section 168(3): patients refusing consent or incapable of consenting

306. The section sets out the conditions and requirements that must be met if medication for mental disorder is to be given for more than two months, or any other treatment specified in regulations made under section 168 is to be given to a patient who is liable to be treated compulsorily, who is unable to or does not consent. An independent designated medical practitioner must certify that the treatment is in the best interests of the patient.

307. Where the patient is aged under 16, either the responsible medical officer in charge of the treatment, or the designated medical practitioner who approves the treatment, must be a specialist in child and adolescent psychiatry.

308. The designated medical practitioner should take into account the views of a capable patient who refuses consent, and if the designated medical practitioner agrees that the treatment should still be given then the reason for that decision should be stated in the certificate produced.

Compulsory medical treatment

Section 170: Treatment not mentioned in sections 162(2), 165(3) or 168(3)

309. The section contains a general authority to give medical treatment where a patient is liable to be given such treatment compulsorily, and the treatment is not specified elsewhere in this Part as requiring particular safeguards. It replaces section 103 of the 1984 Act. Medical treatment for mental disorder may be given provided it is under the direction of the responsible medical officer. If the patient does not or cannot consent, the responsible medical officer must determine that the treatment is in the best interests of the patient. Before doing so, the responsible medical officer must have regard to the views of the patient and named person and, if the patient does not consent, to the patient’s reasons for not consenting. When giving treatment without the patient’s consent, the responsible medical officer must record in writing the reasons for doing so.

Section 171: Urgent medical treatment

310. This section applies to any patient who is detained in hospital, either under the Bill or under the provisions concerning mentally disordered persons in the Criminal Procedure (Scotland) Act 1995. It describes the circumstances in which patients detained in hospital can be
subject to urgent medical treatment, subject to certain provisos expressed in subsection (4), and replaces section 102 of the 1984 Act.

311. The section, unlike section 102 of the 1984 Act, applies to patients subject to emergency detention under Part 5, who are not otherwise liable to compulsory treatment. Currently patients during emergency detention may only be treated with consent, if authorised under the Adults with Incapacity (Scotland) Act, or on the basis of common law authority to treat in emergency situations.

312. The section does not apply to patients who are liable to compulsory treatment as part of a compulsory treatment order but who are not detained in hospital.

313. The section applies to any form of medical treatment for mental disorder, and authorises the treatment being given without consent or the special procedures set out elsewhere in the Act in specified circumstances.

314. Treatment may be given if it is urgently necessary to save the patient’s life. Provided the treatment does not have negative and irreversible consequences, it may be given to prevent serious deterioration in the patient’s condition. Urgent treatment may be given to alleviate serious suffering on the part of the patient or to prevent violent or dangerous behaviour, but only if the treatment would not attract significant risks or irreversible consequences.

315. The responsible medical officer must notify the Commission, within 7 days of the treatment first being given to the patient, of the type of treatment given to a patient under this section and the purpose for which it was given.

Section 172: Certificates under sections 163, 164, 167 and 169

316. The section provides that before giving a certificate which allows treatment to proceed, the certifying doctor must consult the patient, the patient’s named person (where practicable) and those persons with the primary responsibility for the patient’s care and treatment. The certificate must be copied to the Mental Welfare Commission within 7 days of it being given.

Section 173: Scope of consent or certificate under sections 163, 164, 166, 167 and 169

317. The section makes clear that any consent or certificate given in relation to treatments covered by this Part of the Bill may relate to a plan of treatment which may involve one or more of the treatments specified, and may include a timescale for the administration of the treatments. For example, electro-convulsive therapy is usually given as a planned series of treatments. The consent or certificate in any case in which such therapy is to be given may relate to the whole of the proposed series of treatments, rather than to any individual instance of the treatment. The relevant sections provide that, where the circumstances change in a way which affects the authority to treat, (eg a patient withdraws consent) then any subsequent treatment must be dealt with separately.
Section 174: Sections 163, 164, 167 and 169: review of treatment etc.

318. The section provides that where a patient is given treatment under this Part of the Bill, the responsible medical officer must report to the Mental Welfare Commission on the treatment and on the patient’s condition:

- where a compulsory treatment order is in place, at the time it is next renewed; and
- at any other time if so required by the Commission.

319. The Commission may also, at any time, direct that a form of treatment should cease to be given by giving notice to the responsible medical officer that the certificate authorising the treatment shall not apply to the patient after a specified date.

PART 14 – PATIENT REPRESENTATION

Sections 176-181: Named persons

320. These sections establish a procedure for identifying a ‘named person’ who has functions of representing the interests of and supporting a patient subject to proceedings under the Act. In particular, the named person has similar rights to the patient to apply for, appear and be represented at Tribunal hearings concerning compulsory treatment orders, and to appeal against short-term detention. The named person is also entitled to be given information concerning compulsory measures which have been taken or are being sought.

321. Although the responsibilities of the named person are to represent and safeguard the interests of the patient, they do not take the place of the patient in the way that, for example, a welfare guardian or curator would. The named person and the patient are each entitled to act independently of the other.

322. These provisions replace the provisions concerning the ‘nearest relative’ in sections 53-57 of the 1984 Act.

323. The basic framework is as follows. A patient may nominate someone to act as their named person under section 177. If the patient does not choose to make a nomination or is unable to do so, or the nominated person declines, section 178 provides that the patient’s primary carer is the named person. If there is no primary carer or the primary carer declines, the nearest relative, as defined in section 181, is the named person.

324. As well as the right to nominate a named person, a patient also has the right under section 180 to specify someone whom they would not wish to be their named person. If properly made, such a declaration will override any such appointment made by virtue of the other provisions of this Part of the Bill.

325. Section 177 sets out how a patient may nominate a named person or revoke a nomination. The procedure is broadly similar to the procedure for making a welfare power of attorney under section 16 of the 2000 Act. The nomination may be made whether or not the patient is, at the
time, the subject of compulsory measures under the Bill. The procedure in section 180 for making a declaration preventing someone from being a named person is identical.

326. The primary carer is defined in section 228. The definition applies to informal carers, and excludes professional or employed carers (unlike the definition in section 87 of the 2000 Act). The primary carer must be an individual rather than an organisation. If a person is in hospital, the primary carer will be the person who undertook such responsibilities before the patient was admitted to hospital.

327. Where the named person falls to the nearest relative, that nearest relative is the first person on the list in section 181(2). The list starts with spouses and unmarried partners (as defined in subsection (6)), before proceeding respectively to children, parents, siblings and more distant relations. In cases where more two or more people are in the highest category on the list, they may choose between them who is to act as the named person. (It is only possible to have one named person at any particular time).

328. For children under 16, section 179 provides that the named person will normally be the person with parental rights and responsibilities, as set out in Part 1 of the Children (Scotland) Act 1995. The exception is where a local authority has the care of a child under the Children Act 1989 (which principally relates to children in England and Wales). Two parents may agree between them which of them should act as the named person. If no-one has parental rights and responsibilities, the named person is the primary carer.

Section 182: Advocacy

329. The section places a duty on each local authority and health board to ensure the provision of independent advocacy services to persons with mental disorder within their area. The duty lies jointly on local authorities and health boards, who are required to collaborate with each other. Where local authority and health board areas are not coterminous, the section makes it clear that each health board must collaborate with each local authority in its area, and vice versa.

330. Advocacy services must be independent, and may not be provided by the members or staff of the local authority or Health Board which funds them. Advocacy services are defined in subsection (2). The duty to support advocacy is separate from duties to provide services to persons with mental disorder, since advocacy is not a service as traditionally understood, but a means of ensuring that appropriate regard is paid to the needs and wishes of the relevant person.

331. Under sections 50, 74 and 185, information must be given to patients at various stages concerning the provision of advocacy services under this duty. These obligations are additional to the requirement in subsection (1) to take steps to ensure that persons with mental disorders have the opportunity to make use of advocacy services.

332. The duty is not restricted to persons affected by other provisions of the Bill, but applies generally to all mentally disordered persons.
Section 183: Access to medical practitioner

333. This section gives any doctor who may be advising the patient or the patient’s named person in connection with an appeal against compulsory powers the right to examine the patient and the patient’s medical records. It replaces section 35(2) to (4) of the 1984 Act.

PART 15 – MISCELLANEOUS

Section 184: Code of practice

334. Scottish Ministers are required to publish a Code of Practice to give guidance on how people discharging functions under the Act should do so. Before doing so, Ministers must consult and lay a draft before Parliament.

335. Any person who has a function to discharge must have regard to the guidance in the Code of Practice. This would include, in particular, medical practitioners and mental health officers. The Code does not bind the Tribunal, the courts or the Mental Welfare Commission. However, those bodies would be entitled to have regard to whether other parties had properly applied the Code, for example in authorising or reviewing compulsory measures.

336. This replaces section 119 of the 1984 Act. The current Code of Practice was published in 1989.

Section 185: Provision of information to the patient

337. This section contains requirements to take steps to ensure that, at various stages throughout the operation of compulsory measures, patients are aware of their situation and their rights. It replaces section 110 of the 1984 Act.

338. The primary responsibility is placed on the mental health officer to seek to ensure that the patient understands:

- the effect of the compulsory measures;
- how they may be brought to an end, including the powers of the Tribunal, the responsible medical officer and the Mental Welfare Commission; and
- how to obtain legal assistance or advocacy.

339. The duty applies at the beginning of the operation of the compulsory measures, before any Tribunal hearing or whenever the patient requests such information. Where the patient has been made subject to emergency detention, the duty at the beginning of detention rests with the detaining doctor (since it is possible that no mental health officer has been involved).

340. The patient’s named person should be given a copy of any material supplied to the patient.
Section 186: Provision of assistance to patient with communication difficulties

341. The requirements of this section apply in respect of patients subject to compulsory measures who have difficulties in communicating, for example as a result of their mental disorder, any physical or sensory impairment, literacy difficulties or having a language other than English as a first language. The mental health officer is required to take all reasonable steps to ensure that the patient can communicate effectively at any Tribunal proceedings, any review of the patient’s detention, or any medical examination carried out to assess the patient’s mental disorder.

342. No particular form of assistance is specified. Arrangements in fulfilment of this duty might include the provision of interpreters or translators, or of appropriate equipment. The duties imposed here run alongside the general duties in the Disability Discrimination Act 1995 and the Race Relations Act 1976.

Sections 187: Advance statements: making and withdrawal

343. Section 187 sets out a procedure by which a person can make an advance statement setting out how the person would wish or would not wish to be treated for any mental disorder if, at some future time, the person is mentally disordered and unable to make decisions about their treatment. The statement could say, for example, whether or not the patient would wish a particular form of medication.

344. An advance statement must be in writing and must be signed by the granter and a witness. The witness must also certify that, in their opinion, the granter was capable of making the statement at the time. ‘Incapable’ and related terms are defined as in the 2000 Act, which states that:

‘“incapable” means incapable of-

(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions

as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise).’

345. A patient may withdraw an advance statement, by the same means as making one.
Section 188: Advance statements: effect

346. This section sets out the effect of an advance statement which has been made in accordance with section 187.

347. In considering a compulsory treatment order, the Tribunal must have regard to the terms of any advance statement, provided the Tribunal is satisfied that the statement covers any treatment which might be authorised by the order, was competently made and there has been no material change of circumstances. The Tribunal must also be satisfied that the patient’s decision making ability is adversely affected by the mental disorder since, if it were not, the patient’s views at the time of the hearing would take precedence over any prior advance statement.

348. Details of any known advance statement should be given by the mental health officer in applying for a compulsory treatment order (section 50(3)), or when required by the Tribunal in connection with a hearing concerning such an order (section 81(2)).

349. A person giving treatment authorised by a compulsory treatment order (for example, the responsible medical officer) must also have regard to the statement, if satisfied that the statement is valid and that the person’s current decision making ability is significantly impaired. If the Tribunal has considered and approved the advance statement, it is presumed to be valid.

350. The advance statement is not legally binding but must be properly considered. Wherever treatment is given or an order is made which conflicts with the advance statement, the reasons for doing so must be recorded in writing and added to the patient’s medical record.

351. These sections only affect advance statements insofar as they apply to a person subject to compulsory measures. A patient may make an advance statement intended to have more general effect. In situations not covered by these sections, the common law would apply.

Section 189: Education of persons who have mental disorder

352. This amends the Education (Scotland) Act 1980 to provide that education authorities have duties towards children who are subject to compulsory treatment orders. Section 14 of the 1980 Act requires education authorities to make special arrangements for children unable to attend school, including by reason of prolonged ill-health. This duty is extended to children subject to a compulsory treatment order. Section 131 of the 1980 Act excludes children who are detained from the scope of the duties of education authorities under that Act. The amendment in this section removes children subject to a compulsory treatment order from that exclusion.

Section 190: Duty to mitigate adverse effects of compulsory measures on parental relations

353. This section requires local authorities and health boards to take all reasonable steps to reduce any adverse effect on the relationship between a parent and child of either party being made subject to a compulsory treatment order.
Section 191: Information for research

354. This section allows Ministers to require any person having functions under the Act to provide relevant information for the purpose of research, subject to exceptions for information which is legally privileged, or which is confidential and cannot be provided without breaching requirements of confidentiality.

State hospitals

Section 192: Restriction of Scottish Minister’s powers to delegate management of state hospitals

355. Originally, Part VIII of the 1984 Act contained provisions regarding state hospitals for patients who required special security. These provisions have now largely been repealed, and the responsibility of the Scottish Ministers to provide such hospitals is contained in section 102 of the National Health Service Act 1978.

356. Section 102 of the 1978 Act provides that a state hospital may be managed on behalf of Scottish Ministers by:

- a committee constituted under section 91 of the 1984 Act; or
- a Health Board, Special Health Board, the Common Services Agency or an NHS Trust.

357. Section 91 of the 1984 Act is not re-enacted in the Bill. This section removes the reference to it in the 1984 Act.

Communications, security etc.

Section 193: Correspondence of certain patients detained in hospital

358. This section replaces section 115 of the 1984 Act.

359. The section provides powers for a specified person’s incoming and outgoing mail to be inspected and withheld in certain circumstances. The provisions apply to a person detained in hospital who meets other conditions as may be specified by Scottish Ministers in regulations.

360. A postal packet addressed by a specified person to any person may be withheld from a postal operator if the intended recipient has requested in writing that communications from the patient be withheld. The notice should be sent in writing to the managers of the hospital, the responsible medical officer or the Scottish Ministers. Postal packet has the same meaning as in the Postal Services Act 2000, namely a letter, parcel, packet or other article transmissible by post.

361. Managers of a state hospital may withhold a postal packet:
• from a patient if it is likely to cause distress to the person in question or any other person (not being a member of staff of the hospital); or to cause danger to any person;
• to a patient if it is necessary to do so in the interests of the safety of the specified patient or for the protection of other persons.

362. The powers described in the preceding paragraph do not apply to any correspondence between a patient and those persons or organisations listed at subsection (5).

363. The managers of a hospital or any person appointed by them for the purpose, may open and inspect a postal packet to determine whether it is one – or contains anything – which they have the power to withhold, and whether or not they should withhold it or anything contained in it.

**Section 194: Correspondence: supplementary**

364. If a postal packet, or anything contained within it, is withheld by the managers of the hospital they must within 7 days of the action taking place:

- notify the Mental Welfare Commission and provide the name of the specified person, the nature of the postal packet or contents withheld and the reasons for it being withheld;
- notify the specified person of the action within 7 days of it taking place;
- if a postal packet has been withheld from the patient, notify the sender of the packet if known.

365. Scottish Ministers can make regulations which extend the powers conferred by section 193 of the Bill to include other forms of written communications. This could include electronic written communications such as electronic mail, fax machines, and text messages and could be extended for future technological advances.

**Section 195: Review of decision to withhold postal packet**

366. This section replaces section 116 of the 1984 Act.

367. The section requires the Mental Welfare Commission to review any decision to withhold a postal packet (or anything contained within it) if an application is made to them within 6 months of the day on which notification of the action was received.

368. The application can be made by the patient if it was an outgoing postal packet (or anything contained within it) that was withheld and by the patient and the sender if it was an incoming postal packet (or anything contained within it) that was withheld.
369. Having reviewed the decision of the managers of the hospital, the Mental Welfare Commission may direct that the packet or item in question should be released to the addressee, and the managers are required to comply with any such direction.

370. Scottish Ministers may make regulations with respect to the making of applications and as to the production to the Mental Welfare Commission of relevant items.

**Section 196: Certain patients detained in hospital: use of telephones**

371. Scottish Ministers may make regulations in connection with regulating the use of telephones by such persons detained in hospital as may be specified. The regulations may:

- confer rights on specified persons to use telephones, subject to conditions imposed which may include the payment of call charges;
- restrict, or prohibit the use of telephones by specified persons;
- authorise the interception of telephone calls.

372. Interception of telephone calls to certain persons and organisations may not be authorised by regulations unless the person has requested the interception of the calls made by the specified person, or the telephone call is, or would be, unlawful.

**Section 197: Safety and security in hospitals**

373. The section enables regulations to authorise matters in connection with safety and security in hospitals, including searches, the taking and examination of body samples, surveillance, restrictions on property, visit restrictions and the searching of visitors. The regulations may specify conditions which apply to the use of any such powers.

**Sections 198 and 199: Removal to place of safety**

374. These sections give the police the power to detain a person who appears to be mentally disordered for up to 24 hours in a place of safety to allow a doctor to examine the person and for arrangements for care and treatment to be made. The police may use the power to take a person to a psychiatric hospital, or to arrange for a doctor to attend.

375. The power of detention can only be used if the person is in a public place. The police must notify the local authority and other interested parties. “Place of safety” should normally be a hospital or care establishment and should not be a police station except in an emergency.

376. Section 199 imposes duties on the constable to ensure that the relevant local authority is informed as soon as reasonably practicable, and the Mental Welfare Commission is notified within 14 days. The nearest relative or a carer or person who lives with the mentally disordered person should also be notified as soon as reasonably practicable.
377. These sections replace section 118 of the 1984 Act, which allows detention for up to 72 hours.

**Detention pending medical examination**

**Section 200: Nurse’s power to detain pending medical examination**

378. This replaces section 25 of the 1984 Act and empowers nurses of the prescribed class to detain an informal patient who is already in hospital receiving treatment for mental disorder. The nurses may hold the patient for a period of two hours or until a medical practitioner arrives, whichever is the sooner, and, where the doctor arrives after the first hour, for a further period of one hour from his or her arrival. On arrival, the medical practitioner should assess the patient to determine whether an emergency detention or, if he is an approved medical practitioner, a short-term detention is appropriate. (Unlike the 1984 Act, the nurses holding power may be immediately followed by short-term detention.)

379. A nurse of the prescribed class may exercise such power where it appears to the nurse that a medical examination to consider detaining the patient is necessary, that a mental disorder is present, that it is necessary to prevent the patient from leaving, and it is not practicable to secure the immediate medical examination of the patient.

380. It is intended that the regulations governing “prescribed class” will broadly follow the existing Mental Health (Class of Nurse) (Scotland) Order 1994 (SI 1675). (These are nurses registered in part 3, 5, 13 or 14 of the professional register.)

381. As soon as practicable after the period of detention begins, the nurse exercising the power should take all reasonable steps to inform a mental health officer of the detention. This is to increase the likelihood that when the medical practitioner arrives he or she is able to consult a mental health officer. Since short-term detention requires mental health officer consent, it also increases the likelihood of this option being available. Under subsections (6) to (9), the nurse is also obliged to make a contemporary record of matters relating to the detention and to deliver that record to the hospital managers, who must forward it to the Mental Welfare Commission.

**Section 201: Cross border transfer of patients**

382. Section 201 establishes a broad regulatory framework for transfers of patients to and from Scotland. Regulations may make provision for detained patients moving between different parts of the UK, and for patients being treated for mental disorder (whether or not subject to compulsory measures) to be removed from the United Kingdom. The procedure for transferring a patient out of Scotland is intended to be broadly similar to that for transferring patients within Scotland under sections 87-89, with additional provisions reflecting the fact that patients will be moving between different jurisdictions with different mental health law – possibly including different criteria for compulsory measures. Any removal from Scotland will require the consent of the Scottish Ministers and will be subject to a right of appeal for the patient.
Informal patients

Section 202: Application to tribunal in relation to unlawful detention

383. The Bill requires that compulsory measures should only be invoked where necessary. As now, it is envisaged that the majority of persons being treated in hospital for mental disorder will do so on an informal or voluntary basis. The authority for such admission and treatment will be the patient’s consent or, in the case of an incapable adult, may be the Adults with Incapacity (Scotland) Act 2000.

384. It is possible that a patient may be admitted or kept in hospital informally, but without their genuine consent or outwith the scope of the 2000 Act. That Act does not authorise the use of force or detention unless immediately necessary (section 47). This section provides additional protection in such situations.

385. A patient in hospital receiving treatment for mental disorder, or any person specified in subsection (4) may apply to the Tribunal. If the Tribunal determines that the patient is being unlawfully detained, it may require that the detention cease.

386. Unlawful detention may manifest itself in a number of ways and how to affect cessation of detention will depend on the individual case. In some situations, it may be necessary to discharge the patient from hospital. In others, it may be enough to remove certain restrictions on the patient’s liberty, such as being on a locked ward.

387. These provisions do not interfere with any existing rights a person may have to challenge in the courts or seek redress for any unlawful interference with their liberty.

PART 16 – ABSCONDING

388. This Part provides powers to take into custody and return patients who are absent without due authorisation from the place where they are detained or required to reside. Section 203 applies the provisions to patients who are subject to a compulsory treatment order which authorises detention in hospital or which imposes a requirement that the patient resides at a specified address. Section 204 applies the provisions to patients subject to short-term detention or extensions thereof, and emergency detention.

389. Patients subject to a requirement of residence as part of a compulsory treatment order, who are absent without leave, will have breached the terms of the order. The provisions in sections 84 to 86 may apply, alongside the provisions of this Part.

390. Section 205 sets out the powers of authorised persons to make arrangements for the patient to be returned. Sections 206-210 set out the effect of a period of unauthorised absence on a compulsory treatment order, and section 211 sets out the effect on a patient subject to short-term detention or extensions thereof.

391. These powers also apply to patients who fail to return at the end of a period of suspension or variation of detention granted under section 90. A patient may also be absent without leave if
he fails to comply with residence conditions set as part of such a suspension/variation. Failure to comply with other conditions does not make the patient absent without leave.

392. The persons authorised by section 205(3) to take into custody and bring back patients who are absent without leave are:

- a mental health officer;
- a constable;
- any member of the staff employed at an establishment in which the patient could be detained or required to reside;
- any other person authorised in writing by the responsible medical officer.

393. This section applies to Scottish officials acting on Scottish territory. It is intended that regulations under section 212 will allow officials from other jurisdictions to recover patients absent without leave in Scotland. The ability for Scottish officials to retrieve patients absent without leave from a Scottish order but who are to be found in a different jurisdiction depends on authorisation from that jurisdiction. This is a departure from the 1984 Act.

Time limits for retaking patients absent without leave

394. Section 205(1) and (4) provide that a patient subject to a compulsory treatment order who goes absent without leave may be retaken any time up to three months after the date on which he goes absent. This is irrespective of the date on which the patient goes absent without leave and applies even if the compulsory treatment order has expired in his or her absence.

395. For orders of shorter duration, (e.g. short-term detention), liability to be taken and returned expires on the expiry of the original order.

Effects of being absent without leave

396. Any patient who is absent without leave is liable to be taken into custody. Under the terms of section 206, being absent without leave does not affect the renewal/expiry date of the compulsory treatment order or other detention power. However, whilst a patient is absent without leave, no changes can be made to the compulsory treatment order: the responsible medical officer cannot renew the order and the Tribunal cannot discharge the patient, renew or vary the order.

Manner of retaking patient

397. Any of the persons listed under section 205(3) may use reasonable force for the purposes of restoring the patient to the place specified in the compulsory treatment order. A police constable may additionally make forcible entry on to premises to which admission has been refused on obtaining a warrant obtained from a sheriff or justice.
Procedure when the patient returns

398. Under section 211, where a patient subject to short-term detention under Part 6 is returned before the expiry of the order, the period of detention will last for at least a further 14 days. This is to allow time for further assessment of the patient and, where appropriate, an application for a compulsory treatment order.

399. The period of absence without leave is deemed to end when the patient is restored to the hospital or place of residence specified in his compulsory treatment order. However, if the unauthorised absence has been for a prolonged period, the hospital bed or specified address may have been taken by someone else. Therefore, section 205(1) provides that, where it is not reasonably practicable to return the patient to the specified hospital or address, the patient may be returned to any other place which is considered appropriate by the RMO.

400. If the patient has been away for 28 days or less and is returned 14 or more days before a compulsory treatment order is due to expire, section 206 provides that the order continues as if the patient had not been absent without leave without further action being necessary.

401. Sections 207 and 208 deal with absence from a compulsory treatment order for more than 28 days, where the patient is returned while the order still has a significant period to run. If the patient has been away for more than 28 days and is returned 14 or more days before the compulsory treatment order is due to expire, the responsible medical officer has 14 days, during which the compulsory treatment order continues to apply, in which to assess the patient to determine whether the order should continue. To continue the existing compulsory treatment order to its expiry date, the responsible medical officer must complete the procedure under section 60 before the expiry of the 14 days.

402. Where the order has more than 2 months to run, the effect of section 207 is that, by completing this procedure, the responsible medical officer has continued the compulsory treatment order to the next renewal date. Under section 208, if the patient is returned within two months of the expiry of the compulsory treatment order, i.e. during the period within which it would normally be competent to renew the compulsory treatment order, the responsible medical officer may, by completing the appropriate review procedure under Part 7 Chapter 2, authorise the continuation of the existing compulsory treatment order to its expiry date and its renewal from that date.

403. Sections 209 and 210 deal respectively with patients subject to a compulsory treatment order who are returned when the order has less than 14 days to run, (which may leave insufficient time for the normal renewal procedures), or when the normal date for renewal has passed. If the patient is returned within 14 days of the expiry of the compulsory treatment order or after the compulsory treatment order would have expired, the compulsory treatment order shall be deemed to continue for a period of 14 days from the return of the patient in order to enable the responsible medical officer to assess the patient. If the responsible medical officer wishes to renew the compulsory treatment order, he must complete the review procedure within those 14 days and the renewed compulsory treatment order will be deemed to have commenced at the original expiry date.
PART 17 – OFFENCES

404. This Part replaces sections 104-109 of the 1984 Act with modified offences relating to sexual abuse, ill-treatment and neglect, and obstruction of persons carrying out functions under the Bill.

Section 213: Non-consensual sexual acts

405. This replaces and substantially amends section 106 of the 1984 Act and, in respect of male homosexual acts, section 13(3) of the Criminal Law (Consolidation) Act 1995. It creates a statutory offence of carrying out a sexual act with a person with a mental disorder who does not consent to the act or is incapable of consenting to the Act. It applies to all forms of sexual act involving persons of any gender (unlike section 106, which was restricted to sexual intercourse and could only be committed by a man on a mentally impaired woman.) It also widens the scope of the offence, by applying to all forms of mental disorder, whereas section 106 was restricted to mental handicap.

406. The maximum sentence has also been increased, from two years imprisonment to life imprisonment.

407. The offence also differs from section 106 in relation to the issue of consent. The 1984 Act offence was committed if a man had sex with a woman who met the statutory test of significant mental impairment, and the question of consent or lack of consent was immaterial. In this section it is necessary to establish that the mentally disordered person did not consent or was unable to do so. However, the offence reflects the fact that a mentally disordered person may be vulnerable to being persuaded or coerced to carrying out sexual acts. The fact that a person appears to acquiesce in a sexual act will not prevent it being an offence if this has happened as a result of the mentally disordered person being intimidated or tricked.

408. It will still be possible for a sexual act involving a mentally disordered person to be charged as a common law offence such as rape.

Section 214: Offences under section 213: extended sentences

409. Under section 210A of the Criminal Procedure (Scotland) Act 1995, it is possible for a person convicted of a sexual offence to be given an extended sentence. This enables a court to add a period of extended post-release supervision to the prison sentence it would normally impose. This may last for up to ten years following the expiry of the prison term. This section provides that a person convicted under the preceding section may be given an extended sentence.

Section 215: Persons providing care services: sexual offences

410. This replaces section 107 of the 1984 Act. It creates an offence which may be committed by a paid carer who has a sexual relationship with a mentally disordered person for whom they care. The offence attracts a maximum sentence of two years.
411. Unlike the offence created by section 213, it is not necessary to establish that the mentally disordered person did not consent to the sexual act. The essence of the offence is in the abuse of the caring relationship. The offence is not committed where the carer is the spouse of the mentally disordered person or where a sexual relationship existed between the carer and the mentally disordered person before the provision of care service commenced.

412. The offence does not apply to informal carers. It applies to persons providing certain care services within the meaning of the Regulation of Care (Scotland) Act 2001, including care homes and support services.

413. Sections 213 and 215 are not mutually exclusive. It would be possible for a person providing care services to be charged under section 213 or under the common law.

Section 216: Notification requirements for offenders under sections 213 and 215

414. The Sex Offenders Act 1997 provides that persons convicted of one of a list of offences are liable to be placed on the Sex Offenders Register. The effect is that the person must register certain personal details with the police. The offences created by sections 213 and 215 are added to the list.

Section 217: Ill treatment and wilful neglect of a mentally disordered person

415. This section makes it an offence for a carer to ill-treat or wilfully neglect a mentally disordered person. The maximum penalty on indictment is 2 years imprisonment. It is not necessary for the mentally disordered person to be subject to any formal procedures under the Bill. The offence may be committed by staff or by informal carers.

416. This replaces the offence currently contained in section 105 of the 1984 Act. Section 83 of the Adults with Incapacity (Scotland) Act 2000 also contains an offence of ill-treatment and wilful neglect, by anyone exercising powers under the Act relating to the personal welfare of the adult, which offence is not affected by this section.

Section 218: Obstruction

417. This section makes it an offence to behave in a way which obstructs a person authorised to carry out functions under the Bill. The maximum penalty is 3 months imprisonment or a fine not exceeding level 3 on the standard scale.

418. Persons who may be authorised under the Bill include mental health officers and medical practitioners. It would also encompass police officers or nurses when detaining patients or escorting patients subject to compulsion, and members and officers of the Mental Welfare Commission.

419. A mentally disordered person who is the subject of any intervention under the Bill cannot be guilty of the offence in relation to that intervention.
These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

420. This replaces section 109 of the 1984 Act.

PART 18 – APPEALS

421. This part creates an appeal structure against decisions of the Tribunal. Appeals are made to the sheriff principal but, in complex cases, may be remitted directly to the Court of Session. There is a further right of appeal from the sheriff principal to the Court of Session. Appeals concerning restricted patients go directly to the Court of Session. The basis of any such appeal is that the Tribunal has erred in law in some way.

422. Under the 1984 Act, there is no appeal (other than by judicial review) against a decision of the sheriff in relation to detention proceedings. The exception is for restricted patients, where an appeal to the Court of Session was introduced by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

Section 219: Appeal to the sheriff principal against certain decisions of the tribunal

423. The patient or the patient’s named person may appeal to the sheriff principal if the Tribunal refuses an appeal against short-term detention, grants a compulsory treatment order, or refuses to vary or discharge a compulsory treatment order. There are also appeal rights against decisions of the Tribunal concerning transfers, and where the Tribunal refuses to hold that an informal patient has been unlawfully detained.

424. Either the responsible medical officer or the mental health officer may appeal against the making of a compulsory treatment order, a refusal of an application for a compulsory treatment order, or a decision to vary a compulsory treatment order. Appeals are also possible against a determination that an informal patient has been unlawfully detained or a decision concerning a patient transfer. For restricted patients, Scottish Ministers substitute for the responsible medical officers and the mental health officer. However, most matters concerning restricted patients fall to be dealt with under section 221.

425. There is no appeal against a decision by the Tribunal to revoke a compulsory treatment order or short-term detention.

426. The appeal is lodged with the sheriff principal. If the appeal raises important or difficult legal issues, the sheriff principal may decide that the case should be remitted directly to the Court of Session.

427. The decision of the Tribunal continues to have effect unless subsequently overturned on appeal.

Section 221: Appeal to the Court of Session against decisions made under section 133

428. This provides an appeal right in relation to certain decisions concerning restricted patients. It applies to a decision to revoke or refuse to revoke a compulsion order, to remove or to refuse to remove the restriction order, to grant or refuse to grant conditional discharge, or to vary a compulsion order after revoking the accompanying restriction order.
429. Scottish Ministers, the patient or the patient’s named person may appeal.

**Section 222: Appeal by Scottish Ministers under section 221: suspension of Tribunal’s decision**

430. Normally, a decision made by the Tribunal has immediate effect. Where a Tribunal decision is made under section 133, the Scottish Ministers may appeal. If they do so, they may ask the Court of Session to order that the patient should continue to be detained under restrictions, pending the outcome of the appeal. Section 136 operates to prevent the patient from being released until the Scottish Ministers have had an opportunity to seek such an order. This continues the effect of section 66A of the 1984 Act, introduced by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

**Section 223: Appeals: general provisions**

431. This section specifies the grounds on which any appeal from the Tribunal must be based. They reflect various forms of error in law. If an appeal succeeds, the appellate court may make its own decision or remit the case back to the Tribunal for reconsideration.

432. The Tribunal is required under schedule 2, paragraph 12 to give reasons for its decision. This section provides that the Tribunal may also be heard as a party to the appeal by the appellate court at any appeal hearing. This reflects the fact that the Tribunal will not operate in a strictly adversarial manner, deciding between two competing parties, but make its own decision, after considering all the evidence before it.

**SCHEDULE 1: THE MENTAL WELFARE COMMISSION FOR SCOTLAND**

433. This schedule contains provisions as to the membership, organisation and operational arrangements of the Mental Welfare Commission. It replaces sections 2 and 6 of the 1984 Act. The functions of the Commission are set out in the Bill, particularly in Part 2.

434. The Commission is independent of the Scottish Executive. Commissioners are appointed by Her Majesty, on terms and conditions specified by the Scottish Ministers. The membership of the Commission must include a convenor and at least three medical practitioners. The medical commissioners have particular powers under the Bill to conduct examinations of patients and gain access to medical records (section 13).

435. Regulations may add to the prescribed list of members. Section 2(2) of the 1984 Act contains a requirement that a person who has been a solicitor or member of the Faculty of Advocates for at least 5 years be a member. This is not repeated in the Bill but it is intended to prescribe by regulations that the Commission should still have a legally qualified Commissioner. It is also intended to make provision regarding Commissioners who are, or have been, mental health service users or carers.
SCHEDULE 2: THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

436. This schedule sets out the arrangements under which the new Mental Health Tribunal for Scotland will operate.

Part 1: Members of the Tribunal

437. Members will be appointed to the Tribunal by Scottish Ministers. There will be three panels of members, and it is intended that hearings of the Tribunal should be constituted with one member of each panel. Members of the first panel act as convenors for hearings of the Tribunal. It is intended to prescribe that the convenors must be legally qualified. The second panel is of persons with prescribed qualifications, training and experience in medicine and the diagnosis of mental disorder. For the third panel, it is intended that the prescribed qualifying criteria will relate to experience in the assessment and treatment of mental disorder.

438. A President will be appointed who meets prescribed criteria. It is intended that the regulations will prescribe legal qualifications and experience at a senior level.

439. Tribunal members will serve for 5 years, but will normally be entitled to be re-appointed for a further period, unless the circumstances set out in paragraph 3(6) apply. The retirement age is 70. Ministers may not remove from office a serving Tribunal member. This may only be done by a special disciplinary committee chaired by a judge.

Part 2: Organisation and administration of the functions of the Tribunal

440. Funding for the Tribunal will be provided by the Scottish Ministers. It shall be the responsibility of the President to ensure that the Tribunal discharges its functions efficiently and effectively.

Part 3: Tribunal procedure

441. In addition to any requirements set out in the Bill, rules made by the Scottish Ministers in statutory instruments will set out the detail of how the Tribunal should operate. These may be supplemented by practice directions issued by the President. The Tribunal will have the power to cite witnesses.

442. Tribunal decisions may be made by a majority of the three members. Written reasons must be given for decisions.

Part 4: Reports, information etc.

443. The President is required to submit an annual report to Scottish Ministers, which shall be laid before the Scottish Parliament, and may also be required to provide Scottish Ministers with information about the discharge of the Tribunal’s functions.
FINANCIAL MEMORANDUM

INTRODUCTION

444. The Bill introduces new procedures for compulsory care and treatment of people with mental disorders. These procedures are intended to be more thorough and more flexible than the current arrangements for detention in hospital, and contain new mechanisms to protect the rights of patients.

445. The Bill also updates the duties of local authorities to provide care and support for people with mental disorders, and creates a new statutory duty on the NHS and local authorities to support advocacy for mental health service users.

446. The Bill introduces a new Mental Health Tribunal and imposes new responsibilities on the Mental Welfare Commission.

447. Local authorities will be given a new duty to investigate the circumstances of vulnerable people who may be at risk of abuse.

448. In the policy statement, Renewing Mental Health Law (published in October 2001), the Scottish Executive recognised that implementing the new Mental Health Bill would require additional resources. Since then, discussions have been taking place with representatives of service providers and professional associations to assess the additional resources required.

SUMMARY OF COSTS

449. In 2001/02, the NHS spent an estimated £557 million on mental health services in Scotland, up 7% from 2000/1, and local authorities spent £47 million of which £19 million was the Mental Illness Specific Grant and £28 million net local authority expenditure (excluding money raised from fees etc).

450. On current estimates, the additional costs associated with the new Bill amount to £23.1 million per year, with one-off start-up costs of a further £9.25 million to be met before the end of 2007/08. Some of these costs will be met directly by the Executive; others will fall to local authorities and will be reflected in their annual allocations; and the remainder will fall to NHS Scotland, and will be covered by the substantial funding increases already announced.

<table>
<thead>
<tr>
<th>ONGOING COSTS FROM 2004/5</th>
<th>COST £ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scottish Executive costs (net increase)</td>
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<tr>
<td>Tribunal running costs, including the fees of legal and medical members and support staff and general running costs</td>
<td>2.4</td>
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<tr>
<td>Increase in legal aid costs</td>
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<tr>
<td>More responsibilities for MWC</td>
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These documents relate to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

<table>
<thead>
<tr>
<th>ONGOING COSTS FROM 2004/5</th>
<th>COST £ million</th>
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<tr>
<td>2. Local Authority costs (net increase)</td>
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<tr>
<td>Improvements in the packages of care available to people subject to community-based compulsory treatment</td>
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<tr>
<td>45 new full-time equivalent mental health officers</td>
<td>2.5</td>
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<tr>
<td>Improved day-care and after care facilities</td>
<td>7.0</td>
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<tr>
<td>New duties to support advocacy (£0.5m in 2003/4, £1.0m in 2004/5, £1.5m in 2005/6; the 2005/6-figure is shown here)</td>
<td>1.5</td>
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<tr>
<td>3. NHS costs (net increase)</td>
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<tr>
<td>The principle of reciprocity and plans of care</td>
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<tr>
<td>More mental health assessments</td>
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<tr>
<td>New duties to support advocacy (£0.5 million 2003/4, £1.0 million 2004/5, £1.5 million 2005/6; the 2005/6-figure is shown here)</td>
<td>1.5</td>
</tr>
<tr>
<td>Additional psychiatrist workload, including appearing before Tribunals but not sitting on the Tribunals</td>
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<tr>
<td>Improvement of services to informal patients who appeal to Tribunal (Bournewood type patients)</td>
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<tr>
<td>4. TOTAL ONGOING COSTS PER ANNUM</td>
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<tr>
<th>START-UP COSTS</th>
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<tr>
<td>Total start-up costs</td>
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<td>Developing the Code of Practice, printing and distribution costs, and production of training materials</td>
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<tr>
<td>Research programme (£200k per annum starting October 2002)</td>
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<td>Training for non local authority staff</td>
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<td>Establishment of new Tribunal system (admin and recruitment)</td>
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<td>Transfer of patients onto new orders</td>
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<tr>
<td>Additional costs of IT infrastructure for the Mental Welfare Commission (£500k per annum for 2 years)</td>
<td>2003/4-2004/5</td>
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<tr>
<td>Local authority capital expenditure (£2m per annum for 2 years)</td>
<td>2004/5-2005/6</td>
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The above tables show the costs in 2002/3 cash terms.
COSTS TO THE SCOTTISH EXECUTIVE

451. The direct cost to the Scottish Executive associated with the new Bill will be £4.1m per annum, plus start-up costs of £5.25 million. The Scottish Executive will also be spending an estimated £13.0 million per annum funding local authority ongoing costs and meeting their start-up costs of £4.0m.

Mental Health Tribunal

452. The Mental Health Tribunal will replace the role of the sheriff court in mental health hearings. The Scottish Executive will directly fund the Tribunal. Around 3,000 hearings are anticipated, which may take longer than the current sheriff court proceedings, and will involve a 3 member panel rather than a single sheriff.

453. Running costs are estimated at £2.4 million per annum, including members’ fees and staffing costs. Legal aid through the Assistance by Way of Representation system will be available to patients and “named persons”. Annual legal aid costs are estimated to rise by approximately £1.0 million.

454. The start-up costs of the Tribunal are estimated as £1.0 million for recruitment and administration. There are also transitional costs associated with moving existing detained patients onto the new orders, which will cause a higher than average number of hearings in the first year. It is assumed that there will be an additional 300 hearings in the first year, costing £0.45 million for the Tribunal service.

Mental Welfare Commission

455. The Mental Welfare Commission will have additional responsibilities, including the provision of more independent second medical opinions. It is anticipated that it will initiate more inquiries, and broaden the scope of its visiting programme. The Commission will also have a duty of providing guidance and monitoring the operation of the new Act.

456. The Commission is funded by the Executive, and additional running costs of £0.7 million a year are anticipated. One-off start-up costs of £1 million are also anticipated, to assist with improved IT provision, and preparation of new information materials.

Research

457. The Scottish Executive will manage a research programme, evaluating the effectiveness of the new Act, which will cost around £0.2 million per annum, for five and a half years.

Codes of Practice, training and information

458. The Executive will be required to produce statutory Codes of Practice. It is also intended to produce information on the new legislation, prepare training materials and hold training events. The cost of preparing the new Code of Practice is estimated at £250k, with training for non local authority staff at £750k and training for local authority staff at £700k.
COSTS TO LOCAL AUTHORITIES

459. The total additional ongoing cost to local authorities associated with the new Bill is estimated as £13 million per annum. This breaks down into the following components:

- £2.0 million to fund a substantial improvement in the packages of care available to people subject to community based compulsory treatment;
- £2.5 million to fund 45 new f.t.e. mental health officer posts;
- £1.5 million for the development of advocacy services; and
- £7.0 million for improved care, support and developmental services.

Improvements in packages of care

460. It is estimated that there may be around 200 people subject to community based compulsory treatment at an additional cost (compared with the services they may receive currently) of £10,000 per head per annum. This is based on packages of care costing on average £350 per person per week and assuming the current care costs for these people are around £150 per person per week. The increase in expenditure reflects the principle of reciprocity and the need to provide a comprehensive package of care to anyone receiving compulsory treatment. To the extent that community-based compulsory treatment orders allow people to remain in the community who might otherwise be detained in hospital, this will free up NHS mental health resources.

New mental health officer posts

461. The role of mental health officers is significantly enhanced in this Bill. The application procedure for long term compulsion is more complex. Mental health officers will be more involved in decisions relating to, and developing care plans for, patients. All patients receiving compulsory treatment on a long-term basis will have a more comprehensive care plan than current legislation requires, and the mental health officer will be required to play an ongoing role in care management. Overall, this is estimated to require 45 new full-time equivalent posts.

Advocacy services

462. The Bill contains a duty on both local authorities and NHS Scotland to ensure that service users have access to advocacy services. Statutory expenditure on advocacy this year is expected to be £3.7 million. It has been estimated by advocacy interests that the cost of fully comprehensive advocacy services across Scotland for mentally disordered people could be in the region of £10 million. However, the ultimate cost depends on factors including the level of demand from service users and the effect of other changes in the legislation and practice intended to involve service users more closely in decisions about their care. In any event, it takes time to develop the services while maintaining high-quality provision. It is proposed to increase advocacy expenditure by £1 million a year for each of three years so that it will be £6.7 million per annum in 2005/6. Costs have been divided equally between local authorities and NHS Scotland.
Improved local authority care and support services

463. Local authorities already have statutory duties to provide social care services for people with mental disorders. The Bill updates and broadens the duties currently in sections 7, 8 and 11 of the Mental Health (Scotland) Act 1984. It is estimated that additional expenditure of £7.0 million will be required to cover the cost of meeting new duties to provide or arrange the integrated care and support services needed, and to deliver the broader range of day activities, for people who are, or have been, suffering from mental disorders.

Start-up costs

464. A need is anticipated for some additional capital expenditure to support the ongoing revenue costs for improved local authority care and support services, and new services for community based orders. The anticipated cost is £2 million a year for two years.

COSTS TO NHS BOARDS, PRIMARY CARE TRUSTS AND GENERAL MEDICAL PRACTICE

465. The total additional ongoing cost to NHS Scotland associated with the new Bill is estimated to be £6.0 million per annum, as broken down below.

Improvements in packages of care

466. The principle of “reciprocity” and the scrutiny of plans of care by a Tribunal might lead to pressure on the NHS to improve the quality and range of services for patients subject to compulsion. The cost of this is difficult to quantify, as there is already an expectation that NHS Boards should ensure that services meet the standards set out in the Framework for Mental Health Services and other guidance, including the Clinical Standards Board Standards for Schizophrenia. An estimate of the additional cost is £2.0 million.

Additional psychiatric time and support

467. The more complex procedures for the new compulsory treatment orders will increase the workload of psychiatrists, in preparing plans of care and applications for compulsion, appearing before Tribunals, and negotiating with mental health officers and other members of the care team. The cost of the additional psychiatric cover and administrative back-up is estimated at £1.5 million a year.

468. The cost of psychiatric members of the Tribunal service (£0.65 million) is reflected in the Tribunal running costs.

Rights to assessment

469. It is intended to add provisions to the Bill giving mental health service users and carers a new right to request an assessment of needs. The costs of carrying out needs assessments, following the successful request for an assessment by a patient or carer, could be around £0.5 million per year.
Advocacy services

470. As discussed under costs on local authorities (paragraph 460), advocacy services could require an additional £1 million per year each year for three years starting in 2003/4. The costs will be divided equally between local authorities and the NHS. However, the NHS is already working towards the commitment in Our National Health of making advocacy services available to all who need it (in whatever treatment setting) so this should be seen as an existing commitment.

Improvement of services to informal patients

471. Up to 100 informal patients a year may apply to the Tribunal for a consideration on whether they are de facto detained. Assuming 50 such applications are successful, whether or not the applications lead to procedures for formal detention, it is likely that services to the successful patients will have to be improved. If the cost of improved services is £200 per week, then the additional expenditure required is £0.5 million per annum. This estimate is subject to considerable uncertainty.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

472. There should be no additional costs falling on bodies or individuals other than the Scottish Executive, NHS Scotland and local authorities. Although other persons and bodies will be affected by the new Mental Health Bill, including private hospitals and care homes, service users and carers, voluntary organisations (user groups, advocacy service providers), it is not anticipated that the Bill will increase the costs for any of these bodies or individuals. The Bill does not propose any new regulation for caring institutions, therefore the issue of compliance costs does not arise. Legal aid will be provided to cover the cost to service users of making representations to the Tribunal, so although more applications and appeals are expected, the cost of these will not be met by service users.

UNCERTAINTIES IN COST ESTIMATES

473. All the cost estimates are subject to some considerable uncertainty. The factors which might affect the overall cost of the Bill include: the date of implementation; the nature of the Tribunal rulings and the degree to which they specify the services required; any court rulings which specify minimum service standards; developments in psychiatric medicine leading to more expensive or cheaper treatments or a shift to or from hospital detention; and any movement in the boundary between formal and informal patients in order to comply with the European Convention on Human Rights. Taking these factors together the margin of error in the ongoing expenditure from 2004/5, including NHS spending, could be as high as £5 million either way.
EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

474. On 16 September 2002, the Minister for Health and Community Care (Malcolm Chisholm) made the following statement:

“In my view, the provisions of the Mental Health (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

475. On 16 September 2002, the Presiding Officer (Sir David Steel) made the following statement:

“In my view, the provisions of the Mental Health (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”