MENTAL HEALTH (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Mental Health (Scotland) Bill introduced in the Scottish Parliament on 16 September 2002. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 64–EN.

BACKGROUND

2. The Bill is the fulfilment of the commitment in Programme for Government: Making it Work Together to modernise the statutory framework for meeting the needs of people with mental illness.


CONSULTATION

5. Before completing its report, the Millan Committee consulted extensively with a wide range of people and organisations with an interest in mental health legislation. The Committee issued a number of consultation documents, as well as holding a series of consultative events and oral evidence sessions, and visiting services and facilities in Scotland and England.

6. Once the Committee had developed its preliminary recommendations, it issued a detailed consultation paper to interested parties. This confirmed that many of the recommendations reflected a broad consensus. Where views diverged, this was identified in responses to the consultation, and pointed out in the report. Acknowledging this extensive consultation process, the Scottish Executive decided that it was not necessary to carry out a further full consultation on the Committee’s final report, after it was submitted to Scottish Ministers in January 2001.
7. Instead, a Mental Health Legislation Reference Group was set up to consider and comment on the recommendations of the Millan Report, particularly those which were complex or contentious. The membership of the Group was made up of user, carer, service provider, legal and professional interests. The Scottish Executive also sponsored a number of consultative events with a range of stakeholders to enable them to comment on the Millan Report and its implications for policy and practice. In addition, the policy statement indicated that views on its contents would be welcome.

8. The Reference Group continues to operate as a high level consultative body, bringing its expertise to bear on specific issues, and it will remain a key link in the implementation of the Bill.

9. A draft of the Bill, though incomplete in some respects, was published on 27 June 2002, with the undertaking that the Scottish Executive would take account of comments received in considering whether to lodge amendments during Stage 2 of the Parliamentary process.

POLICY OBJECTIVES OF THE BILL

10. In the last two decades, since the Mental Health (Scotland) Act 1984 was passed, much has changed in the delivery of care and treatment to people with mental disorders, including greater emphasis on care in the community and on the rights of service users. The overall policy aim is to update the legal framework:

- to help deliver the best possible support and protection for patients and their families;
- to equip professionals with the legal tools to be able to do their jobs properly; and
- to provide clearer, fairer and safer mental health legislation that underpins modern ways of delivering mental health care.

PART 1 - PRINCIPLES

Policy objective

11. The Millan Committee set out ten key principles which should underlie the drafting and operation of the Bill. The Bill seeks, as far as possible, to give effect to these principles in an appropriate legislative form.

Detailed provisions

12. The Bill contains a provision setting out particular matters to which persons exercising certain functions under the Bill must have regard. These relate to the Millan principles of equality and respect for diversity, least restrictive alternative, participation and respect for carers. The Millan principles of benefit and informal care have been incorporated into the provisions concerning compulsory treatment, with requirements that any compulsory treatment must benefit the patient, and it must be necessary for the order to be made. The principle of reciprocity is reflected in the provisions that the Mental Health Tribunal must consider any compulsory treatment order in the context of a broader plan of care, and in the powers of the
Tribunal to specify certain aspects of the patient’s care as being essential to support the compulsory treatment order. The Executive is giving further consideration to whether it would be appropriate to add a specific provision on child welfare.

**Alternative options**

13. The Millan Committee recommended that the Bill should contain a Statement of Principles, setting out the ten principles which the Committee proposed. The Executive accepts the general intention behind all ten principles but has concluded that not all of them can be given proper legislative effect in such a general statement. The Bill therefore includes certain of the principles in a general provision, in a form intended to have clear legal effect, alongside specific measures which give effect to other principles.

14. The principles of non-discrimination, equality and respect for diversity relate in various ways to the issue of equal opportunities. Equal opportunities is, subject to specified exceptions, a reserved matter, meaning that there are restrictions on the extent to which it can be dealt with in an Act of the Scottish Parliament. The Executive has also taken account of the Report of the Expert Committee on the review of the Mental Health Act 1983 in England and Wales (the Richardson Committee). That Committee proposed a similar principle to the Millan principle of non-discrimination but accepted that it was not something which should be expressed within the Act itself (paragraphs 2.14-2.16).

**PART 2 - THE MENTAL WELFARE COMMISSION FOR SCOTLAND**

**Policy objectives**

15. The Mental Welfare Commission has a key role in promoting and safeguarding the welfare of individuals with mental disorder and this will continue in the Bill. The Bill allows the Mental Welfare Commission the scope to take a more strategic approach to performing its role of protecting individual patients, and gives the Commission the role of monitoring and promoting best practice in the operation of the Act.

16. The Millan Committee’s recommendations form the basis of this part of the Bill.

**Detailed provisions**

17. The provisions relating to membership, appointments, procedures, reports and accounts are designed to allow flexibility where necessary and properly to set out the structure, composition and obligations of the Commission as a public body.

18. It is intended to strengthen the involvement of service users and carers in the Commission. More generally, the Commission’s operational and management arrangements will be considered in the light of its recent quinquennial review.

19. The Commission will maintain a central focus on the protection of the rights and interests of individual patients. It also has a newly stated responsibility to promote best practice in relation to the Bill. It can exercise its powers for the protection of people with mental disorder wherever they happen to be - in hospital, in prison or in the community.
20. The Commission has the power to conduct enquiries and investigations and publish reports on these. In order to ensure that the right lessons are learned from these enquiries, the Commission will also be empowered to investigate and report on whether and how its recommendations have been implemented.

21. The Commission will visit, as often as it thinks appropriate, patients subject to compulsory measures, whether in hospital or the community. It may also visit hospital, prisons and community services to meet people with mental disorders who are not subject to compulsion. There is a corresponding duty imposed upon the NHS, local authorities and other public bodies to co-operate with the Commission in the performance of its functions.

22. The Commission will continue to publish an Annual Report, and may also publish information or guidance on the legislation and its operation. It has powers to advise Scottish Ministers and certain other public bodies and alert them to matters of concern. As part of the Executive's wider research strategy, it is intended to make more strategic use of information gathered by the Commission.

23. It is intended to seek to add provisions to the Bill which will give the following additional powers to the Commission.

- The Commission will have the power to refer the case of any patient subject to long term compulsion to the Tribunal, where the Commission believes that there has been a change of circumstances such that the specific compulsory powers may require to be amended. It may also refer cases back to the Tribunal where the Commission is concerned that essential aspects of the patient’s plan of care have not been delivered.
- The Commission will also have a power to discharge any patient subject to emergency or short-term detention, or long term compulsion, where the Commission is satisfied that the patient no longer meets the relevant criteria for continuing compulsion.

24. The Commission will not be under a duty to review cases upon request, but may review cases as it sees fit - whether they arise as a consequence of a request by the patient, because the Commission has chosen to review particular classes of patient, or the patient has come to the attention of the Commission in exercise of its other functions.

25. The Commission will not have the power to discharge restricted patients. However, it is intended that it will have the power to require Scottish Ministers to refer such cases to a Mental Health Tribunal.

Alternative options

26. The Millan Committee recognised that a new Bill, with additional safeguards for patients, might call into question the need for the Commission to retain a power of discharge and to devote considerable resources to reviewing compulsory measures, to consider whether discharge is warranted.
27. The Executive’s Policy Statement sought views on an alternative proposal: for the Commission to have the power to refer cases, where it felt compulsion was no longer justified, to the Mental Health Tribunal for consideration. The Executive received few direct representations in response to the Policy Statement. Further consultation with the members of the Mental Health Legislation Reference Group revealed widespread support for retention of the Commission’s discharge power. Accordingly, as set out above, the Executive has decided not to remove completely the Commission power of discharge. However, the policy intention is to retain the power in a way which minimises perceived disadvantages, namely:

- the potential for subverting the role of the Tribunal, which approves applications for long term compulsion and hears appeals on a judicial basis, and which tailors long term compulsory orders to the needs of individual patients;
- the fact that the Commission would not be able to amend, rather than completely remove, compulsory powers, and would not be able to consider the effect of such a change on the patient’s care plan, or vice versa;
- the risk of the Commission wastefully duplicating the work of the Tribunal, and directing its efforts at those who are most able to seek review, rather than more vulnerable patients who do not feel able to approach either the Commission or the Tribunal.

28. As noted in paragraph 23, it is intended that provisions will be added to the Bill retaining the Commission’s power of discharge, but, as the Millan Committee recommended, in a way which allows the Commission some control over the cases it chooses to review. In addition, provision is intended to be made for alternative means of dealing with cases where the Commission may not be satisfied that a case for complete discharge from long term compulsion has been made out, but feels that there should be a review of the compulsory powers. This would be done by giving the Commission power to remit such cases to the Mental Health Tribunal.

29. In England and Wales, the Department of Health has proposed that the responsibilities of the Mental Health Act Commission should in future be carried out by a proposed new health care inspectorate, as part of more general monitoring of the quality of health care.

30. The Executive regards it as important to maintain the Mental Welfare Commission as an independent body with a specific focus on the needs of people with mental disorders and the proper application of mental health law.

PART 3 AND PART 18 - MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Policy objectives

31. The role of the legal forum under the Bill is complex and multi-faceted. It approves long-term compulsion, hears appeals, and considers reviews. It will need to consider each of the new criteria for compulsion, and tailor compulsory powers to the needs of the individual patient. In doing so, it will be required to consider a range of matters, including the patient's plan of care. These tasks require a range of expertise in the law and in the care and treatment of mental disorder. To provide this, a new Mental Health Tribunal will be established to hear cases under the Bill.
Detailed provisions

32. The Tribunal will be a national body, with a senior legal figure as its President.

33. The procedures for Tribunal hearings will be designed to encourage the participation of service users and, where appropriate, carers. This will be set out in Rules of Procedure. The Tribunal will operate as informally as possible, while meeting the requirements of due process.

34. Each Tribunal hearing will have three members, with a legally qualified chair. There will also be a medical practitioner with experience in mental health. This will often be a psychiatrist, although it will be possible for other medical practitioners with appropriate experience and expertise to serve. The third member will be a person with experience of the assessment, planning and delivery of mental health services. A range of people may have the skills and experience necessary, including social workers, occupational therapists, psychiatric nurses, and voluntary sector workers. People with personal experience as service users or carers may also serve, if they have the appropriate competencies.

35. It is intended that the Rules of Procedure will provide that the legal chair will be responsible for producing a written decision and may take certain procedural decisions. Otherwise, the three members of the body will each bring different expertise, but will all have equal rights and responsibilities in considering the case.

36. Patients and named persons will have a right of appeal against decisions of the Tribunal. The mental health officer and responsible medical officer may appeal against the terms of a Tribunal order, but not against a decision to discharge the patient from compulsion. In most cases, appeals will be to the Sheriff Principal, but important cases may be remitted to the Court of Session.

37. In cases concerning restricted patients, it is intended that the legal chair will be a sheriff, which will provide reassurance that these serious cases, involving significant issues of public safety, are dealt with by a body carrying a high level of legal expertise and authority. Appeals from the Tribunal concerning restricted patients may be initiated by Scottish Ministers, patients or named persons and will be to the Court of Session.

Alternative options

38. The Millan Committee proposed that either a new, specialist Mental Health Tribunal should be established, or a sheriff should sit alongside two persons with appropriate expertise. The Committee’s preference was for a specialist Tribunal.

39. The Executive shares the Millan Committee’s preference for a new specialist Mental Health Tribunal. It would be administratively extremely complex to fit together the arrangements for normal sheriff court hearings with mental health hearings involving other members, and it would be more difficult to develop shared training and expertise.

40. The Millan Committee recommended that the medical member of the Tribunal should conduct an examination of the patient prior to the hearing. The Executive has concluded that this is not desirable. It would add considerably to the costs and time of the hearing, and could be
This document relates to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

distressing for the patient. More particularly, it might not provide useful information on the real issues of concern at a particular hearing. It would also create a risk of a confusion of roles, with the medical member acting as both a judge and a kind of expert witness. Instead, it is intended that the Rules of Procedure will allow the Tribunal to commission independent medical reports, if it deems it appropriate.

PART 4 - LOCAL AUTHORITY AND HEALTH BOARD FUNCTIONS

Chapter 1: Health board duty

Approved medical practitioners

Policy objectives
41. The Bill requires certain functions to be performed by medical practitioners with special experience or expertise in the diagnosis or treatment of mental disorder. These practitioners must be approved by a health board and have undergone the appropriate level of training.

Detailed provisions
42. A duty is placed on health boards to maintain a list of medical practitioners in their area who have special experience or expertise in the diagnosis or treatment of mental disorder.

43. Scottish Ministers will make provision by directions for the qualifications, experience and training of practitioners who are approved for inclusion on the lists maintained by health boards.

Chapter 2: Local authority functions

Provision of services

Policy objectives
44. The Millan Committee wished to ensure that the Bill set out responsibilities of local authorities to meet the needs of persons with mental disorders. The new duties on local authorities to provide, arrange and support a range of services appropriate to their area for persons with mental disorder have been updated and extended from those in the Mental Health (Scotland) Act 1984 (“the 1984 Act”) and broadly follow the recommendations of the Committee.

Detailed provisions
45. Duties are placed on local authorities to provide or arrange the provision of:

- a range of care and support services to meet the needs of people who have, or have had, a mental disorder;
- a range of day activities for persons with mental disorders designed to promote their well-being and social development; and
- transport in connection with these services and activities.
46. In line with general community care policy, local authorities are not expected to provide all services directly, but may fulfil their duties directly or through arrangements with voluntary, statutory and private agencies.

47. These duties are without prejudice to the general responsibilities of local authorities to provide community care and children’s services. Regulations will establish arrangements for charging for such services, which will be consistent with the provisions for personal care under the Community Care and Health (Scotland) Act 2002. Local authorities and the NHS will be required to co-operate in meeting the needs of people with mental disorders.

Appointment of mental health officers (MHOs)

48. Local authorities will also be responsible for ensuring they have adequate numbers of mental health officers (MHOs) to fulfil their statutory responsibilities. Directions will provide that mental health officers must be qualified social workers with appropriate training and experience.

Inquiry into cases where mentally disordered persons are at risk

Policy objective

49. This part of the Bill sets out procedures to allow mental health officers to intervene where people with mental disorders may be at risk in the community. They draw on the proposals of the Scottish Law Commission in its report, *Vulnerable Adults*.

Detailed provisions

50. Local authorities will be under a duty to make enquiries where they have reason to be concerned that a person may have a mental disorder and be at risk. The risk may be related to suspected abuse, or to a lack of adequate care. If it is not possible to gain access to the person, a warrant may be obtained by a mental health officer from a sheriff or justice of the peace. Once access has been gained, a doctor may examine the person believed to be at risk.

51. Wherever possible, the intention of such action would be to ensure that the person is given the opportunity to receive any necessary help on an agreed basis. In some cases, however, emergency detention might need to be initiated by the doctor. Alternatively, if the person is not able to make decisions about his or her personal welfare, action may follow under the Adults with Incapacity (Scotland) Act 2000.

52. It is intended to add further provisions. In particular, in urgent and serious cases, a sheriff will be empowered to authorise the removal of the person to a place of safety for a period of up to seven days, to allow arrangements to be made for their care in the longer term.

Alternative options

53. The *Vulnerable Adults* proposals were not restricted to people with mental disorders, and also related to elderly people and people with physical disabilities. The Bill is restricted to
people with mental disorders. A separate consultation has been held on whether there should be further legislation covering these other groups. It would not have been appropriate to deal with this wider group in a Mental Health Bill, but nor would it have been right to introduce new mental health legislation without including appropriate provision for urgent intervention when mentally disordered people were at risk.

**PART 5 - EMERGENCY DETENTION**

*Policy objective*

54. Provision is made for the detention of a patient where it is a matter of urgency, while providing appropriate safeguards for the patient. These are intended to ensure that emergency detention is only used as a genuine last resort, and that its duration is as short as possible.

*Detailed provisions*

55. Emergency detention will be possible either direct from the community or if the patient is already in hospital as an informal patient and intends to leave. The criteria reflect the urgent nature of the need for detention for assessment or treatment.

56. An emergency detention will proceed on the certificate of a registered medical practitioner and, where practicable, the consent of the mental health officer. If it is not practicable for the mental health officer to consent, the local authority must be informed of the detention. The Mental Welfare Commission, the named person (when known) and the nearest relative or a responsible person residing with the patient will be informed of any emergency detention.

57. The grounds are based on a likelihood that the person’s ability to make decisions about medical treatment has been significantly adversely affected by mental disorder, a significant risk to the patient or others, and admission to hospital being urgently necessary.

58. Emergency detention can last for a maximum of 72 hours and can end at any time, by the person being discharged, agreeing to treatment informally or moving onto short-term detention or long term compulsion. Once a patient has been admitted, the hospital managers will be required to arrange for an examination to be carried out forthwith by an approved medical practitioner.

59. Treatment of a patient’s mental disorder without consent during the period of emergency detention is only permissible in cases of urgent necessity.

60. The Millan Committee wished to ensure that this power is only used when there is no alternative. A doctor who initiates emergency detention will be required to notify the reasons why detention was necessary, and other options such as short-term detention or an application for a compulsory treatment order could not be used.
Alternative options

61. The Millan Committee considered whether the time limit for emergency detention could be reduced to 24 hours. However, during their consultation it was highlighted that a 24 hour limit could pose practical problems in getting hold of an appropriately qualified psychiatrist, particularly in remote areas or at the weekend.

62. There is no appeal against the use of an emergency detention. The Executive agrees with the conclusion of the Millan Committee that there are practical problems in arranging an appeal within the 72-hour time frame and the introduction of an appeal would give little effective protection for the patient.

PART 6 - SHORT-TERM DETENTION

Policy objectives

63. A person with mental disorder may require detention in hospital for a short period for a formal assessment and the initial treatment of their mental disorder. This may be the preliminary to an application for long-term compulsory measures, or may act as a short-term intervention before returning to treatment being negotiated on a voluntary basis. The Bill will, for the first time, allow short-term detention without a prior emergency detention.

Detailed provisions

64. Short-term detention requires to be authorised by an approved medical practitioner and a mental health officer. The criteria reflect the need to detain an individual for treatment or assessment for a limited period. There must be a significant risk to the patient or others and a likelihood that the patient has a mental disorder which has affected their ability to make decisions about their treatment. An order lasts for up to 28 days, and can be extended for a limited period to allow an application for long-term compulsion to be authorised by the Mental Health Tribunal.

65. It will be possible to treat compulsorily persons subject to short-term detention, in accordance with the provisions in Part 13 of the Bill regulating compulsory treatment.

66. It is possible for the patient or the named person to apply to the Mental Health Tribunal for discharge against short term detention, at any time during that period of detention. It is intended to add provisions giving the Mental Welfare Commission the power to discharge patients from short-term detention (see para 23).

67. The responsible medical officer will be required to keep the patient’s situation under review throughout the period of detention and discharge the patient if the order is no longer justified.

68. The granting of a short-term detention certificate will trigger a requirement for a mental health officer to prepare a social circumstances report to inform future care planning unless, exceptionally, the MHO decides, in the circumstances, that such a report would serve no practical purpose.
Alternative options

69. The Millan Committee considered a number of suggestions on short-term detention during their consultations. These included:

- replacing the short term detention with a seven day assessment order; and
- maintaining the order at 28 days but having a ‘paper’ review at 7 days.

70. A seven day assessment order would avoid a patient being detained for as long as 28 days if they only require a few days admission for a crisis to pass. However, the Committee was not aware of detentions of undue length under the current short-term provisions. The Committee also felt that an advantage of a 28 day detention was that it may take some weeks for the efficacy of a treatment regime to be evaluated and any proposed plan of care put to the Tribunal would be based on better evidence.

71. The Committee was not convinced that a paper review at 7 days would have any appreciable effect or provide a worthwhile safeguard for the patient.

72. After weighing the evidence submitted, the Committee concluded that four weeks is an appropriate maximum duration for short-term detention. The Executive agrees with their conclusion.

PART 7 - COMPULSORY TREATMENT ORDERS

Criteria for long term compulsion

Policy objectives

73. The justification for imposing compulsory measures on someone without their consent is perhaps the most fundamental issue in mental health law. Therefore the Bill sets out clearly the tests that must be satisfied before long-term compulsion can be imposed. These are based on the proposals of the Millan Committee.

Detailed provisions

74. The Mental Health Tribunal must be satisfied (on the balance of probabilities) that all of the criteria are met before it can authorise or continue long-term compulsion. The criteria reflect the following factors:

- presence of mental disorder;
- treatment is available which will benefit the patient;
- there would be a significant risk to the patient or to others if the treatment were not given;
- the person’s ability to make decisions about such treatment has been significantly impaired by the mental disorder; and
• it is necessary to make a compulsory treatment order.

75. The compulsion must be justified in the context of a care plan setting out any wider measures of support necessary to underpin the compulsory treatment, and the general principles of the Bill.

76. Medical treatment is given a broad meaning and includes medical, nursing and other interventions. Treatment may include interventions designed to address aggressive or dangerous behaviour, but mere containment would not amount to treatment.

Alternative options

77. The Millan Committee recommendations form the basis of the criteria in the Bill.

78. It was suggested to the Millan Committee that a capacity test should be used as a criterion for long term compulsion. The effect would be that a person could not be liable to compulsory treatment unless they did not have the ability to make decisions about that treatment, because of the severity of their mental disorder. The Millan Committee considered that incapacity, as such, should not be the fundamental criterion for compulsory interventions, but also argued that it was important to demonstrate that a person’s ability to make decisions about treatment had been adversely affected.

79. For the reasons set out by the Millan Committee, the criterion of ‘impaired decision-making ability’ has been adopted. The effect of the mental disorder on the person’s ability to make choices about treatment must be significant, but need not reach a particular threshold of incapacity. It is necessary to evaluate the extent of impairment of decision-making ability, alongside the risks of not acting, and the likely benefits of treatment, in order to determine whether compulsion is justified.

80. Nevertheless, the intention in using impaired decision making as a criterion is that it will involve similar factors to be taken into account as in assessing ‘incapacity’ under the Adults with Incapacity (Scotland) Act 2000. This would involve consideration of the extent to which the person’s mental disorder might adversely affect their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to communicate those decisions to others.

Procedures for making, varying and renewing compulsory treatment orders

Policy objectives

81. For people who require compulsory care on a long term basis, the Bill will replace the current ‘one size fits all’ detention with a flexible compulsory treatment order (CTO), restricting compulsory measures to those necessary for the individual patient. In some cases, this may allow a person subject to compulsion to remain in the community, rather than be admitted on a long term basis to hospital. The legal protections for persons subject to long term compulsion are also strengthened, with a more open and accessible system of hearings and appeals.
Detailed provisions

82. An application for long term compulsion can be initiated whether the service user is currently in the community, informally admitted to hospital, or subject to short term or emergency detention. The procedure will be initiated by an application from a mental health officer, accompanied by two medical recommendations. At least one recommendation must be from an approved medical practitioner and the other may come from the patient’s GP. The application will include a number of elements including a plan of care, based on an assessment of needs, to which all the relevant agencies and professionals will have contributed. It will be necessary to specify in the application the particular compulsory powers which are sought.

83. The named person and the patient must be informed that a CTO application is proposed, to allow time for arrangement of appropriate support and representation.

84. The mental health officer is obliged to ensure, so far as possible, that the patient understands the implications of the application, and their rights. The patient should be told what advocacy services are available and how to obtain access to them.

85. The application will be considered by the Mental Health Tribunal which must give the patient, the named person and the patient’s primary carer the opportunity of making representations to them. If the patient is too unwell to instruct representation, regulations will provide that a curator ad litem must be appointed to protect the patient’s interests. Patients and named persons will be entitled to free legal representation, through the assistance by way of representation scheme. The Tribunal may authorise a CTO if satisfied that all of the compulsion criteria are met.

86. A CTO when first granted by the Tribunal will last for up to 6 months before it must be renewed or terminated. The CTO will specify the compulsory interventions which are permissible under it throughout its duration.

87. A range of measures are competent under a CTO. These include:

- detention in hospital;
- compulsory medical treatment;
- requirements to attend specified places for treatment;
- requirements to allow care professionals to visit the patient’s home;
- requirements to reside at a specified address, or to notify a change of address.

88. The Tribunal will only specify those powers from this list which it decides are necessary and appropriate.

89. Although it will be possible for a patient to be required to accept compulsory medical treatment while living in the community, it will not be permissible to give treatment forcibly, except in a clinical setting.
90. Although the primary role of the Tribunal is to consider what compulsory powers, if any, are appropriate, it will be expected to do so in the light of the broader plan of care. The Millan principle of *reciprocity* states that people who are obliged to accept compulsory treatment should have a reciprocal entitlement to expect that they will receive the care and support that they need. It is envisaged the Tribunal will wish to be satisfied that the care plan is adequate before finalising the CTO. Also, the Tribunal may specify in the order certain aspects of the care plan which it considers are necessary to underpin the compulsory powers being granted.

91. The NHS and local authority will be expected to ensure that such services are made available. It is intended to add provisions to the Bill setting out that, if this turns out not to be the case, the responsible medical officer will be under a duty to report the matter to the Tribunal. Alternatively, the patient or named person may bring the matter before the Tribunal at any subsequent review or appeal.

92. After 6 months, a CTO can be renewed by the responsible medical officer for another 6 months and thereafter, will be renewable annually. A range of procedures must be followed before a CTO can be renewed, including a full multi-disciplinary review. The Mental Welfare Commission and the Tribunal must be informed of a renewal.

93. The patient and named person can each apply to the Tribunal asking for the order to be varied or terminated. This right applies at any time except in the first three months of an order being authorised by a Tribunal.

94. A major area of concern highlighted during consultation was that, once a community-based order was in place, it might be hard for the patient to show that the order could safely be discharged. It is a requirement that the RMO terminate the order when satisfied that the compulsion criteria are no longer met. However, it is recognised that this may be a difficult matter of judgement, particularly in cases where there is a history of relapse following the removal of compulsion. As set out above, a full multi-disciplinary review must be undertaken before the regular renewals of a CTO, and it will be open to the patient and the named person to request that the Tribunal discharge the order at any renewal. The Millan Committee recommended that the Tribunal should consider all orders at least once every three years. The Bill strengthens this further, for all long term orders, by requiring the Tribunal to review any renewal where there has been no such review within the last two years.

95. The RMO is required to keep the need for a CTO under continuing review during the period of compulsion. A CTO can be terminated at any time by the RMO. A CTO is terminated when the RMO determines that the compulsion criteria are no longer satisfied in respect of all the compulsory measures permitted under the CTO.

96. The responsible medical officer may apply to the Tribunal at any time for a variation of the compulsory measures originally granted.

97. It is proposed to add provisions to allow the Mental Welfare Commission to refer cases to the Tribunal where the Commission believes the compulsory powers may require review, or the services recorded in the CTO are no longer being delivered. The Commission will also be able
to discharge the patient from compulsion if satisfied that compulsion is no longer justified (see paras 23-28).

Alternative options

98. The case for the introduction of an order that will allow compulsory treatment in the community has been the subject of wide debate. The Millan Committee considered that it followed from the move towards patient-centred orders, and the principle of least restrictive alternative, that it should not be necessary in every case for a patient who required some form of compulsory treatment to be detained in hospital. The Committee accordingly recommended that a new form of community order be introduced, alongside a hospital based order, and that the procedures for obtaining both of these orders should be the same.

99. After consideration of the arguments the Executive has concluded that the Millan Committee recommendations are right in principle. It should not be necessary to detain people in hospital, causing great disruption to their personal lives, if the necessary care and treatment can be provided in the community.

100. It has been suggested that, instead of introducing community based compulsory treatment orders, the Executive should improve and support the use of the current community care orders (CCO). The Executive has considered this and does not believe that continued use of the CCO would be effective. The Millan Committee referred to research carried out and their consultation into the use of CCOs which concluded that the orders are little used for two reasons:

- the CCO procedures are unnecessarily cumbersome; and
- the orders are felt to be ‘toothless’, in that it is difficult to intervene effectively if the patient refuses to accept treatment.

101. The Executive believes that the introduction of a single compulsory treatment order where the patient can be based either in hospital or in the community is a more practical and flexible option with effective safeguards for the patient.

102. It has also been suggested that the case for a community-based order is unproven, and that the bigger problem is the lack of adequate support in the community for people with mental health problems.

103. The Executive agrees that community services need to improve. The Bill strengthens the duties on local authorities to provide such services and the costs of this are reflected in the Financial Memorandum. However, this does not alter the general principle that, where a person who requires compulsory treatment can be cared for solely in the community, it should not be a legal requirement to detain them in hospital.
Consultation

104. The broad framework of the long term compulsion process has been widely supported. In particular, the inclusion of a plan of care, detailing the care and treatment the patient is to receive has been seen as a positive step.

105. Some individuals and groups remain opposed to compulsory treatment in the community but the Executive believes that it should be seen within the framework of the whole Bill, which provides for a significantly more open and accountable process with new safeguards for the patient.

Procedures for breach of a community-based CTO

106. Where a patient is detained in hospital, treatment authorised by the CTO and which the RMO determines is necessary may, as a last resort, be administered forcibly (subject to the safeguards in Part 13 of the Bill). The same does not apply in the community. The Bill contains provisions setting out what may happen if a patient subject to a community-based CTO does not comply with the terms of the order.

107. It will be possible for a patient, subject to a community-based CTO, to be admitted compulsorily to hospital if their mental condition deteriorates to the extent which would justify emergency or short-term detention, or if there is a significant breach of the terms of the order which would put the patient at risk.

108. Unless the situation is urgent, the care services will be expected to make attempts to engage with the patient, to establish why the patient is unwilling to comply and to attempt to negotiate a satisfactory resolution. If this does not succeed, and there is a risk of the patient’s condition deteriorating, the responsible medical officer, with the consent of a mental health officer, may require that the patient be admitted compulsorily to hospital. The patient and the named person will have a right to appeal to the Tribunal against this admission.

109. On admission, the patient’s situation will be assessed. He or she may be given any treatment authorised by the CTO.

110. Also, where a patient is required to attend at a particular place for compulsory treatment and fails to do so, the responsible medical officer may, with the consent of the mental health officer, arrange for the patient to be admitted to hospital for the treatment to be administered.

111. In response to concerns raised in consultation, the Millan proposals have been amended to strengthen the safeguards for service users. The procedures for detaining a patient in hospital while on a community-based order will be broadly comparable to that for compulsory admission to hospital of an informal patient. The Tribunal must now review the detention if it continues beyond 28 days.
Transfers between hospitals in Scotland

Policy objective

112. The Millan Committee commented that flexible and straightforward arrangements to allow patients subject to compulsion to move between hospitals are needed. The proposed transfer framework is based on their recommendations.

Detailed provisions

113. Patients detained under a compulsory treatment order must, unless it is impracticable to do so, be given at least 7 days prior notice of an impending transfer. The named person and the primary carer should also be given 7 days prior notice of the transfer. The Mental Welfare Commission must be informed about the transfer within 7 days of it taking effect.

114. There is a right of appeal to the Mental Health Tribunal. An appeal may be initiated within 28 days. In the case of transfer to the State Hospital, 10 weeks are allowed.

Alternative options

115. The Committee considered whether the legislation should set out procedures for transfers during emergency and short term detention and concluded that this is an important issue for operational management but it is not a matter for legislation. The Executive accepts this conclusion.

116. The Committee also considered whether a patient should have the formal right to request a transfer, but concluded that it was not necessary to spell this out in legislation. The Code of Practice will emphasise the need to treat such requests with sensitivity and respect.

Cross border transfers

Policy objective

117. Detained patients frequently move between different parts of the UK, each of which have their own mental health legislation. Procedures are necessary to allow for smooth transfers where this is in the patient’s interest, while safeguarding patients’ rights.

Detailed provisions

118. Mental health law is also under review in England, Wales and Northern Ireland. Regulations are to be made which will provide for a straightforward means of transferring mentally disordered persons to other UK jurisdictions and beyond. The details are being discussed with the other UK jurisdictions. An outline of the Executive’s intentions is as follows:

- patients and other interested parties should receive 7 days notice of an impending transfer. The patient and named person will have a right of appeal to the Mental Health Tribunal against a decision to transfer. Appeal proceedings should usually be concluded before the transfer is effected, although transfers may take place urgently in certain circumstances.
transfers from Scotland will be authorised by Scottish Ministers.

Leave of absence and suspension of orders

Policy objectives

119. Before completely ending compulsion, it may be appropriate to have a preliminary removal of restrictions. This is provided for in two ways - a modification of the long established provision of leave of absence, and a new provision allowing the RMO to suspend the order temporarily.

Detailed provisions

120. Leave of absence (referred to in the Bill as suspension or variation of detention) will allow a patient who is detained to leave the hospital. The RMO will have a wide discretion in deciding when to grant leave of absence.

121. The RMO may grant leave of absence for a period not exceeding 6 months. Total leave of absence granted must not exceed 9 months in any 12 month period. Restricted patients may be granted leave of absence for up to 3 months at a time, subject to the consent of Scottish Ministers.

122. The RMO must consult the patient’s GP and a mental health officer before any leave of absence exceeding 28 days.

123. The other effects of the order to which the patient is subject shall continue. The RMO may also impose other conditions.

124. A patient on leave of absence can be recalled by the RMO to hospital at any time.

125. Suspension of the order operates to remove all the requirements of a compulsory treatment order. It may be granted by the RMO to test whether ending the order may be appropriate. The maximum duration is three months.

PART 8 - MENTALLY DISORDERED PERSONS: CRIMINAL PROCEEDINGS

126. Although the great majority of people with mental disorder do not pose any risk to the public, there is a small number who do offend, usually in relatively minor ways. It is important that proper assessment is available, and that the courts have a wide range of disposals, to ensure that the offender receives the right care and treatment, and that the public interest is safeguarded.

127. The current system contains a sophisticated range of disposals to deal with offenders with mental disorder, and many of the recommendations by the Millan Committee in this area build on, rather than fundamentally change, the existing system. They are designed to ensure a more thorough assessment prior to the court making a disposal, and to deal with some anomalies in current legislation.
128. In relation to mentally disordered offenders who present a high risk to the public, the Millan Committee makes a number of more radical proposals. The Executive supports the general aim of the Committee to move towards a more transparent and fair system of dealing with this group. However, there are practical difficulties with some of the Committee’s proposals, which have therefore been modified - while retaining as much of the general approach as possible.

Chapter 1: Pre-sentence mental health orders

Policy objectives

129. The status of people committed to hospital while awaiting trial should be similar to that of people detained in hospital under civil procedures. The provisions ensure that persons who are suspected of suffering from mental disorder are properly assessed and those who are known to suffer from mental disorder are properly treated.

Detailed provisions

130. It will remain a responsibility of the Crown to make the court aware of any information it has concerning the mental state of an accused person. Where it is necessary for an accused to be admitted to hospital, there will be two distinct orders - an assessment order and a treatment order.

Assessment order

131. An assessment order is designed to allow the appropriate examination and assessment of persons involved in criminal proceedings. It may be sought by the prosecution or, where the accused is already in custody, by Scottish Ministers. The court may also act on its own initiative. The court may make an order on the evidence of a single medical practitioner.

132. Following the making of the order, the responsible medical officer must report back to the court on the patient’s medical condition no later than 28 days after the making of the order. At the 28 day review, the court cannot make another assessment order but may make a treatment order.

133. It is intended to seek to make provision that compulsory treatment is only possible in an emergency or if a second medical opinion from an approved medical practitioner has been obtained.

Treatment order

134. A treatment order is designed to be available in respect of persons awaiting trial or sentence who are known to suffer from a mental disorder (after an assessment order if necessary) and who require care and treatment which can only be provided in hospital.

135. The court may not make a treatment order unless it is satisfied, on the evidence of two medical practitioners, at least one of whom is an approved medical practitioner, that the criteria for making such an order are met. As with assessment orders, the prosecutor or, where the
person is in custody, Scottish Ministers may seek a treatment order, or the court may act on its own initiative.

136. A treatment order will expire at the end of the period for which the person is remanded or committed, unless before the expiration of that period they are liberated in due course of law. While the order is in effect, the person will be detained in hospital and given compulsory medical treatment, if necessary.

137. For both assessment and treatment orders, the court may also make a restriction order. The main practical effect will be that the person may not be given leave of absence from hospital without the consent of Scottish Ministers.

**Interim compulsion order**

**Policy objectives**

138. After conviction and before final disposal, the Court may require further evidence on the mental disorder of the offender and its relation to the risk the offender may present, particularly if the mental disorder may be complicated by other factors such as substance abuse. The current provisions require amendment to ensure that an appropriately thorough assessment takes place. For serious offenders, the assessment will be informed by procedures and guidance developed by the Risk Management Authority, which is being established under the Criminal Justice (Scotland) Bill.

**Detailed provisions**

139. Interim compulsion orders will replace interim hospital orders. They are to be used in cases where the offender may present a high risk to the public and a compulsion order with a restriction order or hospital direction is in prospect. The assessment of the offender’s mental disorder will include a full risk assessment, which would detail how any risk presented is related to the mental disorder and what disposal may be appropriate.

140. The court may make an interim compulsion order on the evidence of two medical practitioners, one of whom must be an approved medical practitioner.

141. The interim compulsion order may last for up to one year but, during that period, must be renewed by the court on the basis of medical evidence at least every 12 weeks.

**Remand for inquiry into mental condition**

142. For offenders whose risk level is less significant, the provisions of section 200 of the Criminal Procedure (Scotland) Act allowing a remand for reports will be retained. Where appropriate, this remand may be in hospital. Where it is, under the amendments made by the Bill, the patient will have an ongoing right to appeal against the continuation of the remand.
Chapter 2: Mental health disposals

Policy objectives

143. Although major changes to the disposals available to deal with mentally disordered offenders are not proposed, the Executive agrees with the Millan Committee that some amendment to current legislation is required. The amendments should lead to clearer legislation which will help to ensure that the right disposal is set by the court, in turn improving public safety.

Detailed provisions

144. The mental health disposals available to criminal courts which are affected by the Bill are:

- compulsion order;
- compulsion order with a restriction order;
- hospital direction; and
- probation with a requirement of treatment.

145. The compulsion order builds on and replaces the hospital order, as provided for in section 58 of the Criminal Procedure (Scotland) Act 1995. A court may make a compulsion order on the evidence of 2 medical practitioners (one of whom must be an approved medical practitioner) and a mental health officer. A compulsion order may authorise detention in a hospital or provide for treatment in the community. The same measures may be authorised by a compulsion order as by a compulsory treatment order (see paragraph 87).

146. The option of a court to impose further restrictions on the offender by the use of a restriction order is maintained, and the criteria for its imposition remain the same. Where a restriction order is added to a compulsion order, the offender must be detained in hospital. In most cases, a risk assessment would have taken place under an interim compulsion order. The effects of a restriction order are outlined in Part 10 below.

147. The option of the court to impose a hospital direction is maintained. A hospital direction exists in conjunction with a prison sentence. It ensures that the offender is initially admitted to hospital, to receive treatment for any mental disorder.

148. To date the hospital direction has been little used, which may be partly because of confusion about the basis upon which this disposal should be considered by the court. The Executive proposes to add provisions to the Bill amending the criteria for the making of hospital directions. The basis of the hospital direction would be that the person has a mental disorder which meets the criteria for admission to hospital, but either the mental disorder and the offence are not closely linked, or the offender is likely to remain a risk to the public, even after appropriate treatment for the mental disorder.
149. The existing provision in section 230 of the Criminal Procedure (Scotland) Act for probation with a condition of treatment is retained, but the time limit for a condition of treatment is extended from 12 to 36 months.

Chapter 3: Mentally disordered prisoners

150. There are occasions when an offender serving a prison sentence will be required to transfer to hospital to receive the appropriate care and treatment for their mental disorder. The Bill retains the basic framework from the 1984 Act of transfer directions to provide for the transfer to hospital and subsequent care and treatment of the offender.

151. A transfer for treatment direction may be made by Scottish Ministers on the basis of reports from 2 medical practitioners, one of whom is an approved medical practitioner, that the transfer to hospital is required and the criteria for compulsion are met. Scottish Ministers have the option to make the offender subject to restrictions.

PART 9 - PATIENTS SUBJECT TO COMPULSION ORDER

152. It is intended that a compulsion order without restrictions shall have the same effects as a compulsory treatment order, subject to certain differences to reflect the different purpose of the order. The principal differences are:

- the compulsion order is made and continues with reference to the forensic criteria (see paragraphs 190-4);
- the compulsion order is made by the sentencing court and not by the Tribunal;
- the first renewal, at 6 months, requires to be authorised by the Mental Health Tribunal; and
- it is not possible for the patient or named person to apply to the Tribunal to vary the compulsion order or to seek discharge during the first 6 months of the order.

PART 10 - PATIENTS SUBJECT TO RESTRICTION ORDERS

Policy objectives

153. Restricted patients are offenders with mental disorders who require additional scrutiny as they progress through the mental health system, to ensure that issues of public safety are given proper consideration at each stage. Restrictions are imposed either by a court, on making a mental health disposal, or when an offender is transferred from prison to hospital. The Bill makes the system for managing restricted patients more transparent, while keeping public safety to the fore. In particular, the Mental Health Tribunal will take on certain of the functions previously exercised by Scottish Ministers, and the Bill introduces a new right to apply periodically to the Mental Health Tribunal to have the restrictions removed.

Detailed provisions

154. The principal effects of a person being a restricted patient are set out below.
155. When a convicted offender is placed under restrictions, the normal time limits for renewal of detention will not apply.

156. A patient who is subject to special restrictions may not be discharged if the effect of his mental disorder is that it is necessary that the patient continue to be detained in hospital to protect the public from serious harm. This retains the effect of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

157. The day to day management of the restricted patient is the responsibility of the responsible medical officer. However, any leave of absence, or transfer, requires the consent of the Scottish Ministers. The responsible medical officer is also required to submit a report at least once a year to Scottish Ministers, detailing progress on the plan of care and on issues of risk management, and must also report whenever there is any material change of circumstances potentially affecting the appropriateness of the order.

158. The following may only be authorised by the Mental Health Tribunal:

- absolute discharge
- conditional discharge
- removal of restrictions
- variation of the compulsion order if restrictions are removed.

159. Scottish Ministers are able to refer a case to the Tribunal at any time if they are satisfied that there may be grounds for granting conditional or absolute discharge. They are required to make such a reference if the responsible medical officer reports to them that, in his or her opinion, the patient meets the grounds for discharge or removal of restrictions. The patient and named person have the right to apply to the Tribunal for discharge after 6 months, 12 months, and annually thereafter. The Executive intends to put forward provisions giving the Mental Welfare Commission the power to require the Scottish Ministers to refer a case to the Tribunal.

160. In any such review, the Tribunal first considers whether the patient is suffering from a mental disorder, the effect of which is such that it is necessary in order to protect others from serious harm that the patient continue to be detained in hospital whether for medical treatment or not. If the answer is yes, the patient remains subject to detention and restrictions.

161. If the answer is no, the second question to the Tribunal is whether the forensic criteria (see paragraph 192) continue to be met, and the third question is whether grounds warranting the Restriction Order continue to exist.

162. If the answer to the second question is no, the patient falls to be absolutely discharged. If the answer to the second question is yes, but the answer to the third question is no, the Tribunal should remove the special restrictions.
163. If a patient subject to a compulsion order with a restriction order is absolutely discharged then both the compulsion order and restriction order cease to have effect. If the restriction order is removed then the patient is treated from that time as if they were subject to a compulsion order without restrictions, whose terms will be set by the Tribunal.

164. If the answer to the second and third questions are both yes, the Tribunal should go on to consider if conditional discharge would be appropriate. Conditional discharge allows return to the community under controlled conditions, with procedures allowing rapid recall following a deterioration in their mental condition or an increase in the risk the patient presents to the public.

165. Scottish Ministers can recall patients subject to conditional discharge when satisfied that circumstances require it. The patient is able to appeal to the Tribunal against any such recall.

166. The patient, the patient’s named person and the Scottish Ministers may appeal against any decision of the Tribunal to the Court of Session, on the basis that the Tribunal has erred in law.

PART 11 - PATIENTS SUBJECT TO HOSPITAL DIRECTION

167. Ministers will receive regular reports on the progress of patients subject to hospital directions. If the patient no longer requires hospital treatment they will be transferred back to prison to serve the remainder of their sentence. A patient subject to a hospital direction cannot be conditionally discharged and would generally be transferred to prison if a conditional discharge would have been appropriate. Patients will have the right to apply to the Tribunal ending the period of hospitalisation.

168. A hospital direction will cease to have effect if the patient’s sentence of imprisonment has ended. At that stage the patient may be detained in hospital under a compulsory treatment order, if appropriate.

PART 12 - PATIENTS SUBJECT TO TRANSFER FOR TREATMENT DIRECTION

169. A transfer for treatment direction without restrictions must be renewed periodically in the same manner as a compulsion order. If Scottish Ministers are satisfied that the forensic criteria are no longer met, or if the Tribunal so orders, they must transfer the patient back to prison.

170. A transfer for treatment direction with a restriction direction has a similar effect to a hospital direction. If the grounds are met to discharge the patient absolutely then they must be transferred back to prison to serve the remainder of their sentence. A patient subject to a transfer for treatment direction with a restriction direction cannot be conditionally discharged and would generally be returned to prison if a conditional discharge would have been appropriate.

171. A transfer for treatment direction, whether subject to restrictions or not, ceases to have effect if the patient’s sentence of imprisonment has ended.
GENERAL ISSUES RELATING TO MENTALLY DISORDERED OFFENDERS

Persons found insane in bar of trial or acquitted by reason of insanity

172. The Bill does not materially alter the legislation governing what should happen if an accused person is found ‘unfit to plead’ (also known as being ‘insane in bar of trial’) or is acquitted by reason of insanity. The Scottish Law Commission is conducting a review of the defences of insanity and diminished responsibility, and it is hoped that it will issue a report by the end of 2003. Consequential amendments will be put forward, to take account of the changes to mental health disposals generally.

Acquitted persons suffering from mental disorder.

173. The Executive intends to put forward amendments creating a new procedure to deal with the situation where an accused person is acquitted of an offence and urgently requires medical assessment, to determine whether admission to hospital as a civil patient is required. In cases where medical reports have been made confirming that the accused person should receive a Compulsion Order if convicted, the court will have the power to order that, on acquittal, the accused person may be held in a place of safety for up to 6 hours, to allow a doctor to examine the patient. This reflects a Millan Committee recommendation.

Management of and responsibility for restricted patients

174. Currently, Scottish Ministers oversee the management of restricted patients, and may discharge such patients, either absolutely or subject to conditions. Patients may also appeal to the sheriff to seek absolute or conditional discharge, and Scottish Ministers are bound to comply with a ruling of the sheriff (where no appeal is made to the Court of Session). The Millan Committee recommended substantial reform to the role of Scottish Ministers and consultation has generally supported the need for reform.

175. The Millan Committee took the view that it was no longer appropriate for Ministers to have responsibility for taking decisions on management on discharge. The Committee proposed that the Parole Board, re-constituted as a Restricted Patients Review Board, should take over responsibility for deciding on questions of discharge and transfers to lower security, while the Risk Management Authority (recommended by the MacLean Committee) should be responsible for approving leave of absence and transfers to the same level of security. The Mental Health Tribunal would take on the role currently performed by the sheriff.

176. The Executive outlined in the Policy Statement Renewing Mental Law a number of difficulties it saw with the Committee’s recommendations, and put forward an alternative system which has been given effect in the Bill.

177. The role envisaged by the Millan Committee for the Risk Management Authority (RMA) was on the basis that this body would be established with the powers recommended by the MacLean Committee. The Criminal Justice (Scotland) Bill will, if passed, establish the RMA. However, as the White Paper on serious violent and sexual offenders indicated, there will be a change to the operational side of the RMA’s work. Its operational role is to be primarily a monitoring one, rather than being ‘hands-on’. There was also concern that taking on
responsibility for the oversight of around 300 restricted patients could distract the RMA from its core task of improving the management of serious violent and sexual offenders, particularly in its initial stages.

178. The Executive has therefore concluded that, for the time being, Scottish Ministers should retain responsibility for authorising leave of absence, and transfers between hospitals of restricted patients (it is intended to add provision that only the Tribunal may authorise transfers outwith the State Hospital). The RMA will provide best practice advice on risk management and assessment issues relevant to restricted patients. It will also be able to provide specific advice on the care plans of individual restricted patients, where its expertise would be useful.

179. The Executive does not consider that the Parole Board could take on the role proposed for it by the Millan Committee without major changes to its membership and operations. This would create major operational problems for the Board, which is already undergoing significant change, as a consequence of the Convention Rights Compliance (Scotland) Act 2001. Furthermore, the Millan proposals would involve two different independent bodies— the Parole Board and the Mental Health Tribunal— having overlapping powers of discharge.

180. The Executive has concluded that the simpler and better option is to provide that it should be for the Mental Health Tribunal to authorise all discharges of restricted patients.

Mental Health (Public Safety and Appeals) (Scotland) Act 1999

181. Another area of concern is how the Bill should deal with restricted patients who may still be suffering from a mental disorder, but who are no longer gaining benefit from treatment for that disorder, and who continue to present a serious risk to public safety.

182. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 introduced a new test, to be applied by Scottish Ministers and the sheriff, in determining whether a restricted patient should be discharged. In effect, a restricted patient cannot be discharged if suffering from a mental disorder, the effect of which is that it is necessary, to protect the public from serious harm, that the patient continues to be detained in a hospital.

183. The Millan Committee considered that this provision should be repealed, on the basis that it would no longer be necessary under the new legislation. The Committee acknowledged, however, that there may be a need to retain a provision such as that in the 1999 Act, for patients who were already detained prior to implementation of the Mental Health Bill, and who might not be detainable under the criteria set out in the Bill.

184. The Committee also endorsed a recommendation of the MacLean Committee that the public safety test should not apply to transferred prisoners who would otherwise be returned to prison.

185. Since the Millan Committee reported, an appeal has been heard by the Judicial Committee of the Privy Council, concerning whether the provisions of the 1999 Act were
This document relates to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

compatible with the European Convention on Human Rights. The Privy Council unanimously upheld the 1999 Act as being compliant with the Convention.

186. Although the Millan Committee’s proposals, alongside those of the MacLean Committee, should greatly improve management of high risk mentally disordered offenders, the Executive has concluded that it is right to retain the effect of the 1999 Act, as a long stop, for both current and future restricted patients.

Appeals on levels of security

187. The Millan Committee recommended that patients held in high or medium secure hospital settings should have a right to apply to the mental health tribunal to be transferred to lower security, if the level of security at which the patient was held was not justified.

188. The Executive believes there are a number of practical difficulties with the proposals made by the Millan Committee, and this appeal right is not specifically provided for in the Bill.

189. Consideration will be given to what further steps might be taken to improve the position of patients held at higher levels of security than justified by clinical need, following the recent consultation on the governance of the State Hospital, on the basis of the document The Right Place, the Right Time.

Compulsion criteria for forensic patients

Policy objectives

190. The Millan Committee considered that the criteria for compulsion for patients going through the criminal justice system (forensic patients) should be the same as the criteria for civil compulsion. After consideration, the Executive proposes a revised set of criteria which would apply to offenders given a mental health disposal by a criminal court, and prisoners being transferred to hospital.

191. The civil criteria are designed to ensure that a patient is only placed under compulsion and deprived of their liberty when there are grounds for over-ruling the patient’s autonomy. The forensic criteria are directed at ensuring that a court disposal and any continuing compulsion are appropriate, given all the circumstances of the offender’s mental disorder and offence. We believe this difference is justified in the context of criminal disposals, where the alternative to a mental health order may be prison. The aim is to place the emphasis on the patient’s need for appropriate care and treatment rather than on a person’s willingness to accept the care and treatment. The intention is also that the criteria should not preclude voluntary transfer of prisoners to hospital under the Bill, when that is the most appropriate course of action.

Detailed provisions

192. All of the forensic criteria must be satisfied before a mental health disposal is warranted. These can be summarised as:

- a mental disorder is present;
• treatment is available for the offender which is likely to improve or prevent a deterioration of the mental disorder, or associated symptoms of that disorder;
• there is a significant risk of harm to the health or safety or welfare of the patient or a significant risk of harm to other persons if such treatment is not administered; and
• in all the circumstances including the nature of the offence, the order is necessary.

Alternative options

193. This approach was generally accepted as reasonable by the Mental Health Legislation Reference Group. The Mental Welfare Commission proposed limiting the use of the forensic criteria to those mentally disordered offenders who presented a risk to public safety. This would arguably require an additional degree of risk to be added to the existing levels which justify respectively a patient being made subject to a mental health disposal and to a restriction order. Also, a patient’s condition and potential dangerousness might, for example, change as his treatment takes effect and difficult decisions would be necessary on the criteria to be applied at various steps of the order.

194. The Executive thus considers that the use of separate criteria for all patients going through the criminal justice system is appropriate. Although different from the tests for a compulsory treatment order, they retain the fundamental requirements of a need for treatment, benefit to the patient, and a risk if treatment is not provided.

Criteria for admission to the State Hospital

Policy objectives

195. The current statutory admission criteria in respect of the State Hospital require amendment to bring them up to date.

Detailed provisions

196. The criteria for admission to a state hospital reflect the requirements that the patient suffers from mental disorder of a nature or degree that he or she:

• requires treatment under conditions of special security, and
• cannot be suitably cared for in a hospital other than a state hospital.

197. These criteria apply to a range of situations where statutory criteria are specified for admission to a state hospital, including civil compulsory treatment orders, compulsion orders and interim compulsion orders, hospital directions and orders transferring civil patients and prisoners. The reference in the current criteria to ‘dangerous, violent or criminal propensities’, which the Millan Committee felt was inconsistent with current clinical practice, has been removed.
Alternative options

198. The Millan Committee recommended an additional criterion, that the patient posed a risk of harm to others or of self-harm. The its Policy Statement the Executive stated that:

‘We have concluded that it would not be desirable to specify self-harm as a potential ground for admission to the State Hospital. The State Hospital should retain its focus on patients who present a potential danger to others.’

199. This meant removing the Millan recommendation that admission to the State Hospital should be possible where there was a risk of self-harm. The Mental Health Legislation Reference Group raised concerns about this. Anxiety was expressed that removing the possibility of admission for patients who self-harm might put some patients at risk, if no other suitable resource is available. Against that, it was accepted that a high security hospital was not the appropriate facility for people who do not present a risk to others, and that it would be unhelpful for the legislation to give the impression that the State Hospital is a resource for this group, if this takes away pressure to develop suitable alternatives.

200. The admission criteria were reconsidered, to avoid encouraging referrals to the State Hospital on the basis of self-harm while not ruling this out in an exceptional case. The revised criteria are designed to reflect this.

PART 13 - MEDICAL TREATMENT

Policy objectives

201. In the majority of cases where compulsory measures are justified, it is in order to deliver necessary medical treatment which the patient will not consent to receiving. The Bill specifies authorised treatment as one of the measures which may be delivered under compulsory powers. The Bill retains and strengthens the protections for patients in receipt of compulsory medical treatment.

202. Authorised treatment is given under the supervision of the responsible medical officer. The Bill retains the concept from the 1984 Act of a general treatment authority. If compulsory medical treatment for mental disorder is authorised, the RMO shall determine the appropriate form of that treatment. However, the Millan Committee accepted the principle already established in the 1984 Act, that some treatments are special and require additional safeguards, if they are to be given to people without their consent. For a number of specified treatments additional steps must be taken before they can lawfully be given to patients subject to compulsion.

203. The treatments specified in the Bill may be added to by regulations. The intended list of specified treatments is set out below.

204. The Bill also contains protections for patients in respect of neurosurgery for mental disorder (NMD), whether such patients are subject to compulsion or treated informally.
Detailed provisions

205. For patients subject to compulsory treatment orders, or compulsion orders without restrictions, treatment can only be given compulsorily (other than in an emergency), if the Tribunal has included compulsory medical treatment within the list of powers granted.

206. Patients subject to short-term detention and compulsion orders with restrictions will, as now, be able to be given compulsory medical treatment. This will also apply to patients in the criminal justice system who are subject to hospital directions, transfer for treatment directions, interim compulsion orders, treatment orders and assessment orders (see paragraph 133 for assessment orders).

207. The following treatments can only be given to a patient who is liable to compulsory treatment, who does not consent or is incapable of consenting to treatment, with the prior authorisation of an expert independent doctor, appointed by the Mental Welfare Commission:

- treatment with drugs, after the expiry of two months from the date of the imposition of compulsory measures;
- treatment with drugs for the purpose of reducing sex drive, other than the surgical implantation of hormones;
- compelling a patient to eat or be given nutrition by artificial means against their will; and
- the administration of medication for mental disorder which exceeds normally recommended doses or is for a purpose other than the medication’s recommended purpose.

The first of these is specified in the Bill and it is intended to add the others by regulations.

208. When treatment is immediately necessary to save life, alleviate serious suffering, or prevent violent behaviour there will be no requirement to obtain a second opinion.

209. There are additional safeguards for electro-convulsive therapy (ECT). It will not be possible to give ECT to a patient who is able to make a competent treatment decision and refuses the treatment. Where a patient who is subject to compulsion is not well enough to make the decision, ECT will, except in an emergency, require authorisation by a doctor appointed by the MWC.

210. As now, the provision of neurosurgery for mental disorder, will be subject to stringent safeguards, and the Bill will extend to all patients the safeguards currently applicable to detained patients. Regulations will specify that medical treatment involving the surgical implantation of hormones for the purpose of reducing sexual drive will also attract these safeguards.

211. If the patient has the capacity to consent to these treatments, such consent must be given, and must be certified by two lay persons appointed by the Mental Welfare Commission. In addition, an independent doctor appointed by the Commission must certify that the treatment is appropriate.
212. Provision is also made for patients who might benefit from these treatments and who do not resist or object to the treatment being given, but are too unwell to give a legally valid consent. In such cases, treatment may be authorised by an application to the Court of Session, who will be required to be satisfied that the treatment is appropriate, and is not objected to by the patient.

213. For the treatments which require additional safeguards, these will be strengthened for children. If the RMO is not a child and adolescent psychiatrist, prior consultation with such a specialist will be necessary.

214. The Millan Committee suggested that additional safeguards were appropriate for children not able to consent on their own behalf to treatment, even where the child is not subject to compulsion. The Executive proposes to seek provision for this possibility in the Bill, and will consult further on the specific treatments which should be so specified.

**Alternative options**

215. ECT is a controversial treatment and it has been suggested that it should never be given to someone who resists, whether or not they are capable of consenting. However, it is a well evidenced and often highly beneficial treatment for some forms of mental illness. The Bill gives effect to the Millan Committee recommendation that ECT cannot be given to a patient who has the capacity to consent and does not agree to the treatment. In cases where the patient is incapable of consenting, it is considered that the additional safeguard given in the legislation - the need for a second opinion by an approved doctor - is appropriate.

216. It could be left to the Tribunal to specify the particular treatments which are authorised, rather than to have a general treatment authority with additional safeguards. The Millan Committee rejected this approach. It would involve the Tribunal becoming involved in judgements which are more properly clinical, rather than its proper role of evaluating whether treatment for mental disorder on a compulsory basis is appropriate.

217. It has been suggested that NMD should never be given to a patient who has not consented. The Executive agrees that NMD should never be given to someone who does not want the treatment. However, the very nature of the illnesses for which NMD might be an appropriate response may compromise the ability of the patient to give a fully competent consent. While the utmost caution is justified, the Executive does not believe it is right absolutely to rule out a particular treatment in such cases. Instead, the Executive has accepted the Millan Committee’s proposal that the most stringent possible safeguard, the approval of the Court of Session, should be imposed.
PART 14 - PATIENT REPRESENTATION

Named persons

Policy objective

218. The Bill seeks to replace the nearest relative provisions in the 1984 Act with a more flexible and comprehensive framework that allows a specified person (the 'named person') to have powers to support the service user and intervene on their behalf.

Detailed provisions

219. The named person will have the same rights as the patient to be notified of, appear, and be represented at hearings of the Mental Health Tribunal. The named person also has the right to initiate appeals against the renewal of compulsory measures, and appeals to higher courts against decisions of the Tribunal. The named person must be advised of any applications in respect of compulsory measures.

220. Service users can, when well enough to do so, decide whom they would (or would not) wish to represent their interests, as a named person. This choice is possible at any time, whether or not the patient is currently subject to compulsion.

221. The mechanism for the appointment of a named person by the service user is designed to be practical and flexible, but with a degree of formality reflecting the importance of the nomination.

222. Where the service user cannot or does not wish to appoint a named person, the named person will be the service user’s primary carer. The identity of the primary carer will be determined by the mental health officer. Where there is no primary carer, or the primary carer declines to act, the named person will be the service user's nearest relative.

223. For children, the named person will be the person with parental rights and responsibilities.

Alternative options

224. The Millan Committee recommended the replacement of the nearest relative provisions in the 1984 Act with proposals for a named person. These form the basis of the provisions in this Bill. The current provisions regarding nearest relatives have been criticised by the European Court of Human Rights, in a case concerning the English Mental Health Act, in that they do not allow a patient to displace a nearest relative whom the patient finds unacceptable.

Advocacy

Policy objectives

225. It is Executive policy that NHS Boards should work with their planning partners (i.e. NHS Trusts, local authorities and voluntary organisations) to ensure integrated independent
advocacy is available to all who need it. This policy is set out in Our National Health; a plan for action, a plan for change, and applies to mental health service users as it does to other groups.

226. Mental health service users may particularly need access to advocacy for a number of reasons. As a group, mental health service users are often marginalised. The nature of mental disorder is such that it may make it difficult for some service users to express their wishes without assistance. Unlike other patients, people with mental disorders may be detained against their will or compelled to accept treatment. The Executive therefore wishes to reinforce the general policy with a specific legal responsibility on the NHS and local authorities to secure advocacy for mental health service users.

Detailed provisions

227. The duty on NHS Boards and local authorities requires both of them to secure suitable independent advocacy services to meet the needs of people with mental disorders in their area and to make sure that the service users are aware of the services and able to make use of them.

228. NHS Boards and local authorities have discretion to decide whether to meet the duty through advocacy agencies who focus solely on clients with mental disorders or more broadly based providers who would include them within their client group.

229. The general duty applies to people with mental disorders generally, not only those subject to compulsory measures. However, it is intended that people who are subject to compulsion, or an application for compulsion, should always have access to independent advocacy if they wish or need it. The Bill therefore requires that patients are informed of the availability of local advocacy services, and are given any necessary assistance in obtaining access to these services.

Alternative options

230. The Millan Committee proposed that mental health service users should have a right to obtain access to an advocate. It is intended that the new statutory duty should ensure that access to an advocate is available, whenever a service user needs one. However, this has not been set this out in the form of an individual enforceable legal right to an advocate.

231. There are a number of practical problems about creating such a right. It would be necessary to specify who did and who did not have such a right, and in what circumstances. It would also be necessary to spell out what the right amounted to i.e. how much advocacy should be available on demand. Defining the right in such a way could hamper the development of new and flexible forms of advocacy and could make it less likely that advocacy will be available to the most vulnerable people, who are less able to enforce such a right.

232. However, the Executive accepts the need to do more than simply specify a general duty in the Bill. The Code of Practice will set out clear guidance on the duty to ensure advocacy services are available, which will be developed in consultation with relevant interests, including the Advocacy Safeguards Agency.
233. Another option would be to restrict the right to patients who are involved in compulsory proceedings. This has been rejected as too narrow an approach to meet the aspirations of the Millan Committee.

Consultation

234. The Millan Committee found general support for their proposals on advocacy. Advocacy organisations have expressed concerns that to legislate for a duty, rather than an individual right to advocacy, waters down the commitment to advocacy. The Executive, while understanding the desire to ensure a strong legislative commitment to advocacy, believes that the Bill’s proposals reflect the general tenor of the Millan Committee’s report.

235. Following discussions with representatives of advocacy organisations, including the Advocacy Safeguards Agency, specific references to advocacy have been added to the provisions concerning detention and compulsory treatment orders, and the Executive will consider carefully whether further detailed provisions are appropriate.

PART 15 - MISCELLANEOUS

Code of practice

Policy objectives

236. The aim of the Code of Practice is to have a clear, straightforward, practical and comprehensive document, which sets out guidance as to how the legislation should operate.

Detailed provisions

237. Scottish Ministers are under a duty to prepare, publish and revise a code of practice under the Bill. The Code proper, which sets out guidance to professionals on their duties under the Act, may be supplemented by guidance and information to others including service users, carers and advocates. Doctors, mental health officers and others exercising statutory functions under the Bill, will be under a duty to have regard to the Code.

Information

Policy objectives

238. The Bill creates a duty to provide information to patients, in a form which takes account of any special needs they may have.

Detailed provisions

239. There will be a duty on a mental health officers to take every practical step to ensure that persons who are subject to compulsory measures under the Bill understand the procedures to which they are subject; what their rights are and where they may gain assistance.

240. The patient’s named person will be entitled to the same information as the patient. Where a patient may have special communication needs (e.g. because of a sensory impairment) the
mental health officer and the detaining doctors must take all reasonable steps to ensure that the patient can communicate effectively at any Tribunal proceeding or formal review.

Advanced statements

Policy objectives
241. The aim of the provisions on advance statements is to support the principle of participation, in situations where service users anticipate that they may at times be too unwell to be in control of decisions about their care and treatment.

242. Where compulsion is necessary, the advance statement is intended to make it more likely that the nature of the compulsory measures takes full account of the circumstances and views of the patient. If successful, advance statements might in some cases reduce the need for compulsory measures.

Detailed provisions
243. Service users will be entitled to make advance statements, setting out their views on any issues of concern to them about their care and treatment. An advance statement will be in writing and witnessed. No particular form of statement will be prescribed, but guidance on advance statements will be given in the Code of Practice.

244. The advance statement will not be legally binding, but medical practitioners and the Tribunal will be required to take an advance statement into account, in making any decision about compulsory care and treatment.

Alternative options
245. Some user and carer groups proposed that advance statements should be legally binding. After careful consideration, the Executive has concluded that the Millan Committee was right to be concerned that this would create practical problems, and would not be the best way to promote the aim of greater user involvement. If the statement were to be legally binding, there would be potential for considerable dispute about which statements should be treated as valid, or should be set aside. For example, the validity of a statement may be questioned if it is old, if it is ambiguous, or if the person may have been mentally unwell at the time of making the statement.

246. It has also been suggested that an advance statement should be legally binding on care professionals unless and until it is overruled by the Mental Health Tribunal. The Executive believes that it would be unduly onerous for Tribunals to rule on whether individual treatments should be given, in the face of an advance statement. It is also inconsistent with the general approach of the Bill, that the Tribunal grants authority for compulsory treatment, but decisions about particular treatments are a matter for the RMO, in consultation with the clinical team.

247. The Bill only deals with the position of advance statements in relation to compulsory treatment. The Millan Committee did not propose any change to the law regarding advance statements more generally.
Education

Policy objectives

248. The Bill strengthens the duty of education authorities towards children who are subject to compulsion under the Bill.

Detailed provisions

249. The Education (Scotland) Act 1980 provides that education authorities do not have statutory duties to educate children detained under the 1984 Act. This provision is removed so that the education authority's normal powers and duties will continue in respect of a child or young person subject to compulsory measures under the Bill.

Parental relations

Policy objectives

250. The Bill requires local authorities and NHS Boards to promote a continuing relationship between mental health service users and their children.

Detailed provisions

251. Where it is in the interests of the child and the relevant mental health service user, local authorities and NHS Boards are placed under a duty to promote personal relations and direct contact between them. A similar duty is also placed to promote such relationships between a child who uses mental health services and the child's parents, where this is in the interests of the child.

Research

Policy objectives

252. The Millan Committee proposed that there should be a systematic research programme into the operation of mental health legislation. The Executive agree and specific provision is made in the Bill to allow Scottish Ministers to require information to be provided to them, or others on their behalf, for research purposes.

Detailed provisions

253. There is a duty on bodies and persons having statutory functions under the Bill to provide certain information requested by Scottish Ministers. A regulation making power allows Scottish Ministers to make detailed provision about the information sought and how they might require to receive it.

254. Any information obtained is only to be used for research purposes and the provisions take account of data protection legislation.
Communications, security etc

Policy objectives

255. The Bill makes provision to regulate any interference by hospitals of certain civil rights of detained patients, including withholding correspondence, monitoring or restricting other forms of communication, searching patients or their belongings, and restricting access to visitors.

Detailed provisions

256. Correspondence from patients at the State Hospital may be withheld if it is considered likely to cause distress or danger. Correspondence to such patients may be withheld for their own safety on the protection of others. These special restrictions do not apply to correspondence with official bodies including the Mental Welfare Commission, the Mental Health Tribunal and MPs or MSPs.

257. Hospital managers may also withhold correspondence from detained patients where the person to whom it is addressed has so requested.

258. The Mental Welfare Commission must be notified of any decision to withhold correspondence, and can review any use of the special restrictions at the State Hospital.

259. The Bill also sets up a framework for regulations authorising measures in connection with the use of telephones, searches, surveillance and restrictions on patients or visitors. The intention is that hospitals be required to develop policies setting out how any such security measures will be applied, recorded and monitored, and that the Executive and the Mental Welfare Commission will monitor the terms of these policies and their operation.

Removal to place of safety

Policy objectives

260. Where a person appears to be experiencing mental distress, the police may be called on to intervene. Balancing the requirements to uphold the law and protect public safety with the need to treat people who are mentally unwell with sensitivity and respect is a difficult task. It is important that the police have the legal tools that they need, and the training to give them the skills to do this job well.

Detailed provisions

261. The 1984 Act allows the police to take a person who is in a public place and appears to be exhibiting mental disorder to a place of safety, where this is necessary to protect that person or other people. The Bill retains this power but, as the Millan Committee recommends, reduces the time during which the person can be detained from 72 hours to 24 hours. This should allow time for health and social work professionals to assess the situation, and determine what further steps need to be taken. The Bill also provides that families or other responsible persons should be notified as soon as possible of the removal of a person to a place of safety.
Alternative options

262. The Millan Committee expressed particular concern about the availability of suitable places of safety. The 1984 Act requires, rightly, that a police station should only be used as a place of safety in an emergency. The Committee recommended that NHS Boards should be under a duty to secure the provision of places of safety to accommodate people detained by the police.

263. The Executive recognises the importance of such places of safety. However, there is a range of provision which may be appropriate, not all of which is best provided by the NHS. There may be different solutions for different parts of Scotland - for example, the issues in remote and rural areas are very different to inner cities. Local care agencies will be expected to continue to work together to develop local arrangements to provide suitable places of safety. Principles for the provision of places of safety will be set out in the Code of Practice.

Nurses’ holding power

264. If a patient is already in hospital receiving treatment on a voluntary basis and decides to leave the hospital, an appropriately qualified nurse may hold a patient for up to two hours to allow a medical practitioner to arrive and assess the patient. The holding power is capable of being extended for up to a further hour following the arrival of the medical practitioner, to allow time for a decision to be made on whether to proceed to detention. Whenever practicable, a mental health officer should also participate in the decision.

Informal patients

Policy objectives

265. The Millan committee drew attention to the situation of patients who may be admitted and treated for mental disorder without having fully consented—either because they are incapable of consenting, or because they feel they have been subject to pressure to accept treatment to which they have not truly agreed. The Bill seeks to provide protection for patients in such situations, additional to the protections afforded by the Adults with Incapacity (Scotland) Act 2000.

Detailed provisions

266. A patient who has been admitted to hospital, or any person having an interest in that patient’s welfare, may apply to the Tribunal. If the Tribunal is satisfied that the patient has been subject to restrictions on their liberty which amount to unlawful detention, it may order that the detention cease. This may be by discharging the patient from hospital, or by removing the restrictions which amount to unlawful detention (for example, placing an informal patient in a locked ward.) Guidance on protecting informal patients from unjustified restrictions on liberty will also be contained in the Code of Practice. This new right will be additional to existing rights to sue in the civil courts where a person has been treated unlawfully, or to raise the matter with the Mental Welfare Commission.
Alternative options

267. Consideration was given to including in the Bill a formal procedure for admission to psychiatric care. This might have helped to ensure that any restrictions on liberty were properly considered and justified from the outset. However, many members of the Reference Group argued that setting out a formal process of admission to psychiatric care for all patients would be a retrograde step, harking back to a pre-1960s notion of ‘certification’. This would be inconsistent with the Millan principles of non-discrimination and informal care, as well as being needlessly bureaucratic. The Scottish Association for Mental Health (SAMH) has suggested that, on its own, the new right may be of limited benefit, since the most vulnerable patients may not be in a position to apply to the Tribunal. SAMH have made a number of practical suggestions, based on consultation with service users, and the Executive is considering these.

PART 16 - ABSCONDING

Policy objective

268. It is necessary to make arrangements for people who are absent without leave from a place where they are detained, or required under a compulsory treatment order to reside. The Bill maintains the broad structure of the 1984 Act provisions for such patients, but seeks to simplify and clarify them. It also gives effect to the Millan Committee’s recommendation that the period within which a patient who is absent without leave is liable to be taken into custody and returned to hospital be reduced to three months.

Detailed provisions

269. A patient subject to emergency or short term detention who is absent without leave may be taken into custody and returned to the hospital at any time while the order remains in effect. A patient subject to a compulsory treatment order may be returned to the hospital at which they were detained or the place they were required to reside, within three months of having gone absent without leave (even if the order would have expired in their absence). If a patient is returned shortly before the relevant order is due to expire, the order will be deemed to continue for 14 days from the patient’s return to allow the patient to be re-assessed. Where a patient subject to a compulsory treatment order is absent without leave for more than 28 days, it will be necessary to complete formal steps to review the order within 14 days of the patient’s return.

270. It is intended to put forward further provisions to the Bill, dealing with patients subject to mental health disposals from the criminal courts. The Executive’s general intention is that patients subject to compulsion orders without restrictions should be subject to similar provisions to patients subject to compulsory treatment orders. For restricted patients, the time limit of three months will not apply.
PART 17 - OFFENCES

Sexual abuse

Policy objective

271. In recent years, there has been increased awareness of the extent to which people with mental disorders, particularly with learning disabilities, are at risk of sexual abuse. At the same time, people with learning disabilities have campaigned for recognition of their rights to live normal lives, and to have normal relationships. The policy objective for the Bill is to balance the need for special measures to protect vulnerable people from abuse, with recognition of their rights to choice and personal freedom.

272. The Millan Committee considered carefully the special offences in the 1984 Act and elsewhere, which are intended to protect against the sexual abuse of mentally disordered adults. The Committee concluded that substantial reform was necessary. The Executive agrees with this conclusion, and with the approach taken by the Committee in setting out a new framework.

Detailed proposals

273. The Bill replaces sections 106 and 107 of the 1984 Act, and the relevant provisions of section 13 of the Criminal Law (Consolidation) (Scotland) Act 1995 with new statutory offences, which reflect the following criteria:

- they are gender-neutral;
- they apply to all forms of mental disorder; and
- they apply to sexual intercourse and other sexual acts.

274. The most serious offence is that of sexual abuse of a mentally disordered person. This will be committed when a person knowingly commits a sexual act with a person who is mentally disordered, and that person has not consented to the acts. The absence of consent can arise either due to lack of capacity, or because consent has not been freely given, due to for example intimidation or deception.

275. The maximum penalty for such an offence will be life imprisonment. The maximum penalty under the equivalent provision in the 1984 Act is 2 years, which may not be adequate for the most severe cases. The Executive believes it is appropriate to make the range of penalties comparable with other serious sexual offences such as rape, incest, and intercourse with a girl under 13.

276. The comparable current provisions only apply to people with learning disabilities. The Bill extends this to cover other kinds of mental disorder.

277. There will also be an offence of sexual abuse by staff and formal carers, replacing section 107 of the 1984 Act. This is intended to apply to sexual acts involving:

- a mentally disordered person and a person employed to deliver care to that person; or
• a mentally disordered person and a doctor or therapist involved in a professional relationship with that person.

278. The maximum penalty for this offence will remain at two years. Where serious abuse is involved, warranting a higher sentence, it could well be charged under the alternative offence of sexual abuse of a mentally disordered person, or as a common law crime.

279. The new offences will be included in Schedule One to the Sex Offenders Act 1997, requiring a person convicted of any of these offences to be included on the Sex Offenders Register.

Alternative options

280. The Millan Committee considered whether it was necessary to have special legislation to protect vulnerable mentally disordered people. They concluded that such legislation was necessary on the basis that common law sex offences did not offer adequate protection.

281. After the Millan Committee reported, the decision of the High Court in Lord Advocate’s Ref No 1 of 2001 (the Watt case), provided an important clarification of the law of rape. This confirmed that the crucial issue in a rape case is lack of consent, not the use of force, and that lack of consent could be presumed where a mentally disordered woman was incapable of giving such consent.

282. Although the decision was specifically about rape, this decision arguably strengthens the case that mentally disordered people can generally be protected from sexual abuse through the common law, and that a specific statutory offence is no longer necessary. Nevertheless, the Executive has decided that it is right to provide certainty in the law, by continuing to have specific statutory crimes designed for the protection of people with mental disorders. These will run alongside, and not replace, common law sex offences.

Consultation

283. The Millan Committee found widespread support for their recommendations in relation to sex offences, and the Bill largely reflects the Millan proposals. The Executive consulted further with the Reference Group, equality interests and ENABLE. Although the intentions behind the proposals were widely supported, there was concern that some relationships which were not abusive should not be criminalised.

284. It was pointed out that extending the scope of the offence of sexual abuse from learning disability to include mental illness and dementia meant that people involved in a pre-existing sexual relationship, including married couples, might potentially be liable to commit the offence. Consideration was given to excluding such pre-existing relationships from the scope of the offence. It was concluded that this would not be desirable. It would be difficult to define a ‘pre-existing relationship’ adequately, and wrong to exclude such relationships if they are, in fact, abusive.
Another point of concern was that the offence of sexual abuse by a formal carer should not criminalise situations where one member of a couple happened to have caring responsibilities for another, or work in an establishment from which the other person was in receipt of care. This is not the intention of the legislation and consideration is being given to how best to clarify this.

Ill-treatment and neglect

Section 105 of the 1984 Act makes it an offence to ill-treat or wilfully neglect a person with a mental disorder. The Millan Committee took the view that such a provision should be retained, but needed to be updated. The Executive agrees with the Millan Committee that the provision is an important safeguard.

The Mental Health Bill therefore includes a provision making it an offence for an individual wilfully to ill-treat or neglect a person with mental disorder who is in their care. The statutory offence will apply to the full range of care settings, including a person’s home. The maximum penalty will remain as two years imprisonment.

The Executive has given careful consideration to the position of people receiving care from a family member. As the Millan Committee states, informal carers perform a vital task, often in difficult circumstances. The offence is not intended to apply to carers who are unable to cope with the demands of caring, but only those whose actions demonstrate the necessary criminal intent. Nevertheless, although it is rare, abuse can happen. The Executive therefore endorses the view of the Millan Committee that all mentally disordered people in receipt of care, whether formal or informal, should be protected.

The Committee proposed that there should be a statutory defence, which would prevent a carer from being convicted, unless he or she had acted in bad faith or without reasonable care. However, the definition of the offence itself will not cover actions in good faith, and the Executive has concluded that an additional statutory defence is not required.

Obstruction

Under the 1984 Act, it is an offence to refuse to allow access to any premises or individual by a person authorised in that behalf by or under the Act or to otherwise obstruct a person in the exercise of their duties under the Act. This offence is retained in the Bill, but a mentally disordered person, who is the subject of proceedings under the legislation, is explicitly excluded from capacity to commit this offence.

PART 19 - GENERAL

Meaning of “mental disorder”

Policy objectives

The term ‘mental disorder’ is retained from the 1984 Act, as a widely used term, which is capable of encompassing the range of relevant conditions.
Detailed provisions

292. Mental disorder is subdivided into three categories: mental illness, personality disorder and learning disability. The Bill does not contain further definitions of the three categories. Guidance on the meaning of these terms will be contained in the Code of Practice.

293. The following examples are illustrative of the conditions which it is intended should fall within the category of mental disorder:

- mental illness encompasses functional conditions such as schizophrenia and manic depressive psychoses, and non-psychotic conditions such as anorexia nervosa, obsessive compulsive disorders and disorders of mood. It also encompasses organic conditions - irreversible such as dementia (including Alzheimer’s syndrome) and temporary, such as acute or delirious reactions to physical illness, or toxic confusional states induced by drugs or alcohol (but not simply intoxication). It also covers acquired brain injury with associated mental symptoms;

- personality disorder is an accepted, if controversial, medical diagnosis that is used to describe a wide range of conditions where a person manifests behaviour, and responses to personal and social situations, which represent extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. It is generally accepted that personality disorders are distinguishable from mental illness and it is therefore stated as a separate category;

- learning disability is generally accepted as incorporating the following facets: a significant lifelong condition; involving reduced ability to understand new or complex information or to learn new skills; reduced ability to cope independently; and a condition which started before adulthood with a lasting effect on the individuals development.

Alternative options

294. It would be possible for the Bill to be based on a single definition of mental disorder with no sub-categories. However, the Executive has accepted the framework proposed by the Millan Committee. The sub-categories will make it easier to identify how the legislation is being used for different types of patient, and a change of diagnosis from one category to another would be a significant issue for the Tribunal to consider on any review.

295. The inclusion of learning disability as a category in mental health legislation has been questioned. For the vast majority of people with learning disabilities, use of compulsory powers would be inappropriate. However, the Executive accepts the Millan Committee’s view that inclusion of the category affords a measure of protection for individuals who may be at risk of harm and in need of protection.

296. In the same manner the inclusion of personality disorder as a separate category has also been questioned. The Executive agrees with the conclusion of the Millan Committee that it should be included in the Bill. As with other mental disorders, people with personality disorders will often need, and should expect to receive, appropriate care and treatment. However, it is not
anticipated that there will be a significant increase in the very small numbers of people with a primary diagnosis of personality disorder who are made subject to compulsory measures. This is because it is unlikely that such a person would meet the statutory criteria for such measures, unless they also had some degree of mental illness or learning disability.

297. The 1984 Act specifically excluded certain categories from the definition of mental disorder, stating that ‘no person shall be treated under this Act as suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.’ The Millan committee recommended retention of these exclusions in an updated form, by reference to sexual orientation or behaviour, alcohol or substance misuse, anti-social behaviour, or acting as no prudent person would act.

298. The Bill as introduced does not contain such exclusions. It is still the policy intention that such conditions or behaviours should not, on their own, constitute mental disorder. It can be argued that there is a degree of redundancy in a legal definition specifying that conditions which are not mental disorders should be excluded from the definition of mental disorders. That said, the Executive is giving further consideration to whether to seek to reinstate specific exclusions to the definition at a later stage in the progress of the Bill.

EQUAL OPPORTUNITIES ISSUES

299. The following set of questions was prepared by the statutory equality bodies in 1999 and has been used by the Equal Opportunities Committee and the Scottish Executive.

What is the policy for? Who is the policy for? What are the desired and anticipated outcomes?

300. The Mental Health Bill is the fulfilment of the commitment in Programme for Government: Making it Work Together to modernise the statutory framework for meeting the needs of people with mental illness.

301. The general aims of the policy are:

- to promote more appropriate use of compulsory measures:
  - by allowing an individualised set of compulsory measures to be identified for each patient;
  - by ensuring decisions on compulsory measures are based on all relevant factors, including the user’s situation, needs and wishes; and
  - by improving the relationships between the various forms of compulsion.

- to improve the treatment of patients subject to compulsory measures, without negatively affecting services for others:
  - by providing an entitlement to receive essential aspects of the planned care; and
  - by ensuring that decisions are taken in full knowledge of the user’s situation, needs and wishes.
This document relates to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

- to promote greater respect for the human rights of patients:
  - by increasing the opportunities for review of compulsion;
  - by strengthening arrangements for representation; and
  - by strengthening safeguards in relation to particular treatments.

- to increase the participation of users and carers in mental health care:
  - by providing rights of notification, attendance and representation;
  - by establishing procedures which are accessible and non-intimidating;
  - by establishing a duty to support advocacy; and
  - by promoting the use of advance statements.

- to improve protection for vulnerable adults with mental disorder:
  - by improving arrangements for emergency intervention;
  - by updating offences regarding exploitation and abuse and
  - by introducing new protective arrangements for informal patients.

- to improve public safety and rehabilitation of offenders with mental disorder:
  - by supporting more effective assessment; and
  - by clarifying the purposes of the various disposals.

- to make the operation of mental health legislation more efficient, effective and robust:
  - by clarifying and consolidating roles and responsibilities within the system;
  - by promoting best practice among professionals involved;
  - by ensuring the system is well understood;
  - by removing the anomalies present in existing legislation; and
  - by making mental health legislation more consistent with human rights norms.

302. The policy is for people with and affected by mental disorder. The desired and anticipated outcomes are that the new system should:

- give effect to the Millan principles;
- promote the most appropriate use of compulsory measures in each case;
- respect the human rights of service users;
- promote effective treatment for those subject to compulsory measures;
- promote participation of users and carers in the consideration of compulsory measures and in the provision of mental health services more generally;
• promote the safety of vulnerable adults with mental disorder;
• promote public safety and rehabilitation of offenders with mental disorder;
• be robust, be fully understood and be operated effectively by those involved;
• be open to inspection;
• be non-discriminatory;
• be uniformly applied across Scotland; and
• meet the needs of specific groups, including for example, minority ethnic users, or users in rural areas.

Do we have full information and analyses about the impact of the policy upon all equalities groups? If not, why not?

303. The Millan Committee was concerned about the lack of adequate statistical and research information concerning the operation of mental health legislation. Although the Mental Welfare Commission does receive and hold some information there are significant gaps. The Committee highlighted the fact that there was virtually no monitoring of how the legislation affected particular groups, for example, minority ethnic communities.

304. The Millan Committee recommended that the Executive should initiate a co-ordinated programme of statistical and other information gathering and of research relating to a new Mental Health Act. This recommendation has been accepted and more detail is given below.

305. In so far as it was possible, in the current state of knowledge, the impact of the policy on equality groups was considered.

306. The Millan Committee consulted very widely and in different ways in order to gather information and to assess the impact of the different options available. This included:

• visits to different services and facilities, including user groups, advocacy services and learning disability facilities;
• a consultation document aimed at users and informal carers;
• a consultation document aimed at people with learning disabilities;
• consultation events for service users and their carers and on issues of interest such as learning disability and dementia;
• oral evidence sessions and a meeting with members of organisations with an interest in minority ethnic mental health issues.

307. The Committee also commissioned a literature review, and research into the operation of the Sheriff Courts in relation to detention under the Mental Health (Scotland) Act 1984.
308. The Executive acknowledged the extensive consultation process undertaken by the Millan Committee and decided that it was not necessary to carry out a further full consultation on the Committee’s final report, after it was submitted to Scottish Ministers in January 2001.

309. Instead, the Executive formed the Mental Health Legislation Reference Group - made up of a range of interests - to consider and comment on the Millan Report, in particular the more contentious aspects. The Executive also sponsored a number of consultative events with a range of stakeholders to enable them to comment on the Millan Report and its implications for policy and practice, and met with representatives of the Commission for Racial Equality, the Disability Rights Commission and the Equality Network.

310. In addition, the Executive sponsored an event specifically for service users and carers. This was described in an independent evaluation report of the day as ‘a great success’. The evaluation report recommended that the event should be used as a model to build on and develop future consultation with mental health service users and carers. The Executive wishes to ensure that the views of mental health service users and carers continue to be heard in the implementation of the Bill and in the drafting of the Code of Practice, and is developing a policy participation strategy which aims to promote and ensure structured consultation in the longer term.


312. The next step from the introduction of the Mental Health (Scotland) Bill is the production of the associated regulations and the Code of Practice. The Reference Group has a key role to play in the further development of legislative proposals and was expanded to include organisations such as the Disability Rights Commission and Alzheimer’s Scotland - Action on Dementia, to add further depth and knowledge to the group’s considerations.

313. In conclusion, the development of policy has sought to overcome the lack of statistical and research information on the operation of mental health legislation. This is in large part due to the comprehensive consultation process undertaken by the Millan Committee. The Executive has maintained the inclusive nature of the policy development process and the impact of the proposals on the range of groups effected by the legislation has been taken into account. The Bill provisions, and its emphasis on the active participation of the service user in relation to their care and treatment, highlight the consideration that must be given towards the service user's gender, race, religion, disability, sexual orientation, age or any other characteristic.

**Has the full range of options and their differential impacts on all equality groups been presented?**

314. It would not be helpful to list every option considered during the policy development process and this memorandum presents the alternative options to the provisions included in the Bill. It is anticipated that there should be no differential impact of the proposals on equality groups. The Bill provisions have been drafted to ensure that every attempt is taken to ascertain what the service user's needs and wishes are and that they are properly taken into account.
regardless of the user’s gender, race, religion, disability, sexual orientation, age or any other characteristic. This is exemplified by the inclusion of:

- a principle promoting equal opportunities;
- a mechanism for the nomination by the service user of a named person - someone who will represent their interests and who will have particular rights under the Bill;
- a duty on local authorities and health boards to ensure the provision of advocacy services for all people with mental disorder within their area;
- a requirement on care professionals to ensure that a service user is provided with and understands relevant information when they are subject to compulsion under the Bill;
- where a service user is unable to communicate, or has difficulty communicating, a requirement on the care professionals to take all reasonable steps to enable the service user to communicate at certain events, namely: any medical examination of the patient; any review under the Bill of the patient’s detention; or any proceedings before the Tribunal relating to the patient.
- a requirement that valid advance statement must be taken into account when giving medical treatment to a person under compulsion;
- amendment of the Education (Scotland) Act 1980 to ensure that the duties of education authorities towards children and young people apply to those subject to compulsion under the Bill;
- a requirement on the NHS and local authorities to take steps to promote family relationships where a child or parent is affected by compulsory measures.

What are the outcomes and consequences of the proposals? Have the indirect, as well as the direct, effects of proposals been taken into account?

315. Both the direct and indirect outcomes and consequences of the proposals have been taken into account. The outcome of the Bill provisions will be a comprehensive legislative framework that deals with the compulsory care and treatment for people with mental disorder and other issues including the rights of service users and carers, and protection from abuse and ill treatment.

How have policy makers in the Executive demonstrated they have mainstreamed equality?

316. The policy makers have demonstrated that they have mainstreamed equality by seeking internal advice to ensure that the Millan Committee’s recommendations and the Executive’s subsequent consultation fitted in with the wider Equality Strategy, together with ensuring that service user and carer groups were included in the policy development process. At the same time the impact on equality groups has been considered and will be factored into the implementation of the Bill and the monitoring and research programme that is being developed.
How will the policy be monitored and evaluated? How will improved awareness of equality implications be demonstrated.

317. As previously stated, the Executive is aware of the lack of ongoing research into the operation of mental health legislation. There is a need to identify to what extent the intended improvements in the delivery of services and protection of patients rights are achieved. In doing so, the differing needs associated with gender, race, religion, disability, sexual orientation, age or any other characteristic require to be addressed.

318. The Executive is in the process of establishing a co-ordinated programme of information collection, and targeted research to establish baseline data on how the current legislation operates. This information will inform the implementation of the new Bill. An ongoing research and information gathering process is also planned to continue once the Bill has been enacted, for the purpose of monitoring and evaluating the working of the Bill in practice. The new statutory forms will be designed to facilitate the collection of more pertinent data, including equality data.

319. The collection and publication of data on the use of the Bill may identify areas in which the aims of the Bill are not being met. This process will include the effects on equality groups. This would highlight the need for those organisations and individuals making decisions under the powers of the Bill to be aware of the equality implications. It would then be for a range of organisations and agencies - including the Executive, the Mental Welfare Commission, NHSScotland, local authorities - to act on any shortfall in service provision.

320. The Mental Welfare Commission is under a general duty to monitor the operation of the Bill and promote best practice. The Commission currently has, and will continue to have, service users as Commissioners to allow a service user perspective in its work.

321. Furthermore, as mentioned above, the Mental Health Legislation Reference Group has a key role to play in the further development of legislative proposals and it includes a wide range of representative organisations.

HUMAN RIGHTS

321. The Scottish Executive considers that the provisions of the Bill are compatible with those provisions in the European Convention on Human Rights (“the Convention”) which constitute “the Convention rights” within the meaning of the Scotland Act and the Human Rights Act 1998.

322. The area of mental health law is one which tends to throw up a large number of issues of compatibility with the Convention rights. That law will to varying extents focus on the need to authorise the imposition of measures of care and treatment on persons with a mental disorder (whether for their own benefit or for the benefit of the wider community) where those concerned may not be prepared willingly to consent to such care or treatment. The measures may, in certain circumstances, extend to the deprivation of liberty of the individual by way of compulsory detention in hospital or elsewhere, whether or not following upon the commission by the person of a criminal offence (or the commission by that person of an act which, had he or she had sufficient mental capacity, would have constituted a criminal offence).
323. In the view of the Executive, the main Articles of the Convention by reference to which issues arise under the Bill are Articles 5 (right to liberty and security) and 8 (right to respect for private and family life). There is also the possibility of issues arising by reference to Article 3 which states that “No-one should be subjected to torture or to inhuman or degrading treatment or punishment”. However, available Convention case-law points strongly in the direction that treatment imposed on an unwilling individual within a fully regulated regime of psychiatric treatment is most unlikely ever to infringe that Article.

324. Article 5(1)(e) provides that one of the exceptions to the general right under that Article for a person not to be deprived of his liberty is “the lawful detention of…persons of unsound mind”. The Convention has been interpreted so that detention of such a person requires to fulfil three criteria, namely that:

(a) the person is of unsound mind, on the basis of objective medical expertise which establishes that the person suffers from a true mental disorder;

(b) the mental disorder is of a kind or degree wanting compulsory confinement; and

(c) the disorder must persist if the continued confinement is to be valid.

325. In the opinion of the Executive, any compulsory detention of a person which is authorised by way of the Bill fits these criteria. The Bill authorises detention in certain circumstances where a person is within the criminal law regime (the relevant provisions in the Bill principally do this by way of amending the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”)) or where detention is authorised in a “civil” context (where there is no suggestion of the individual having committed any criminal offence). Under both regimes, detention may only be authorised on the basis of appropriate medical evidence that the person is suffering from a mental disorder and the person or body authorising the detention must make an assessment of whether the disorder is of a kind or degree warranting compulsory confinement.

326. The various detention provisions contain with them requirements for continued detention to be reviewed from time to time so that the third criteria (that the disorder must persist) is also fulfilled. In terms of Article 5(4) of the Convention, a person deprived of his liberty “shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful”. This provision of the Convention has been interpreted as entitling a person both to test before a court the initial lawfulness of his detention and, at intervals, the continuing appropriateness and lawfulness of that detention in light of changing circumstances (which, in the context of mental disorder, will crucially involve whether the relevant disorder persists). The right of a person to have a court test the lawfulness of initial detention does not extend to producing a right for an individual to have another court (or an appeal court) test lawfulness where the initial authority to detain is provided by a court or a court-like body. In the view of the Executive, the Bill has built in in all relevant places appropriate mechanisms for a detained individual to be able to test both the lawfulness of initial detention and its continuing lawfulness. Central to this is the new body created by section 18 of the Bill, which is to be known as the Mental Health Tribunal for Scotland. This body will, in the view of the Executive, constitute an independent and impartial tribunal for the purposes of Article 6 of the Convention. As well as having jurisdiction in respect of relevant decisions to detain individuals, the Tribunal is, by way of section 202 of the Bill, given jurisdiction to
This document relates to the Mental Health (Scotland) Bill (SP Bill 64) as introduced in the Scottish Parliament on 16 September 2002

consider applications by persons (“informal patients”) in respect of whom no authority to detain applies but who may contend that they are de facto being unlawfully detained.

327. Turning to Article 8, paragraph 1 of this Article states that “Everyone has the right to respect for his private and family life, his home and his correspondence”. Any interference by a public authority with the exercise of this right must, under paragraph 2, be in accordance with the law and necessary in a democratic society. In addition, any interference must satisfy a further test that it is “in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”. In the context of any interferences with the Article 8(1) rights which may be authorised by the Bill, the relevant justifications are likely to lie in the area of “public safety….the prevention of disorder or crime….the protection of health….[or] the protection of the rights and freedoms of others”.

328. A main area of the Bill where Article 8 issues may arise is Part 13, which relates to the giving of medical treatment to those with a mental disorder. The majority of the provisions in that Part relate only to those who are subject to compulsory measures of care and treatment under the Bill or the 1995 Act (as proposed to be amended by the Bill), but section 162 (concerning certain surgical operations, etc.) is applicable to all persons, whether subject to compulsory measures or not. Section 162 provides as to the only permissible circumstances in which types of treatment mentioned in subsection (2) of that section may be given. Subsection (2) allows types of medical treatment to be specified for the purposes of that section by way of regulations and, in addition, lists specifically “any surgical operation for destroying (i) brain tissue, or (ii) the functioning of brain tissue”. This type of treatment is often referred to as neurosurgery for mental disorder (“NMD” in paragraph 329 below).

329. Where a patient is capable of consenting, section 163 allows treatment specified in section 162 to be given only where the patient is capable of consenting. Where the patient is incapable of consenting, section 164 provides as to the circumstances in which NMD may be given. There are various safeguards, including the need for the Court of Session to make an order declaring that the treatment may lawfully be given. Whilst aware that sensitive issues of giving NMD to patients incapable of consenting arise, the Executive views the regime established by sections 162 to 164 of the Bill as being compatible with Article 8 and justifiable in terms of paragraph 2 of that Article. The Executive similarly views the remaining provisions in Part 13 regarding treatment (some of which authorise the giving of other treatment to a person who is incapable of consenting or does not consent) as compatible with Article 8.

330. Sections 193 to 197 in the Bill provide a group of sections concerning communications and security. Sections 193 and 196 allow regulations to be made which may, in certain circumstances, authorise the interception of postal packages sent to or by a patient in a hospital, or the interception of telephone communications involving such a person. Prima facie provisions included in regulations under these powers might be taken to be in breach of Article 8(1). However, case-law on the Convention recognises the right for proportionate measures to be taken involving action of this sort on the part of those who manage hospital facilities for persons with a mental disorder. As with any provisions in an Act of the Scottish Parliament which must be compatible with Convention rights, any provisions contained in subordinate legislation made by Scottish Ministers must similarly be compatible (section 57(2) of the Scotland Act). Whilst it will therefore be necessary to assess in due course whether any regulations made in terms of sections 193 and 196 of the Bill fully respect the Convention rights,
the Executive is of the view that provision of the general nature authorised by these sections is capable of being made compatibly with Article 8.

**RURAL AND ISLAND COMMUNITIES**

331. The Bill is intended to provide a legislative framework for the care and treatment of people with mental disorder allowing the flexibility for appropriate decisions to be made at a local level. The Bill places a number of responsibilities on local authorities and NHS boards which will apply to all areas.

332. It is recognised that people in rural areas and island communities may already experience difficulty in gaining access to some services. In order to be accessible, the Mental Health Tribunal will be able to operate in a range of venues and locations.

333. Where appropriate, the Bill will allow some people to receive compulsory treatment in the community. This provision will allow those with mental disorder to remain close to the additional support of their local community and may be especially relevant where families and friends would have long distances to travel for hospital visits.

**LOCAL GOVERNMENT**

334. Local government will play a vital role in implementing the changes which the legislation aims to achieve. The detail of the specific requirements to be placed on local authorities is given throughout this policy memorandum.

335. Local authorities will be required to maintain an effective mental health officer service for their area. The powers and responsibilities of mental health officers have been extended in various ways. Local authorities will also be under duties to provide or arrange a range of services for people with mental disorders, covering care and support, developmental opportunities, and transport to such services. Alongside the NHS, local authorities will be required to secure independent advocacy services for people with mental disorders.

336. The Bill will also require effective partnerships between local authorities, NHS Boards and Trusts and the Scottish Executive.

337. The Executive recognises that there are resource implications relating to the additional requirements placed upon local authorities. These are set out in the Financial Memorandum.

**SUSTAINABLE DEVELOPMENT**

338. The Bill aims to allow people receiving compulsory treatment for a mental disorder to access the help and support they require while continuing to participate as fully as possible in society. This will contribute to sustainable development through promoting inclusion and social justice. In addition, guidance will also be provided to the Mental Health Tribunal, including advice on sustainable development.
MENTAL HEALTH (SCOTLAND) BILL

POLICY MEMORANDUM

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