Passage of the

Mental Health (Scotland) Bill 2014

SPPB 218
Passage of the

Mental Health (Scotland) Bill 2014

SP Bill 53 (Session 4), subsequently 2015 asp 9

SPPB 218

EDINBURGH: APS GROUP SCOTLAND
## Contents

Foreword

### Introduction of the Bill

<table>
<thead>
<tr>
<th>Document</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill (As Introduced) (SP Bill 53)</td>
<td>1</td>
</tr>
<tr>
<td>Explanatory Notes (and other accompanying documents) (SP Bill 53–EN)</td>
<td>39</td>
</tr>
<tr>
<td>Policy Memorandum (SP Bill 53–PM)</td>
<td>78</td>
</tr>
<tr>
<td>Delegated Powers Memorandum (SP Bill 53–DPM)</td>
<td>112</td>
</tr>
</tbody>
</table>

### Stage 1

<table>
<thead>
<tr>
<th>Document</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 Report, Health and Sport Committee</td>
<td>121</td>
</tr>
<tr>
<td>Oral evidence to the Health and Sport Committee</td>
<td>175</td>
</tr>
<tr>
<td>Written evidence to the Health and Sport Committee (including supplementary and late submissions)</td>
<td>235</td>
</tr>
<tr>
<td>Correspondence to the Health and Sport Committee from the Mental Health Tribunal for Scotland</td>
<td>588</td>
</tr>
<tr>
<td>Correspondence to the Health and Sport Committee from Healthcare Improvement Scotland</td>
<td>591</td>
</tr>
<tr>
<td>Correspondence to the Health and Sport Committee from the Scottish Government</td>
<td>593</td>
</tr>
<tr>
<td>Report from the Delegated Powers and Law Reform Committee</td>
<td>599</td>
</tr>
<tr>
<td>Correspondence between the Scottish Government and the Delegated Powers and Law Reform Committee</td>
<td>613</td>
</tr>
<tr>
<td>Correspondence from the Finance Committee</td>
<td>621</td>
</tr>
<tr>
<td>Extracts from the Minutes of the Parliament, 12 March 2015</td>
<td>652</td>
</tr>
<tr>
<td>Official Report, Meeting of the Parliament, 12 March 2015</td>
<td>653</td>
</tr>
<tr>
<td>Scottish Government response to the Stage 1 Report, 27 March 2015</td>
<td>678</td>
</tr>
<tr>
<td>Correspondence from the Scottish Government, 24 April 2015</td>
<td>694</td>
</tr>
</tbody>
</table>

### Stage 2

<table>
<thead>
<tr>
<th>Document</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Marshalled List of Amendments for Stage 2 (SP Bill 53–ML1)</td>
<td>702</td>
</tr>
<tr>
<td>1st Groupings of Amendments for Stage 2 (SP Bill 53–G1)</td>
<td>736</td>
</tr>
<tr>
<td>Extract from the Minutes, Health and Sport Committee, 19 May 2015</td>
<td>739</td>
</tr>
<tr>
<td>Official Report, Health and Sport Committee, 19 May 2015</td>
<td>741</td>
</tr>
<tr>
<td>2nd Marshalled List of Amendments for Stage 2 (SP Bill 53–ML2)</td>
<td>769</td>
</tr>
<tr>
<td>2nd Groupings of Amendments for Stage 2 (SP Bill 53–G2)</td>
<td>783</td>
</tr>
<tr>
<td>Extract from the Minutes, Health and Sport Committee, 26 May 2015</td>
<td>785</td>
</tr>
<tr>
<td>Official Report, Health and Sport Committee, 26 May 2015</td>
<td>786</td>
</tr>
<tr>
<td>Bill (As amended at Stage 2) (SP Bill 53A)</td>
<td>807</td>
</tr>
</tbody>
</table>
Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected. An exception is the groupings of amendments for Stage 2 and Stage 3 (a list of amendments in debating order was included in the original documents to assist members during actual proceedings but is omitted here as the text of amendments is already contained in the relevant marshalled list).

Where documents in the volume include web-links to external sources or to documents not incorporated in this volume, these links have been checked and are correct at the time of publishing this volume. The Scottish Parliament is not responsible for the content of external Internet sites. The links in this volume will not be monitored after publication, and no guarantee can be given that all links will continue to be effective.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:
Introduction, followed by publication of the Bill and its accompanying documents;
Stage 1: the Bill is first referred to a relevant committee, which produces a report informed by evidence from interested parties, then the Parliament debates the Bill and decides whether to agree to its general principles;
Stage 2: the Bill returns to a committee for detailed consideration of amendments;
Stage 3: the Bill is considered by the Parliament, with consideration of further amendments followed by a debate and a decision on whether to pass the Bill.

After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available for sale from Stationery Office bookshops or free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

The oral and written evidence received by the Health and Sport Committee at Stage 1 was originally published on the web only. That material is included in this volume after the Stage 1 Report.

The Health and Sport Committee’s Stage 1 Report did not include material relating to the Delegated Powers and Law Reform Committee’s consideration of the delegated powers provisions in the Bill or the Finance Committee’s consideration of the Financial Memorandum. The Delegated Powers and Law Reform Committee’s report at Stage 1 is included in this volume. The Committee did not take oral evidence on the Bill and agreed its report without debate. No extracts from the minutes or the Official Report of the relevant meeting of the Committee are, therefore, included in this volume.
The Finance Committee did not produce a report, but forwarded the submissions it had received to the Health and Sport Committee. The correspondence from the Finance Committee and the written submissions are included in this volume.

The Delegated Powers and Law Reform Committee considered the delegated powers in the Bill after Stage 2, and agreed its report without debate. No extracts from the minutes or the Official Report of the relevant meeting of the Committee are, therefore, included in this volume.
## Mental Health (Scotland) Bill

[AS INTRODUCED]

### CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART 1</strong></td>
<td><strong>THE 2003 ACT</strong></td>
</tr>
<tr>
<td>1</td>
<td>Procedure for compulsory treatment</td>
</tr>
<tr>
<td>2</td>
<td>Measures until application determined</td>
</tr>
<tr>
<td>3</td>
<td>Information where order extended</td>
</tr>
<tr>
<td><strong>Emergency, short-term and temporary steps</strong></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Emergency detention in hospital</td>
</tr>
<tr>
<td>5</td>
<td>Short-term detention in hospital</td>
</tr>
<tr>
<td>6</td>
<td>Meaning of temporary compulsion</td>
</tr>
<tr>
<td><strong>Suspension of orders and measures</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Suspension of orders on emergency detention</td>
</tr>
<tr>
<td>8</td>
<td>Suspension of orders on short-term detention</td>
</tr>
<tr>
<td>9</td>
<td>Suspension of detention for certain purposes</td>
</tr>
<tr>
<td>10</td>
<td>Maximum suspension of detention measures</td>
</tr>
<tr>
<td><strong>Orders regarding level of security</strong></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Process for enforcement of orders</td>
</tr>
<tr>
<td>12</td>
<td>Orders relating to non-state hospitals</td>
</tr>
<tr>
<td>13</td>
<td>Qualifying non-state hospitals and units</td>
</tr>
<tr>
<td><strong>Removal and detention of patients</strong></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Notifying decisions on removal orders</td>
</tr>
<tr>
<td>15</td>
<td>Detention pending medical examination</td>
</tr>
<tr>
<td><strong>Time for appeal, referral or disposal</strong></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Appeal on hospital transfer</td>
</tr>
<tr>
<td>17</td>
<td>Periodical referral of cases</td>
</tr>
<tr>
<td>18</td>
<td>Recording where late disposal</td>
</tr>
<tr>
<td><strong>Representation by named persons</strong></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Opt-out from having named person</td>
</tr>
<tr>
<td>20</td>
<td>Consent to being named person</td>
</tr>
<tr>
<td>21</td>
<td>Appointment of named person</td>
</tr>
</tbody>
</table>
Mental Health (Scotland) Bill

Advance statements, support and services
21 Registering of advance statements
22 Communication at medical examination etc.
23 Services and accommodation for mothers

Cross-border transfers and absconding patients
24 Cross-border transfer of patients
25 Dealing with absconding patients

Arrangements for treatment of prisoners
26 Agreement to transfer of prisoners
27 Compulsory treatment of prisoners

PART 2
CRIMINAL CASES

Making and effect of disposals
28 Making certain orders in remand cases
29 Periods for assessment orders
30 Periods for treatment orders
31 Periods for short-term compulsion
32 Periods for compulsion orders
33 Periods for hospital directions

Variation of certain orders
34 Variation of interim compulsion orders
35 Transfer of patient to suitable hospital

Specification of hospital units
36 Compulsion orders
37 Hospital directions
38 Transfer for treatment directions
39 Transfer from specified unit
40 Consequential repeals

Miscellaneous amendments
41 Information on extension of compulsion order
42 Notification of changes to compulsion order

PART 3
VICTIMS’ RIGHTS

Information and representations
43 Right to information: offender imprisoned
44 Right to information: compulsion order
45 Right to make representations

Additional provisions
46 Information sharing
47 Associated definitions
48  Power to make modifications
49  Amendments to the 2003 Act

PART 4

COMMENCEMENT AND SHORT TITLE

50  Commencement
51  Short title
Mental Health (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

PART 1

Procedure for compulsory treatment

1 Measures until application determined

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 64 (powers of Tribunal on application under section 63: compulsory treatment order), after subsection (8) there is inserted—

“(8A) If the patient has been detained in hospital under section 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 6 months referred to in subsection (4)(a)(i) above is to be regarded as reduced by the period during which the patient has been so detained under that section.

(8B) Subsection (8A) above is of no effect if the patient has been detained in hospital in accordance with an interim compulsory treatment order made in connection with the application by virtue of which this section applies.”.

(3) In section 65 (powers of Tribunal on application under section 63: interim compulsory treatment order), after subsection (6) there is inserted—

“(7) If the patient has been detained in hospital under section 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 56 days referred to in subsection (3) above is to be regarded as reduced by the period during which the patient has been so detained under that section.”.

(4) In subsection (2)(a) of section 68 (extension of short-term detention pending determination of application), for the word “5” there is substituted “10”.

(5) In section 69 (time limit for determining application etc. where section 68 applies), for the word “5” there is substituted “10”.
Information where order extended

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 87 there is inserted—

"87A Further information where order extended"

(1) Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 86 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 101(2) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and

(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—

(i) a copy of the record, and

(ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—

(a) the name and address of the patient,

(b) if known by the mental health officer, the name and address of—

(i) the patient’s named person, and

(ii) the patient’s primary carer,

(c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 85 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),

(d) so far as relevant to the extension of the compulsory treatment order—

(i) the details of the personal circumstances of the patient, and

(ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),

(e) the views of the mental health officer on the extension of the compulsory treatment order, and

(f) any other information that the mental health officer considers relevant in relation to the extension of the compulsory treatment order.

(5) The matters referred to in subsection (2)(c) above are—
(a) whether the mental health officer is sending a copy of the record to the patient, and
(b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.

(6) For the purposes of subsection (2)(c) above, the persons are—
(a) the patient’s named person,
(b) the patient’s responsible medical officer, and
(c) the Commission.”.

Emergency, short-term and temporary steps

10 3 Emergency detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 36 (emergency detention in hospital), after paragraph (d) there is inserted—

“(da) section 113(5) of this Act;”.

15 (3) In section 38 (duties on hospital managers: examination, notification etc.)—

(a) in paragraph (b)(i) of subsection (3), for the words “persons mentioned in subsection (4) below” there is substituted “Commission of the granting of the certificate and”;

(b) after subsection (3) there is inserted—

“(3A) The managers of the hospital may, so far as they consider it appropriate, give notice of the matters notified to them under section 37 of this Act to the persons mentioned in subsection (4) below.”,

(4) In subsection (2) of section 40 (revocation of emergency detention certificate: notification), after the word “inform” there is inserted “the Commission and”.

(5) In subsection (4) of section 42 (certificate under section 41: revocation), after the word “inform” there is inserted “the Commission and”.

4 Short-term detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 44 (short-term detention in hospital), after paragraph (c) there is inserted—

“(ca) section 113(5) of this Act;”.

(3) In section 46 (hospital managers’ duties: notification)—

(a) in subsection (3), the words “, and send a copy of it,” are repealed,
(b) after subsection (3) there is inserted—

“(4) When giving notice under subsection (2) or (3) above, the managers of the hospital are to send a copy of the certificate to each recipient of the notice.”.

5 Meaning of temporary compulsion

5 (1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

5 (2) In section 230 (appointment of patient’s responsible medical officer), in paragraph (c) of the definition of “appropriate act” in subsection (4), the words “under section 54(1)(c) of the 1995 Act” are repealed.

5 (3) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—

““temporary compulsion order” means an order made under section 54(1)(c) of the 1995 Act;”.

Suspension of orders and measures

6 Suspension of orders on emergency detention

6 (1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

6 (2) In section 43 (effect of subsequent emergency detention certificate on compulsory treatment order)—

(a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,

(b) in subsection (2), for the words “The compulsory treatment order” there is substituted “A relevant order”,

(c) in subsection (3)—

(i) after the word “Act” there is inserted “or (as the case may be) section 57A(8)(b) of the 1995 Act”,

(ii) for the words “compulsory treatment order” in each place where they occur there is substituted “relevant order”,

(d) after subsection (3) there is inserted—

“(4) In this section, the references to a relevant order are to—

(a) a compulsion order, or

(b) a compulsory treatment order or an interim compulsory treatment order.”.

6 (3) In relation to section 43—

(a) its title becomes “Effect of emergency detention certificate on certain earlier orders”,

(b) the italic heading immediately preceding it becomes “Effect of emergency detention certificate on certain orders”.

7 Suspension of orders on short-term detention

7 (1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 56 (effect of subsequent short-term detention certificate on compulsory treatment order)—
   (a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,
   (b) for subsection (2) there is substituted—
      “(2) A relevant order shall cease to authorise the measures specified in it for the period during which the patient is subject to—
      (a) the short-term detention certificate, or
      (b) an extension certificate.”,
   (c) after subsection (2) there is inserted—
      “(3) In this section, the references to a relevant order are to—
      (a) a compulsion order, or
      (b) a compulsory treatment order or an interim compulsory treatment order.”.

(3) In relation to section 56—
   (a) its title becomes “Effect of short-term detention certificate etc. on certain earlier orders”,
   (b) the italic heading immediately preceding it becomes “Effect of short-term detention certificate etc. on certain orders”.

8 Suspension of detention for certain purposes

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 127 (suspension of measure authorising detention)—
   (a) subsection (4) is repealed,
   (b) after subsection (4) there is inserted—
      “(4A) The purpose for which a certificate under subsection (1) or (3) above is granted must be recorded in the certificate.”.

(3) In section 221 (assessment order: suspension of measure authorising detention)—
   (a) after subsection (3) there is inserted—
      “(3A) Subsection (3) above does not require the consent of the Scottish Ministers if the granting of the certificate is for the purpose of enabling the patient to—
      (a) attend a hearing in criminal proceedings against the patient, or
      (b) meet a medical or dental appointment made for the patient.”,
   (b) subsection (4) is repealed,
   (c) after subsection (4) there is inserted—
      “(4A) The purpose for which a certificate under subsection (2) above is granted must be recorded in the certificate.”.

(4) In section 224 (patients subject to certain other orders and directions: suspension of measure authorising detention)—
(a) in subsection (1), after paragraph (b) there is inserted—

“(ba) a temporary compulsion order;”,

(b) after subsection (3) there is inserted—

“(3A) In the case of a treatment order, an interim compulsion order or a temporary compulsion order, subsection (3) above does not require the consent of the Scottish Ministers if the granting of the certificate is for the purpose of enabling the patient to—

(a) attend a hearing in criminal proceedings against the patient, or

(b) meet a medical or dental appointment made for the patient.”,

(c) subsection (5) is repealed,

(d) after subsection (5) there is inserted—

“(5A) The purpose for which a certificate under subsection (2) above is granted must be recorded in the certificate.”.

9 Maximum suspension of detention measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 127 (suspension of measure authorising detention)—

(a) in subsection (2), for the words “9 months” there is substituted “200 days (or a higher total by virtue of subsection (10) below),”;

(b) after subsection (2) there is inserted—

“(2A) Subsection (2) above does not prevent the responsible medical officer from granting a certificate under subsection (1) above specifying a period—

(a) of not more than 12 hours, and

(b) that does not include any time between 9pm and 8am.

(2B) In any calculation for the purpose of subsection (2) above, no account is to be taken of a certificate granted under subsection (1) above which specifies a period of the sort described in subsection (2A) above.”,

(c) after subsection (9) there is inserted—

“(10) The total of 200 days referred to in subsection (2) above is increased in the patient’s case to a higher total if it is approved by the Tribunal on an application by the patient’s responsible medical officer under this subsection, but—

(a) an increase in the total is effective only in relation to a particular period of 12 months mentioned in subsection (2) above,

(b) only one increase in the total is allowed in relation to a particular period of 12 months mentioned in that subsection.

(11) Where the patient’s responsible medical officer makes an application under subsection (10) above, that officer must inform the Commission of the application and the result of it.

(12) A higher total by virtue of subsection (10) above must not exceed 300 days.”.
(3) In section 224 (patients subject to certain other orders and directions: suspension of measure authorising detention)—

(a) in subsection (4), for the words “9 months” there is substituted “200 days (or a higher total by virtue of subsection (11) below)”,

(b) after subsection (4) there is inserted—

“(4A) Subsection (4) above does not prevent the responsible medical officer from granting a certificate under subsection (2) above specifying a period—

(a) of not more than 12 hours, and

(b) that does not include any time between 9pm and 8am.

(4B) In any calculation for the purpose of subsection (4) above, no account is to be taken of a certificate granted under subsection (2) above which specifies a period of the sort described in subsection (4A) above.”,

(c) after subsection (10) there is inserted—

“(11) The total of 200 days referred to in subsection (4) above is increased in the patient’s case to a higher total if it is approved by the Tribunal on an application by the patient’s responsible medical officer under this subsection, but—

(a) an increase in the total is effective only in relation to a particular period of 12 months mentioned in subsection (4) above,

(b) only one increase in the total is allowed in relation to a particular period of 12 months mentioned in that subsection.

(12) Where the patient’s responsible medical officer makes an application under subsection (11) above, that officer must inform the Commission of the application and the result of it.

(13) A higher total by virtue of subsection (11) above must not exceed 300 days.”.

Orders regarding level of security

10 Process for enforcement of orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Section 266 (order under section 265: further provision) is repealed.

(3) In section 267 (orders under sections 264 to 266: recall)—

(a) in subsection (1), for the words “, 265(3) or 266(3)” there is substituted “or 265(3)”,

(b) in subsection (3), for the words “, 265(4) to (6) or 266(4) to (6)” there is substituted “or 265(4) to (6)”.  

(4) The title of section 267 becomes “Order under section 264 or 265: recall”.

(5) Section 270 (order under section 269: further provision) is repealed.

(6) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), for the words “, 269(3) or 270(3)” there is substituted “or 269(3)”,


Mental Health (Scotland) Bill
Part 1—The 2003 Act

(b) in subsection (3), for the words “, 269(4) to (6) or 270(4) to (6)” there is substituted “or 269(4) to (6)”.

(7) The title of section 271 becomes “Order under section 268 or 269: recall”.

(8) In section 272 (proceedings for specific performance of statutory duty)—

(a) in subsection (1), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 264(2) of this Act, or
(c) an order under section 268(2) of this Act,”,

(b) in subsection (2), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 265(3) of this Act, or
(c) an order under section 269(3) of this Act,”.

(9) In paragraph 13A of Schedule 2 (the Mental Health Tribunal for Scotland), after the words “sections 101(3)(c)” there is inserted “, 264(8) and 268(8)”.

11 Orders relating to non-state hospitals

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals)—

(a) in subsection (1), the word “qualifying” in the first place where it occurs is repealed,

(b) in subsection (2), the word “qualifying” in each place where it occurs is repealed,

(c) in subsection (5), for the words from “to the managers” to the end there is substituted “of the name of the hospital so identified to the managers of the hospital in which the patient is detained”,

(d) in subsection (6), the word “qualifying” in each place where it occurs is repealed,

(e) in subsection (10)—

(i) except in paragraph (e), the word “qualifying” in each place where it occurs is repealed,

(ii) in paragraph (e), for the words “qualifying hospital” there is substituted “hospital in which the patient is detained”,

(f) subsections (11) to (14) are repealed.

(3) In section 269 (order under section 268: further provision)—

(a) in each of subsections (1) and (2), the word “qualifying” is repealed,

(b) in subsection (3), for the words “qualifying hospital” there is substituted “hospital in question”,

(c) in subsection (6), for the words from “to the managers” to the end there is substituted “of the name of the hospital so identified to the managers of the hospital in which the patient is detained”.

(4) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), the word “qualifying” is repealed,
(b) in subsection (2), for the words “qualifying hospital” there is substituted “hospital in question”.

(5) In section 273 (interpretation of Chapter), for the definition of “relevant patient” there is substituted—

“relevant patient” means a patient whose detention is authorised in hospital by—

(a) if the patient is also subject to a restriction order, a compulsion order,

(b) a hospital direction, or

(c) a transfer for treatment direction.”.

12 Qualifying non-state hospitals and units

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) The italic heading immediately preceding section 273 becomes “Application and interpretation of Chapter”.

(3) Before section 273 (and after that italic heading) there is inserted—

“272A Qualifying hospital and application of sections 268 to 271

(1) A hospital is a “qualifying hospital” for the purposes of sections 268 to 271 of this Act if it—

(a) is a hospital other than a state hospital, and

(b) falls within such further meaning (if any) as is given to that expression by regulations.

(2) Regulations may make provision in accordance with which is to be determined for the purposes of sections 268 to 271 of this Act the question in a patient’s case of whether the patient’s detention in a hospital involves the patient being subject to a level of security that is excessive.

(3) Regulations may make further provision as to the operation of sections 268 to 271 of this Act in particular circumstances.

(4) Regulations under this section may make provision by reference to—

(a) a specified hospital or hospital unit, or a type or description of hospital or hospital unit, or

(b) measures of security or containment under which a patient is detained, or arrangements for the accommodation or supervision of a patient.

(5) In sections 268 to 271 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(6) For the purposes of subsections (4) and (5) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(4) In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “268(11) to (14)” there is substituted “272A”.

13
Removal and detention of patients

13 Notifying decisions on removal orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 295 there is inserted—

“295A Notification of decision under section 293 or 295

(1) Subsection (2) below applies in relation to a decision of a sheriff or a justice of the peace under section 293 of this Act making, or refusing to make, a removal order.

(2) As soon as practicable after the decision is made, the mental health officer who made the application for the removal order must notify the Commission of the decision.

(3) Subsection (4) below applies in relation to a decision of a sheriff under section 295 of this Act making, or refusing to make, an order recalling or varying a removal order.

(4) As soon as practicable after the decision is made, the mental health officer specified in the removal order must notify the Commission of—

(a) the decision, and

(b) any additional order made under subsection (6) of section 295 of this Act.”.

14 Detention pending medical examination

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 299 (nurse’s power to detain pending medical examination)—

(a) in subsection (2)—

(i) paragraph (b) is repealed together with the word “and” immediately preceding it,

(ii) in the text following paragraph (b), for the words from “subject” to the end there is substituted “be detained in the hospital for a period not exceeding 3 hours (“holding period”) for the purposes mentioned in subsection (3A) below”,

(b) in paragraph (c) of subsection (3), for the words “to carry out a medical examination of the patient” there is substituted “for a medical examination of the patient to be carried out by a medical practitioner”;

(c) after subsection (3) there is inserted—

“(3A) The purposes referred to in subsection (2) above are—

(a) enabling the carrying out of a medical examination of the patient by a medical practitioner, and

(b) ensuring that the patient does not leave the hospital before the granting by the medical practitioner of an emergency detention certificate or a short-term detention certificate (if warranted).”,

(d) subsection (4) is repealed.
Time for appeal, referral or disposal

15 Appeal on hospital transfer

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (3) of section 220 (appeal to Tribunal against transfer under section 218 to state hospital), for the words “12 weeks” in each place where they occur there is substituted “28 days”.

16 Periodical referral of cases

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 189 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2) for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(3) In section 213 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2) for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(4) In paragraph 13A of Schedule 2 (the Mental Health Tribunal for Scotland), the words “, 189(2)(a)(ii) and (b)(ii) and 213(2)(a)(ii) and (b)(ii)” are repealed.

17 Recording where late disposal

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In Schedule 2 (the Mental Health Tribunal for Scotland), after paragraph 13A there is inserted—

“13B (1) Sub-paragraph (2) below applies if the Tribunal fails to comply with a time limit, or otherwise fails to do something within a particular period, by reference to which there falls to be determined—

(a) an application or appeal made to it under this Act, or

(b) another matter coming before it by virtue of this Act.

(2) The Tribunal must—

(a) except where by reason of lapse of time no useful purpose would be served by doing so, determine the application, appeal or other matter without undue delay,

(b) state in its record of the proceedings—
(i) that the failure has occurred, and
(ii) the reason for the failure.”.

**Representation by named persons**

18 **Opt-out from having named person**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 251 (named person where no person nominated or nominated person declines to act), at the end there is inserted—

“(9) Where a person has made a declaration under section 253(1) of this Act precluding a carer or relative of the person from being the person’s named person, this section operates as if the person does not have that carer or relative.

(10) This section is subject to section 253(1A) of this Act.”.

(3) In section 253 (declaration in relation to named person)—

(a) in subsection (1), for the words “Subject to subsection (4) below and to section 257 of this Act, where” there is substituted “Where”,

(b) after subsection (1) there is inserted—

“(1A) Where a person who has attained the age of 16 years (“the declarer”) makes a declaration in writing in accordance with subsection (2) below stating that the declarer does not wish to have a named person, section 251 of this Act does not apply in relation to the declarer.”,

(c) in subsection (4), for the words “under subsection (1) above” there is substituted “for the purpose of subsection (1) or (1A) above”.

19 **Consent to being named person**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 250 (nomination of named person)—

(a) in subsection (1), for the words “(3) and (6)” there is substituted “(2A), (3) and (6)”,

(b) after subsection (2) there is inserted—

“(2A) A nomination under subsection (1) above is valid only if—

(a) a docket to the nomination states that the person nominated has consented to the nomination,

(b) the docket is signed by the nominated person, and

(c) the nominated person’s signature is witnessed by a prescribed person.”,

(c) in subsection (6), for the words “may decline” there is substituted “ceases”.

(3) In section 251 (named person where no person nominated or nominated person declines to act)—

(a) in each of subsections (5) and (6), for the word “declines” there is substituted “ceases”,

(4) A docket to a nomination states that the person nominated has consented to the nomination when—

(a) the docket is signed by the nominated person, and

(b) the nominated person’s signature is witnessed by a prescribed person.”.
Mental Health (Scotland) Bill

Part 1—The 2003 Act

(b) after subsection (6) there is inserted—

“(7) A carer or relative of a person can be the person’s named person by virtue of this section only if—

(a) a document states that the carer or (as the case may be) relative has consented to being the person’s named person,

(b) the document is signed by that carer or relative, and

(c) the signature of that carer or relative is witnessed by someone.

(8) Where a carer or relative of a person cannot in accordance with subsection (7) above be the person’s named person, this section operates as if the person does not have that carer or relative.”.

(4) In section 257 (named person: Tribunal’s powers)—

(a) in subsection (3), after the word “(4)” there is inserted “or (5),

(b) after subsection (4) there is inserted—

“(5) An order under this section appointing a person to be a patient’s named person may be made only if—

(a) a document, signed by the person, states that the person has consented to being the patient’s named person, and

(b) the person’s signature is witnessed by someone.

(6) A person appointed by an order under this section to be a patient’s named person ceases to be the patient’s named person by giving notice to that effect to—

(a) the Tribunal,

(b) the patient, and

(c) the local authority for the area in which the patient resides.”.

Appointment of named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 255 (named person: mental health officer’s duties etc.)—

(a) subsections (3) to (5) are repealed,

(b) in paragraph (b) of subsection (7), sub-paragraph (i) is repealed together with the word “or” immediately following it.

(3) In section 256 (named person: application by patient etc.)—

(a) paragraph (a) of subsection (1) is repealed,

(b) in paragraph (b) of subsection (1), for the words “the applicant” there is substituted “a person mentioned in subsection (2) below (“the applicant”)”.

(4) In section 257 (named person: Tribunal’s powers)—

(a) subsection (1) is repealed,

(b) in subsection (2), for the words from “declaring” to the end there is substituted “as allowed by subsection (3A),”

(c) after subsection (3) there is inserted—
“(3A) For the purpose of subsection (2), this subsection allows an order—

(a) in any case, to declare that the acting named person is not the named person,

(b) if the patient has not attained the age of 16 years, to appoint the person specified in the order to be the patient’s named person in place of the acting named person.”.

Advance statements, support and services

21 Registering of advance statements

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 276 there is inserted—

“276A Advance statements to be put with medical records

(1) Subsection (2) below applies where a Health Board receives a copy of an advance statement, or a copy of a document withdrawing an advance statement, from—

(a) the person who made the statement, or

(b) any individual acting with the person’s authority in relation to the statement.

(2) The Health Board must—

(a) place a copy of the statement or document with the person’s medical records, and

(b) send a copy of the statement or document to the Commission.

276B Advance statements to be kept by the Commission

(1) Subsection (2) below applies where the Commission receives a copy of an advance statement, or a copy of a document withdrawing an advance statement—

(a) by virtue of section 276A(2) of this Act, from a Health Board, or

(b) from—

(i) the person who made the statement, or

(ii) any individual acting with the person’s authority in relation to the statement.

(2) The Commission must keep a copy of the statement or document in a register of advance statements maintained by the Commission.

276C Persons entitled to inspect advance statements

(1) Subsection (2) below makes provision as to the register of advance statements maintained by the Commission in accordance with section 276B(2) of this Act.

(2) The Commission must allow anything kept in the register to be inspected at a reasonable time—

(a) by the person to whom the thing relates,
(b) with respect to treatment of the person for mental disorder, by any individual acting on the person’s behalf,

(c) for the purpose of making decisions or taking steps with respect to the treatment of the person for a mental disorder, by—

(i) a mental health officer dealing with the person’s case,

(ii) the person’s responsible medical officer,

(iii) the Health Board responsible for the person’s treatment.”.

22 Communication at medical examination etc.

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 261 there is inserted—

“261A Help with communication at medical examination etc.

(1) Subsection (2) below applies where—

(a) a medical examination or interview referred to in subsection (4)(a) or (b) below is to be carried out, and

(b) the subject of it—

(i) has difficulty in communicating, or

(ii) generally communicates in a language other than English.

(2) The appropriate person must take all reasonable steps to secure that, for the purpose of enabling the subject of the medical examination or interview to communicate during it—

(a) arrangements appropriate to the subject’s needs are made, or

(b) the subject is provided with assistance, or material, appropriate to those needs.

(3) As soon as practicable after taking any steps under subsection (2) above, the appropriate person must make a written record of the steps.

(4) This subsection refers to—

(a) a medical examination by virtue of section 36(1)(a), 44(1)(a), 57(2), 57A(2) or 136(2) of this Act,

(b) an interview by virtue of—

(i) section 45(1)(a) or 61(2)(a) of this Act, or

(ii) section 59B(2)(a) or 57C(2)(a) of the 1995 Act.

(5) In subsections (2) and (3) above, “the appropriate person” means—

(a) in relation to a medical examination by virtue of section 136(2) of this Act, the Scottish Ministers,

(b) in relation to a medical examination by virtue of any of the other sections of this Act mentioned in subsection (4)(a) above—

(i) if it is to be carried out at a hospital, the managers of the hospital,

(ii) if it is to be carried out elsewhere, the medical practitioner carrying it out,
(e) in relation to an interview referred to in subsection (4)(b) above—
   (i) if it is to be carried out at a hospital, the managers of the hospital,
   (ii) if it is to be carried out elsewhere, the mental health officer
        carrying it out.”.

23 Services and accommodation for mothers

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 24 (provision of services and accommodation for certain mothers with post-natal depression), for the words “for post-natal depression,” in subsection (1)(d) there is substituted “for—
   (i) post-natal depression; or
   (ii) a mental disorder (other than post-natal depression),”.

(3) The title of section 24 becomes “Services and accommodation for mothers”.

24 Cross-border transfer of patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 289 (cross-border transfer: patients subject to requirement other than detention), in paragraph (b) of subsection (1)—
   (a) the words from “a person” to the end become sub-paragraph (i),
   (b) after that sub-paragraph (as so numbered) there is inserted—

      “(ii) a person subject to corresponding requirements in a member State of the European Union (apart from the United Kingdom) and removed from that State.”.

(3) In section 290 (cross-border transfer: patients subject to detention requirement or otherwise in hospital), in paragraph (c) of subsection (1)—

   (a) the words from “a person” to the end become sub-paragraph (i),
   (b) after that sub-paragraph (as so numbered) there is inserted—

      “(ii) a person subject to corresponding measures in a member State of the European Union (apart from the United Kingdom) and removed from that State.”.

(4) In section 309A (cross-border visits: leave of absence), in subsection (1)—

   (a) the words from “a person” to the end become paragraph (a),
   (b) after that paragraph (as so numbered) there is inserted—

      “(b) a person who is subject to a corresponding suspension of detention in a member State of the European Union (apart from the United Kingdom).”.

25 Dealing with absconding patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In paragraph (a)(iii) of subsection (3) of section 303 (taking into custody and return of absconding patients), after the words “compulsory treatment order” there is inserted “or an interim compulsory treatment order”.

(3) In section 309 (patients from other jurisdictions)—

(a) in subsection (1)—

(i) the words from “persons” to the end become paragraph (a),

(ii) after that paragraph (as so numbered) there is inserted—

“(b) persons in Scotland who are subject to corresponding requirements or corresponding measures in a member State of the European Union (apart from the United Kingdom).”,

(b) in subsection (2), for the words “Those regulations” there is substituted “Regulations under subsection (1) above”,

(c) after subsection (2) there is inserted—

“(2ZA) Regulations may make provision applying some or all of Part 16 of this Act to persons to whom sections 301 to 303 of this Act apply by virtue of subsection (1) above.

(2ZB) Regulations under subsection (2ZA) above may make such modifications of that Part in that application as the Scottish Ministers think fit.

(2ZC) But regulations under subsection (2ZA) above may not apply any of that Part to persons who are subject to requirements or measures corresponding only to detention in hospital in accordance with an emergency detention certificate.”.

(4) In section 310 (regulations as to absconding by other patients), after subsection (3) there is inserted—

“(3A) In making provision as described in paragraphs (a) and (b) of subsection (1) above, regulations under that subsection may specify persons who are authorised by patients’ responsible medical officers.”.

Arrangements for treatment of prisoners

26 Agreement to transfer of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after subsection (4) there is inserted—

“(4A) A transfer for treatment direction may be made only if a mental health officer has agreed to the making of it.”.

27 Compulsory treatment of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In schedule 2 (the Mental Health Tribunal for Scotland), in paragraph 7—

(a) in sub-paragraph (4), for the words “(other than proceedings relating solely to an application under section 255 or 256 of this Act)” there is substituted “(other than excepted proceedings)”;

(b) after sub-paragraph (4) there is inserted—
“(4A) For the purpose of sub-paragraph (4) above, the following are excepted proceedings—

(a) proceedings relating solely to an application under section 255 or 256 of this Act, or

(b) proceedings relating to an application for a compulsory treatment order in respect of a patient subject to—

(i) a hospital direction, or

(ii) a transfer for treatment direction.”.

(3) In schedule 3 (application of Chapter 1 of Part 7 to certain patients), after paragraph 1 there is inserted—

“1A In the case of a patient subject to a hospital direction or a transfer for treatment direction, section 60(1) of this Act shall have effect as if, after paragraph (b), there were inserted—

“(ba) to the Scottish Ministers;”.”.

PART 2
CRIMINAL CASES
Making and effect of disposals

28 Making certain orders in remand cases

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In each place where they occur as follows, before the words “in custody” there is inserted “remanded”—

(a) in section 52B (prosecutor’s power to apply for assessment order), in subsection (3)(c),

(b) in section 52C (Scottish Ministers’ power to apply for assessment order), in subsection (1)(c),

(c) in section 52D (assessment order), in subsection (10)(d),

(d) in section 52F (assessment order: supplementary), in subsection (1)(a),

(e) in section 52K (prosecutor’s power to apply for treatment order), in subsection (3)(c),

(f) in section 52L (Scottish Ministers’ power to apply for treatment order), in subsection (1)(c),

(g) in section 52M (treatment order), in subsection (9)(d)(i) and (ii),

(h) in section 52P (treatment order: supplementary), in subsection (2)(a) and (b)(ii).

29 Periods for assessment orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 52D (assessment order)—

(a) in subsection (6)—
(i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”;
(ii) in each of paragraphs (b) and (c), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (6A) below”;

(b) after subsection (6) there is inserted—

“(6A) For the purpose of subsection (6)(b) and (c) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring at the end of the 28 days following that day.”.

(3) In section 52F (assessment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 52G (review of assessment order)—

(a) in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”;

(b) in subsection (4), for words from “7 days” to the end there is substituted “the relevant period given by subsection (4A) below”,

(c) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above, the relevant period is the period—

(a) beginning with the day on which the order would otherwise cease to authorise the detention of the person in hospital,

(b) expiring at the end of the 14 days following that day.”.

(5) In section 52H (early termination of assessment order)—

(a) in subsection (1)—

(i) in paragraph (a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,

(ii) in paragraph (b), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,

(b) after subsection (1) there is inserted—

“(1A) For the purpose of subsection (1)(a) and (b) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring—

(i) as regards subsection (1)(a) above, at the end of the 7 days following the day mentioned in paragraph (a) of this subsection,

(ii) as regards subsection (1)(b) above, at the end of the 28 days following the day mentioned in paragraph (a) of this subsection.”.
30 Periods for treatment orders
(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 52M (treatment order)—
  (a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”,
  (b) in subsection (6)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.
(3) In section 52P (treatment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.
(4) In section 52R (termination of treatment order)—
  (a) in subsection (1)(a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,
  (b) after subsection (1) there is inserted—
    “(1A) For the purpose of subsection (1)(a) above, the relevant period is the period—
     (a) beginning with the day on which the order is made,
     (b) expiring at the end of the 7 days following that day.”.

31 Periods for short-term compulsion
(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 53 (interim compulsion order)—
  (a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”,
  (b) in subsection (8)—
    (i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”,
    (ii) in paragraph (b), for the words “12 weeks beginning with the day on which the order is made” there is substituted “the relevant period given by subsection (8A) below”,
    (iii) in paragraph (c), for the words “period of 12 weeks beginning with the day on which the order is made” there is substituted “relevant period given by subsection (8A) below”,
  (c) after subsection (8) there is inserted—
    “(8A) For the purpose of subsection (8)(b) and (c) above, the relevant period is the period—
     (a) beginning with the day on which the order is made,
     (b) expiring at the end of the 12 weeks following that day.”.
(3) In section 53A (interim compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.
(4) In section 53B (review and extension of interim compulsion order)—
(a) in subsection (4), for the words from “(not exceeding” to “not made)” there is substituted “not exceeding the relevant period given by subsection (4A) below”,

(b) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above, the relevant period is the period—

(a) beginning with the day on which the order would cease to have effect if it were not extended,

(b) expiring at the end of the 12 weeks following that day.”,

(c) in subsection (5), for the words “12 months beginning with the day on which the order was first made.” there is substituted “the period—

(a) beginning with the day on which the order was first made,

(b) expiring at the end of the 12 months following that day.”.

(5) In section 54 (unfitness for trial: further provision), in subsection (2B)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

32 Periods for compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 57A (compulsion order)—

(a) in subsection (2), for the words “period of 6 months beginning with the day on which the order is made” there is substituted “relevant period given by subsection (2A) below”,

(b) after subsection (2) there is inserted—

“(2A) For the purpose of subsection (2) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring at the end of the 6 months following that day.”,

(c) in subsection (5)(b), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 57B (compulsion order authorising detention in hospital or requiring residence at place: ancillary provision), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 57D (compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

33 Periods for hospital directions

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 59A (hospital directions)—

(a) in subsection (4)(b), for the words “expiry of the period of” there is substituted “end of the day following the”,

(b) in subsection (7)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 59C (hospital direction: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

Variation of certain orders

34 Variation of interim compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 53B (review and extension of interim compulsion order)—

(a) in subsection (4)—

(i) the words from “if satisfied” to the end become paragraph (a),
(ii) after that paragraph (as so numbered) there is inserted “and

(b) if it seems appropriate to do so, direct that the offender be admitted to
the hospital specified in the direction.”,

(b) in subsection (6), after the word “order” there is inserted “or make a direction
specifying a hospital”,

(c) after subsection (7) there is inserted—

“(7A) Where a direction is made under subsection (4) above, the interim compulsion
order has effect as if the hospital specified in the direction were the hospital
specified in the order.”.

35 Transfer of patient to suitable hospital

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) The italic heading immediately preceding section 61 becomes “Miscellaneous
provision”.
(3) After section 61 there is inserted—

“61A Transfer of person to suitable hospital

(1) Subsection (2) below applies in relation to a person who is subject to—

(a) an assessment order,
(b) a treatment order, or
(c) an interim compulsion order.

(2) Before the end of the day following the 7 days beginning with the day on
which the person is admitted to a hospital by virtue of the order in question, the
person’s responsible medical officer may transfer the person from the specified
hospital to another hospital.

(3) The responsible medical officer may transfer the person only if satisfied that,
for the purpose for which the order in question is made—

(a) the specified hospital is not suitable, and
(b) the other hospital is suitable.

(4) In considering the suitability of each hospital, the responsible medical officer is
to have particular regard to the specific requirements and needs in the person’s
case.

(5) As far before the transfer as practicable, the responsible medical officer must—

(a) inform the person of the reason for the transfer,
(b) notify the managers of the specified hospital, and
(c) obtain the consent of—
   (i) the managers of the other hospital, and
   (ii) the Scottish Ministers.

(6) As soon after the transfer as practicable, the responsible medical officer must notify—
   (a) any solicitor known by the officer to be acting for the person, and
   (b) the court which made the order in question.

(7) A person may be transferred under subsection (2) above only once with respect to the order in question.

(8) Where a person is transferred under subsection (2) above, the order in question has effect as if the other hospital were the specified hospital.

(9) In this section—
   “managers” has the meaning given by section 329(1) of the Mental Health (Treatment and Care) Scotland Act 2003,
   “responsible medical officer” has the meaning given by section 329(4) of that Act,
   “specified hospital” means hospital to which the person is admitted by virtue of the order in question.”.

36 Compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 57D there is inserted—

   “57E Compulsion order: specification of hospital unit

   (1) In sections 57(2)(a), 57A, 57B and 57D of this Act, a reference to a hospital may be read as a reference to a hospital unit.

   (2) Despite subsection (1) above, a compulsion order may not specify the hospital unit in which a person is to be detained unless a restriction order is also made in respect of the person.

   (3) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

37 Hospital directions

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 59A (hospital directions), after subsection (10) there is inserted—

   “(11) In this section and section 59C of this Act, a reference to a hospital may be read as a reference to a hospital unit.

   (12) For the purposes of subsection (11) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.
38 Transfer for treatment directions

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment of mental disorder), after subsection (10) there is inserted—

“(11) A reference in this section to a hospital may be read as a reference to a hospital unit.

(12) For the purposes of subsection (11) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

39 Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 218 there is inserted—

“218A Transfer of patient from specified hospital unit

(1) Subsection (2) below applies where—

(a) a patient is subject to—

(i) a compulsion order and a restriction order,

(ii) a hospital direction, or

(iii) a transfer for treatment direction, and

(b) that order or (as the case may be) direction specifies the hospital unit in which the patient is to be detained.

(2) If the condition in subsection (3) below is satisfied, the managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) The condition is that the Scottish Ministers consent to the transfer.

(4) In relation to a transfer or proposed transfer under subsection (2) above, section 218(4) to (14) of this Act applies subject to the following modifications—

(a) a reference to section 218(2) is to be read as a reference to subsection (2) above,

(b) in subsection (10)(a), a reference to section 218(3) is to be read as a reference to subsection (3) above,

(c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,

(d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.

(5) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

40 Consequential repeals

The following enactments are repealed—
(a) section 9 of the Crime and Punishment (Scotland) Act 1997,

(b) paragraph 66 of schedule 7 to the Criminal Justice and Licensing (Scotland) Act 2010.

Miscellaneous amendments

5  Information on extension of compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 153 there is inserted—

“153A Further information on extension of compulsion order

(1) Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 152 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 165(2) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and

(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—

(i) a copy of the record, and

(ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—

(a) the name and address of the patient,

(b) if known by the mental health officer, the name and address of—

(i) the patient’s named person, and

(ii) the patient’s primary carer,

(c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 151 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),

(d) so far as relevant to the extension of the compulsion order—

(i) the details of the personal circumstances of the patient, and

(ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),
(e) the views of the mental health officer on the extension of the compulsion order, and

(f) any other information that the mental health officer considers relevant in relation to the extension of the compulsion order.

(5) The matters referred to in subsection (2)(c) above are—

(a) whether the mental health officer is sending a copy of the record to the patient, and

(b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.

(6) For the purposes of subsection (2)(c) above, the persons are—

(a) the patient’s named person,

(b) the patient’s responsible medical officer, and

(c) the Commission.”.

42 Notification of changes to compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 157 (application for extension and variation of compulsion order: notification), paragraph (f) is repealed together with the word “and” immediately preceding it.

(3) In section 160 (application for variation of compulsion order: notification), for the word “(f)” there is substituted “(e)”. 

PART 3

VICTIMS’ RIGHTS

Information and representations

43 Right to information: offender imprisoned

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) In section 16 (victim’s right to receive information concerning release etc. of prisoner), in subsection (3)—

(a) in paragraph (e)—

(i) for the words “or young” there is substituted “, young”,

(ii) after the word “institution” there is inserted “or hospital”,

(b) the word “and” immediately preceding paragraph (f) is repealed,

(c) in paragraph (f)—

(i) for the words “or young” there is substituted “, young”,

(ii) after the word “institution” there is inserted “or hospital”,

(d) after paragraph (f) there is inserted—

“(g) where the convicted person is liable to be detained in a hospital under a hospital direction or transfer for treatment direction—
(i) that a certificate has been granted, for the first time, under the Mental Health Act which suspends the person’s detention and does not impose a supervision requirement,

(ii) that the certificate mentioned in sub-paragraph (i) has been revoked.”.

(3) In section 16, in subsection (4)—

(a) the word “or” immediately preceding paragraph (b) is repealed, and

(b) at the end of paragraph (b) there is inserted “; or

(c) modify section 18A, by adding, amending or repealing definitions of terms used in the descriptions of information in subsection (3) of this section.”.

44 Right to information: compulsion order

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 16 there is inserted—

“16A Victim’s right to receive information concerning offender subject to compulsion order

(1) Subsection (2) applies where—

(a) an offence has been perpetrated against a natural person,

(b) another person (“O”) has been made subject to a compulsion order and a restriction order in proceedings in respect of that offence,

(c) a person has asked to be given information about O under this section and that person is, or was at the time of asking, a person entitled to ask to be given the information (see section 16B), and

(d) O has attained the age of 16 years.

(2) The Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).

(3) But the Scottish Ministers need not give a person information under this section if they consider there to be exceptional circumstances which make it inappropriate to do so.

(4) If the compulsion order or the restriction order mentioned in subsection (1)(b) is revoked, subsection (2) ceases to apply when the Scottish Ministers give the person mentioned in subsection (1)(c) the information that the order has (or both orders have) been revoked.

16B Person entitled to ask to be given information under section 16A

(1) The reference in section 16A(1)(c) to a person entitled to ask to be given information under that section is to—

(a) the natural person (“V”) against whom the offence mentioned in section 16A(1)(a) (“the relevant offence”) was perpetrated,

(b) if V is dead—
(i) any or all of the four qualifying persons highest listed in section 14(10), and

(ii) if V died before attaining the age of 16 years, any other person who cared for V immediately before the relevant offence was perpetrated, or

(c) if V has attained the age of 12 years and is incapable for the purposes of this section, the qualifying person highest listed in section 14(10).

(2) If a person (including V) who would be entitled to ask to be given information by virtue of subsection (4) has not attained the age of 12 years—

(a) the person is not entitled to ask to be given the information, and

(b) someone who cares for the person is entitled to ask to be given it instead.

(3) For the purposes of this section—

(a) the references to a qualifying person are to a person—

(i) whose relationship to V is listed in subsection (10) of section 14 (read with the other subsections of that section),

(ii) who is not incapable for the purposes of this section, and

(iii) who is not a person accused of, or reasonably suspected of being the perpetrator of, or having been implicated in the perpetration of, the relevant offence,

(b) when determining who is the qualifying person highest listed in section 14(10), if two or more persons have the same relationship to V they are to be listed according to age with the eldest being the highest listed of them,

(c) the expressions “cared for” and “cares for”, are to be construed in accordance with the definition of “someone who cares for” in paragraph 20 of schedule 12 to the Public Services Reform (Scotland) Act 2010,

(d) a person is to be considered incapable for the purposes of this section if the person would be considered incapable of making a victim statement by virtue of section 14(6)(b)(i) and (7).

16C Information to be given under section 16A

(1) This section sets out the information that is to be given under section 16A about the person referred to in that section as O.

(2) The following information is to be given in any case—

(a) that the compulsion order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(b) that the restriction order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(c) the date of O’s death,

(d) that the compulsion order has been varied by way of a modification of the measures specified in it,

(e) that O has been transferred to a place outwith Scotland,
(f) that the Mental Health Tribunal has made an order under section 193(7) of the Mental Health Act conditionally discharging O,

(g) that the Scottish Ministers have recalled O to hospital under section 202 of the Mental Health Act.

(3) The following information is to be given in a case where the compulsion order authorises O’s detention in hospital—

(a) that O is unlawfully at large from hospital,

(b) that O has returned to hospital having been unlawfully at large,

(c) that a certificate has been granted, for the first time, under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,

(d) that the certificate mentioned in paragraph (c) has been revoked.”.

45 Right to make representations

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17A there is inserted—

“17B Mentally-disordered offender: victim’s right to make representations

(1) A person (“V”) who is to be given information about another person (“O”) under section 16 or 16A, must be afforded an opportunity to make representations—

(a) in a case where O is subject to a hospital direction or a transfer for treatment direction, before a decision of a type described in subsection (4) is taken in relation to O,

(b) in a case where O is subject to a compulsion order and a restriction order, before a decision of a type described in subsection (5) is taken in relation to O.

(2) Representations under this section must be about how the decision in question might affect V or members of V’s family.

(3) Subsection (1) does not apply unless V has intimated to the Scottish Ministers a wish to be afforded an opportunity to make representations about O under this section.

(4) For the purpose of section (1)(a), the type of decision is a decision by O’s responsible medical officer about granting a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement.

(5) For the purpose of subsection (1)(b), the types of decision are a decision—

(a) by O’s responsible medical officer about granting a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,

(b) by the Mental Health Tribunal under section 193 of the Mental Health Act (including a decision under that section as applied by section 201(3) or 204(3) of that Act),
(c) by the Scottish Ministers under section 200 of the Mental Health Act about varying conditions in a way which may have an effect on V or members of V’s family.

5 (6) The Scottish Ministers need not afford V an opportunity to make representations before taking a decision of the type described in subsection (5)(c) if it is not reasonably practicable to afford V that opportunity.

17C Making representations under section 17B

(1) Representations under section 17B—

(a) may be made orally in relation to a decision of a type described in paragraph (b) or (c) of section 17B(5), but

(b) otherwise, must be made in writing.

(2) The Scottish Ministers are to issue guidance as to how—

(a) written representations under section 17B should be framed, and

(b) oral representations under that section should be made.

17D Right to information after section 17B decision

(1) Subsection (2) applies where—

(a) before a decision was taken, a person (“V”) was afforded an opportunity to make representations under section 17B,

(b) the decision has since been taken,

(c) the Scottish Ministers are not required under section 16A to give any information to V as a result of the decision, and

(d) V has intimated to the Scottish Ministers a wish to receive information under this section.

(2) The Scottish Ministers must, unless they consider that there are exceptional circumstances which make it inappropriate to do so, inform V that the decision has been taken.”.

Additional provisions

46 Information sharing

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17D there is inserted—

“17E Information sharing in respect of mentally-disordered offenders

(1) Where the Scottish Ministers are subject to a duty under section 16 or 16A to give a person (“V”) information about another person (“O”), they must give notice to—

(a) O’s responsible medical officer, and

(b) if O is subject to a compulsion order, the Mental Health Tribunal.
(2) A notice under subsection (1) is to request that the recipient of the notice provide the Scottish Ministers with information in such circumstances as may be specified in the notice.

(3) The information that the Scottish Ministers may request in a notice under subsection (1) must be information about O which they will require in order to fulfil their duty to give information to V under section 16, 16A or 17D.

(4) The recipient of a notice under subsection (1) must provide the Scottish Ministers with the information requested in the notice in the circumstances specified in it.

(5) If the Scottish Ministers cease to be required to give anyone information about O under section 16 or 16A—
   (a) they must intimate that fact to anyone to whom they sent a notice in relation to O in accordance with subsection (1), and
   (b) on receiving that intimation, subsection (4) ceases to apply to the person who received the intimation.”.

47 Associated definitions

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18 there is inserted—

   “18A Interpretation of Part

   (1) In this Part—
   “Mental Health Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003,
   “Mental Health Tribunal” means the Mental Health Tribunal for Scotland,
   “transfer for treatment direction” means a direction made under section 136 of the Mental Health Act.

   (2) A reference in this Part to a certificate under the Mental Health Act which suspends a person’s detention and does not impose a supervision requirement is to a certificate under subsection (2) of section 224 of that Act, which does not include a condition under subsection (7)(a) of that section.”.

48 Power to make modifications

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18A there is inserted—

   “18B Power to modify Part

   (1) The Scottish Ministers may by order amend—
   (a) sections 16A and 16B, by substituting for any age for the time being specified in those sections a different age,
   (b) section 16C, by adding descriptions of information,
   (c) section 18A, by adding, amending or repealing definitions of terms used in the descriptions of information in section 16C.
(2) The Scottish Ministers may by order amend—

(a) section 16A, so that information may be given under that section in some or all cases where a person has been made subject to a compulsion order and either—

(i) the person has not been made subject to a restriction order, or

(ii) the restriction order to which the person was made subject has been revoked,

(b) section 17B, to specify types of decision in respect of which representations under that section may be made by persons who have a right to be given information under section 16A as amended by virtue of paragraph (a).

(3) In an order under subsection (2) which amends section 16A or 17B, the Scottish Ministers may make any amendment to the following enactments which they consider necessary or expedient in consequence of the amendment to section 16A or 17B—

(a) sections 16C, 17E and 18A,

(b) the Mental Health (Care and Treatment) (Scotland) Act 2003.”.

(3) In section 88 (orders), after “16(4)” there is inserted “, 18B”.

49 Amendments to the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 193 (powers of Tribunal on reference or application under certain sections), after subsection (9) there is inserted—

“(9A) Where—

(a) a person (“V”) is entitled to make victim’s representations before the Tribunal makes a decision under this section, and

(b) V has not been afforded the opportunity of making representations under subsection (8),

before making the decision, the Tribunal must have regard to any victim’s representations made by V.”.

(3) In section 200 (variation of conditions imposed on conditional discharge), after subsection (2) there is inserted—

“(2A) Before varying any conditions under subsection (2), the Scottish Ministers must have regard to any victim’s representations.”.

(4) In section 224 (patients subject to certain orders and directions: suspension of measure authorising detention), after subsection (6) there is inserted—

“(6A) Before deciding what conditions such as are mentioned in subsection (7) below to include in a certificate under subsection (2) above (if any), the responsible medical officer must have regard to any victim’s representations.”.

(5) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—
““victim’s representations” means representations made under section 17B of the Criminal Justice (Scotland) Act 2003 in relation to the matter being considered;”.

PART 4
COMMENCEMENT AND SHORT TITLE

50 Commencement
(1) This Part comes into force on the day after Royal Assent.
(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.
(3) An order under subsection (2) may include transitional, transitory or saving provision.

51 Short title
The short title of this Act is the Mental Health (Scotland) Act 2015.
Mental Health (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Introduced by: Alex Neil
Supported by: Michael Matheson
On: 19 June 2014
Bill type: Government Bill
MENTAL HEALTH (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Mental Health (Scotland) Bill introduced in the Scottish Parliament on 19 June 2014:

- Explanatory Notes;
- a Financial Memorandum;
- a Scottish Government statement on legislative competence; and
- the Presiding Officer’s statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 53–PM.
EXPLANATORY NOTES

INTRODUCTION

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

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

THE BILL

3. The Bill’s overarching objective is to help people with a mental disorder to access effective treatment quickly and easily. The on-going monitoring to which the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) was subject to identified some aspects of the legislation which were not operating as efficiently and effectively as had been intended. To address these matters this Bill amends provisions within the 2003 Act and some related provisions in the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”). The Bill also makes provision, through amendments to the Criminal Justice (Scotland) Act 2003, for the introduction of a notification scheme for victims of mentally disordered offenders.

4. A more detailed explanation of the Bill’s purpose can be found in the Policy Memorandum, this also explains the thinking and policy intentions that underpin it.

THE STRUCTURE & A SUMMARY OF THE BILL

5. The Bill is structured in the following Parts:

- **Part 1** amends the 2003 Act in respect of a number of issues relating to compulsory treatment for patients, including procedures for compulsory treatment, suspension of detention, removal of patients and timescales for referrals and disposals. Part 1 also amends provisions relating to representation by named persons and advance statements.

- **Part 2** amends the 1995 Act in respect of treatment for mentally disordered offenders. It amends timescales for assessment and treatment orders for such patients and provides for variation of certain orders.

- **Part 3** creates a new notification scheme for victims of mentally disordered offenders.

- **Part 4** sets out general provisions on coming into force and modification of enactments.

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1 Asp13
Glossary of terms used

AMP – approved medical practitioner
AO – Assessment Order
CO - compulsion order
CORO – compulsion order and a restriction order
CTO – compulsory treatment order
EDC – emergency detention certificate
HD – hospital direction
MHO – mental health officer
RMO – responsible medical officer
STDC – short term detention certificate
The 2003 Act – The Mental Health (Care and Treatment) (Scotland) Act 2003
The Commission – the Mental Welfare Commission for Scotland
The Tribunal – the Mental Health Tribunal for Scotland
TTD – transfer for treatment direction

PART ONE – THE 2003 ACT

Section 1: Measures until application determined

Amendment of sections 64, 65, 68 and 69

6. Compulsory treatments orders (CTOs) are orders made by the Mental Health Tribunal for Scotland (the Tribunal). A CTO can authorise detention and/or medical treatment in hospital or it can impose compulsory measures in the community. The arrangements for the application and making of CTOs are contained in part 7 of the 2003 Act (sections 57 to 129). Section 64 of the 2003 Act sets out powers of the Tribunal when considering an application for a CTO under section 63 of the 2003 Act. If the Tribunal is satisfied that the conditions for a CTO are met, then it may authorise for a period of up to 6 months, measures listed in section 66 of the 2003 Act. Section 65 of the 2003 Act empowers the Tribunal to grant an interim compulsory treatment order where an application has been made for a CTO. An interim CTO can be authorised for a period of up to 56 days.

7. Short term detention certificates (STDCs) can be granted in respect of a patient living in the community or a patient in hospital on a voluntary basis and can authorise the detention of a patient in hospital, for 28 days under section 44 of the 2003 Act and for a further 3 days if an extension certificate is granted under section 47.

8. For patients who are already subject to an STDC (or an extension certificate), section 68 provides that once an application for a CTO has been made under section 63, the patient's detention in hospital under authority of the certificate is automatically extended for a further five working days. This is to enable the Tribunal to have sufficient time to come to a decision on the application.
9. Section 1 of the Bill provides that if the Tribunal is making a CTO under section 64 or an interim CTO under section 65 and the patient subject to the orders has been detained in hospital under a STDC or an extension certificate under section 44 or 47 of the 2003 Act, the length of time the patient has been detained under section 68(2)(a) must be deducted from the 6 month period, in the case of section 64, or 56 days under section 65.

10. Section 1 of the Bill also extends the period of short term detention possible under section 68(2)(a) from 5 days to 10 days, and makes consequent amendments to section 69 of the 2003 Act.

Section 2: Information where order extended

11. Section 87 of the 2003 Act sets out the steps that a responsible medical officer (RMO) must take when he or she has determined that a CTO is to be extended without change. In such cases an RMO must prepare a record setting out the reasons for the determination and whether the Mental Health Officer (MHO) agrees, disagrees or has not expressed a view. Also required to be recorded in the case of a disagreement, are the reasons for the disagreement, the type of mental disorder suffered by the patient and whether that has changed from the disorder in the original CTO.

12. This record must be submitted to the Tribunal and a copy sent to the patient (unless the RMO considers there would be significant risk to the patient in doing so), the patient’s named person, the MHO and the Mental Welfare Commission for Scotland (the Commission). The Tribunal must be told if the RMO is sending a copy or not to the patient and, if not, the reasons for that decision.

New section 87A

13. Section 2 of the Bill inserts new section 87A which sets out new duties for the MHO when the Tribunal is required by section 101(2) of the 2003 Act to review the determination. That situation occurs when the determination states that there is a difference between the type of mental disorder that the patient has, and that recorded in the original CTO, or the MHO disagrees with the determination, or has failed to express a view, or when the Tribunal has not reviewed the CTO during the period of 2 years prior to the date on which the CTO would have lapsed had it not been extended by the RMOs determination.

14. When section 101(2) applies, section 87A requires the MHO to prepare and submit a record to the Tribunal with the patient’s name and address and that of the patient’s named person and primary carer (if known), details of what the MHO has done in compliance with section 85 of the 2003 Act, and so far as relevant to the extension of the CTO, the details of the personal circumstances of the patient, any advance statement of the patient (if known by the MHO), the views of the MHO on the extension of the CTO and any other information the MHO considers relevant in relation to the extension of the CTO. A copy of this record must also be sent to the patient, the patient’s named person, RMO and the Commission. The MHO need not send a copy of the record if the MHO considers so doing would carry a significant risk of harm. The Tribunal must be told if the patient is not receiving the report, and the reasons for this decision.
Section 3: Emergency detention in hospital

Amendment of sections 36, 38, 40 and 42

15. Part 5 (sections 36 to 43) of the 2003 Act makes provision for the emergency detention and admission of patients to hospital by means of an emergency detention certificate (EDC). Section 36 sets out the procedure for the granting of an EDC authorising the detention of a patient in hospital for a period of 72 hours. Section 36(2) lists a number of orders, in respect of which, if a patient is subject to any of those orders listed, an EDC cannot be granted in respect of that patient.

16. Section 3(2) of the Bill adds short term detention under section 113(5) of the 2003 Act (non-compliance with order) to that list.

17. Section 38 of the 2003 Act at present provides that in the case of an emergency detention, a hospital manager must inform the following persons: the patient’s nearest relative, any additional person who may reside with the patient, the patient's named person (if known), and the Commission. Section 3(3) of the Bill amends section 38 so that hospital managers will be required to notify the Commission of any emergency detention, but will have discretion as to whether the other persons listed in section 36(4) of the Act, are notified of an emergency detention. Section 3(4) and 3(5) of the Bill make consequent amendments in respect of the revocation of EDCs in sections 40 and 42 of the 2003 Act.

Section 4: Short term detention in hospital

Amendment of sections 44 and 46

18. Periods of short term detention in hospital are provided for in section 44 of the 2003 Act. In a similar way to section 36(2) of the Act, section 44(2) lists certain orders, which if in place in respect of a patient, a short term detention certificate (STDC) cannot be granted in respect of the patient. Section 4(2) of the Bill adds a detention under section 113(5) of the 2003 Act to the list of orders in section 44(2) of the 2003 Act.

19. Section 46 of the 2003 Act provides that hospital managers must send a copy of a STDC to the Tribunal and the Commission. Section 4(3) of the Bill amends section 46 to provide that a copy of the certificate must now be sent to all recipients as notification of the STDC.

Section 5: Meaning of temporary compulsion

Amendment of section 329

20. Section 5(3) of the Bill inserts a definition of “temporary compulsion order” into section 329 (interpretation) of the 2003 Act. In consequence of this, the reference to section 54(1)(c) in the definition of ‘appropriate act’ in paragraph (c) of section 230(4) of the 2003 Act is repealed.
Section 6: Suspension of orders on emergency detention

Amendment of section 43

21. Section 43 of the 2003 Act deals with the effect of subsequent emergency detention certificates (EDCs) on compulsory treatment orders (CTO). At present where a patient is subject to a CTO and an EDC is granted (for example because a patient’s condition has perhaps deteriorated suddenly to the extent that detention in hospital is required), any measures authorised by the CTO cease to have effect whilst the patient is subject to the EDC (with the exception of any measures authorised under section 66(1)(b) of the 2003 Act, i.e., the giving of medical treatment, in accordance with Part 16 of the Act).

22. Section 6 of the Bill amends section 43 of the 2003 Act to make equivalent provision as regards patients subject to a compulsion order or an interim CTO, and who then become subject to an EDC. The result of the amendments in such cases is that any measures authorised by a CO, interim CTO or CTO will cease to have effect for the duration of the EDC, with the exception of the giving of medical treatment in accordance with Part 16 of the 2003 Act (as authorised under section 66(1)(b) of the 2003 Act as regards CTOs and interim CTOs, or section 57A(8)(b) of the 1995 Act as regards compulsion orders).

23. Section 6(2)(d) and section 6(3) make consequent changes to section 43 and its title.

Section 7: Suspension of orders on short term detention

Amendment of section 56

24. Section 56 of the 2003 Act makes provision for the effect of subsequent short term detention certificates (STDC) on compulsory treatment orders (CTO). At present where a patient is subject to a CTO and a STDC is granted (because a patient’s condition has perhaps deteriorated suddenly to the extent that hospital treatment is required), any measures authorised by the CTO cease to have effect whilst the patient is subject to the STDC.

25. Section 7 of the Bill amends section 56 to provide that if a patient is subject to a CTO, CO, or an interim CTO, and that patient becomes subject to a STDC, any measures authorised by the CO, interim CTO or CTO cease to have effect for the duration of the STDC. Section 7(2)(c) of the Bill and section 7(3) make consequent changes to section 56 and its title.

Section 8: Suspension of detention for certain purposes

26. Section 221 of the 2003 Act makes provision for the suspension of detention for patients subject to an assessment order (AO) made under the 1995 Act. At present, the consent of the Scottish Ministers is required for suspending the AO for any period of time.

27. Section 8 of the Bill provides that consent of the Scottish Ministers will no longer be required if the suspension of detention is required to enable the patient to attend either a hearing in criminal proceedings against the patient or a medical or dental appointment.
28. Section 224 of the 2003 makes provision for the suspension of detention for patients subject to a treatment order, interim compulsion order, compulsion order and a restriction order, hospital direction or transfer for treatment direction. Section 8 of the Bill amends section 224 to provide that the consent of the Scottish Ministers will no longer be required when suspension of detention is necessary for such patients to attend either a hearing in criminal proceedings against the patient, or a medical or dental appointment.

29. Sections 127 (suspension of detention under CTO), 221 and 224 of the 2003 Act are also amended to provide that a certificate suspending detention must record the purpose for which the certificate has been granted.

**Section 9: Maximum suspension of detention measures**

30. A patient who is subject to a CTO or an interim CTO can have measures authorising the detention under those orders suspended in terms of section 127 of the 2003 Act. At present, a patient’s responsible medical officer (RMO) can grant a certificate suspending detention, as an important part of the patient’s rehabilitation process, allowing patients extended time out of hospital, but still subject to conditions imposed by the RMO. The power is exercised at the RMO’s discretion. Under the current provisions, an RMO can suspend measures for up to 6 months. More than one certificate can be granted but the period of suspension cannot exceed 9 months in any 12 month period. For the purposes of this provision, section 127(4) provides that a period may be expressed as the duration of an event or a series of events and any associated travel.

**Amendment of section 127**

31. Section 9 of the Bill amends section 127 by providing that the maximum period of suspension of detention may not exceed 200 days in any 12 month period; however, that does not include any period of suspension authorised by the RMO between 9 pm and 8am which is less than 12 hours in duration. Section 9 further amends section 127 by providing that the total of 200 days may be increased by up to a further 100 days in a given 12 month period, if the Tribunal approves an application for an extension. Only one such increase is allowed in a 12 month period and the total must not exceed 300 days. Where an RMO makes an application to the Tribunal for an increase of the 200 day limit, they must notify the Commission of the application and its outcome. The amendments made to section 127 will also apply to patients subject to a compulsion order (CO) by virtue of section 179 of the 2003 Act.

**Amendment of section 224**

32. Section 9 further amends section 224, by making similar amendments to those made to section 127 referenced above. As is the case with section 127, a patient’s RMO can, with the consent of the Scottish Ministers, grant suspension of detention for a maximum of 9 months in a 12 month period. Section 9 amends this to provide that suspension of detention can now be granted for a maximum of 200 days in any 12 month period. Any period of suspension authorised which is less than 12 hours and does not include any time between 9 pm and 8 am does not count towards the maximum of 200 days. This total can be increased on application to the Tribunal, to a maximum of 300 days in any 12 month period and when an application for an increase in the period of suspension is made to the Tribunal, the RMO is required to notify the Commission of the making of the application and its outcome.
Section 10: Process for enforcement of orders

Amendment of sections 266, 267, 270, 271, and schedule 2 paragraph 13A

33. Chapter 3 of Part 17 of the 2003 Act is concerned with appeals against detention in conditions of excessive security.

34. Section 264 of the 2003 Act provides at present that a patient detained in the State Hospital by virtue of a compulsory treatment order (CTO), a compulsion order (CO), a hospital direction (HD) or a transfer for treatment direction (TTD), can apply to the Tribunal for an order declaring that the patient is being detained in conditions of excessive security. Similar provision is made at section 268 for patients detained in hospitals other than the State Hospital. The Tribunal can make an order declaring that the patient is being detained in conditions of excessive security and can specify a period of three months or less for the health board in which the patient ordinarily resides, to identify another hospital where the patient could be appropriately detained. Under section 265, if a suitable alternative hospital has not been found, a further period of between 28 days and 3 months can be given to the relevant Health Board to find a placement and under section 266, another 28 days can be given to the relevant Health Board to find a placement.

35. Section 10(2) of the Bill repeals section 266 so that a Health Board now has a maximum of six months in which to find a suitable alternative placement for a patient declared to be held in conditions of excessive security. Sections 10(3) and (4) make changes consequent on this amendment.

36. Section 10(5) repeals section 270. This repeal has the same effect as repealing section 266, but in respect of orders relating to detentions in conditions of excessive security for patients in non-state hospitals. Sections 10(6) and 10(7) make changes consequent on the amendment at section 10(5).

37. Section 10(8) reflects the repeal of section 266 and 270 in section 272 of the 2003 Act (proceedings for specific performance of statutory duty).

38. Section 10(9) adds applications under section 264(8) and 268(8) to the list of applications in schedule 2 to the 2003 Act which are treated as not having been made if withdrawn before determination.

Section 11: Orders relating to non-state hospitals

Amendment of section 268

39. Section 268 of the 2003 Act provides patients in non-state hospitals with a right of appeal against conditions of excessive security. At present, that right extends to “qualifying patients” in “qualifying hospitals”, with the definition of what constitutes a qualifying patient or hospital to be provided in regulations. If the Tribunal is satisfied that a patient is being held in conditions of excessive security, then it may make a declaration to that effect and require that the Health Board in which the patient usually resides identifies a hospital where the patient could be detained in conditions of security which are not excessive for that patient.
40. Section 11 of the Bill makes a number of amendments to the provisions relating to appeals against excessive security for patients detained in a hospital other than in the State Hospital. Section 11 removes references to “qualifying” in respect of patients who may appeal under this section (section 12 below makes alternative provision determining the application of section 268). This section also requires, in both section 268 and section 269, that notification of the proposed hospital, or hospital unit (see section 12 below which provides that references to ‘hospital’ can include a ‘hospital unit’) to which the patient is to be moved, is given to the managers of the hospital or unit where the patient is currently resident. This is a slight change from the current requirement (to notify the managers of the ‘qualifying hospital’) to recognise the fact that notification that a patient is moving between units in a hospital may need to be given to the managers of the units as opposed to simply the overall manager of the hospital.

41. Subsections (11) to (14) of section 268, relating to the definition of qualifying patients are repealed and re-enacted (with adjustments) in section 272A (as inserted by section 12 of the Bill). A new definition of a relevant patient is inserted at section 273 of the 2003 Act by section 11(5) of the Bill, namely a patient who may appeal under section 268, provided that patient is detained by virtue of a restriction order, a compulsion order a hospital direction or a transfer for treatment direction.

Section 12: Qualifying non-state hospitals and units.

New section 272A

42. Section 12 of the Bill inserts new section 272A into the 2003 Act, defining a qualifying hospital for the purposes of appeals under section 268. Section 272A provides that a qualifying hospital is a hospital other than a state hospital, with the other requirements for qualification to be defined by regulations.

43. Subsections (2) and (3) of section 272A provide that regulations may also set out what requires to be determined in consideration of whether a patient is subject to an excessive level of security whilst in detention, how sections 268 to 271 operate in particular circumstances and may specify a particular hospital unit or hospitals operating particular measures of security or containment as a “qualifying hospital”.

44. New section 272A also clarifies that a reference to a hospital in sections 268 to 271 may be read as a reference to a hospital unit and that hospital unit means any part of a hospital treated as a separate unit; this will, for example, have the effect that the duty arising on a Health Board under section 268(3) to identify a hospital can be fulfilled by identifying a hospital unit (whether or not in the same hospital as the patient is currently detained).

Section 13: Notifying decisions on removal orders

New section 295A

45. Under section 293 or 294 of the 2003 Act a mental health officer (MHO) can apply for a removal order if he or she considers that a person over 16 who has a mental disorder, is at risk of significant harm and that certain circumstances are met. These circumstances are that the person is being subject or exposed to ill treatment or neglect, or that the person’s property is suffering loss or damage, or at risk of such loss or damage and the person is living alone or without care
and unable to look after him or herself. Application is made to the sheriff, or justice of the peace, in urgent cases, for the removal of the person at perceived risk, and detention of that person for a maximum of 7 days.

46. Section 13 of the Bill inserts new section 295A into the 2003 Act which places a new duty on MHOs to notify the Commission of the decision of the sheriff or justice, and any subsequent recall or variation of the removal order.

Section 14: Detention pending medical treatment

Amendment of Section 299

47. Under section 299 of the 2003 Act a nurse has the power to detain certain patients for a period of up to two hours to enable a medical examination to be carried out. Section 14 of the Bill amends section 299 to provide that a nurse will now be able to detain a patient for a maximum of 3 hours, for the purpose of enabling the carrying out of a medical examination of the patient by a medical practitioner and ensuring the patient does not leave the hospital before the granting of an emergency detention certificate (EDC) or a short term detention certificate (STDC), if either is needed.

Section 15: Appeal on hospital transfer

Amendment of section 220

48. Under section 218 of the 2003 Act, the managers of a hospital have the power to transfer a patient detained in a hospital, subject to a compulsion and restriction order (CORO), a hospital direction (HD), or a transfer for treatment direction (TTD), to a state hospital, even when the state hospital is not specified in the order. A patient who is notified of an intention to transfer, or who has been transferred to a state hospital in terms of section 218 of the 2003 Act, has a right of appeal to the Tribunal against the transfer or proposed transfer.

49. Section 15 of the Bill reduces the time limit for making an appeal to the Tribunal from 12 weeks to 28 days.

Section 16: Periodical referral of cases

Amendment of section 189 and 213

50. Section 189 of the 2003 Act requires the Scottish Ministers to refer the case of a patient who is subject to a compulsion and restriction order (CORO) to the Tribunal for review every 2 years. The requirement applies where during the relevant 2-year period none of the following references or applications have been made to the Tribunal; namely, a reference under section 185 by a responsible medical officer or an application under section 191 by the Scottish Ministers. Both of these actions would trigger a Tribunal hearing.

51. Section 16 of the Bill provides that a case has to be referred under section 189 if a reference or application under section 185 or section 191 has not been determined by the Tribunal, rather than whether a reference or application has been made, which does not necessarily mean that the Tribunal will have considered and determined the case within the
relevant 2 year period. Paragraph 13A, schedule 2 of the 2003 Act is amended in consequence of these changes.

Section 17: Recording where late disposal

New paragraph 13B, Schedule 2

52. Schedule 2 to the 2003 Act establishes the membership, organisation and some of the procedural rules of the Tribunal, as well as setting out the reporting requirements of the Tribunal. Section 15 of the Bill inserts new paragraph 13B to schedule 2 requiring that if the Tribunal fails to comply with a time limit imposed by the 2003 Act, or otherwise fails to do something within a particular period as required by the 2003 Act, such as determining an application or an appeal, it must do so without delay, unless no useful purpose would be served by doing so. The Tribunal must also record that the failure has occurred and the reasons for the failure.

Section 18: Opt out from having named person

53. Chapter 1 of Part 17 of the 2003 Act makes provision for the appointment and duties of named persons. Under section 250 of the 2003 Act, a person who is 16 years or over is entitled to nominate another person, over the age of 16 to act as a named person. A named person has a similar role to that of a safeguarder and represents the interests of the patient, but does not necessarily represent the patient. The named person should be involved in discussions about care options for the patient and may take part in any legal proceedings relating to compulsory measures.

54. At present, if a person has not appointed a named person then in the absence of a declaration to the contrary, the person’s primary carer becomes the named person, or the person’s nearest relative where there is no primary carer by virtue of section 251 of the 2003 Act. An individual can decline to be a named person, and a person can make a declaration that a particular person or persons shall not be a named person. The Tribunal also has the authority to appoint a named person in certain cases under section 257.

Amendment to section 251

55. Section 18 amends section 251 to provide that if a person has made a declaration stating that the person’s carer or relative may not become that person’s named person, then the section operates as though such a carer or relative did not exist. The effect of this is that a carer or relative will no longer become a named person unless the person and the carer or relative both agree to that position. Section 18 also amends section 253, by inserting a new subsection (1A) which allows a person over 16 to make a written declaration that the person does not wish to have any named person. Where such a declaration is made, section 251 will not apply.

Section 19: Consent to being named person

Amendment to sections 250, 251 and 257

56. At present, an individual may become a named person under section 251 of the 2003 Act without necessarily consenting to that role, albeit that he or she may decline to act. Section 19 of the Bill makes provision for a person to be appointed as a named person by virtue of sections
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250, 251 or 257, only if he or she has agreed to act as the person’s named person and signed a docket to that effect. If no such signed and witnessed docket exists, the appointment of the named person is null and void.

Section 20: Appointment of named person

Amendment of sections 255, 256 and 257

57. The Tribunal currently has power to appoint a named person, in the absence of an existing named person. Section 20 of the Bill removes this power from the Tribunal, together with associated amendments to section 255 and 256 of the 2003 Act which currently allow the Mental Health Officer and certain persons listed in section 256(2) (including the patient) to apply to the Tribunal to have a named person appointed.

New section 257(3A)

58. Subsection (4) of section 20 adds subsection (3A) to section 257. Subsection (3A) makes provision for the Tribunal to remove an existing person if they are considered inappropriate to act as a named person and, if the individual appearing before the Tribunal is under 16, substitute another person to act as named person.

Section 21: Registering of advance statements

New sections 276A, 276B and 276C

59. An advance statement is a statement which may be made by a person at any time provided the person making the statement has capacity to make such a statement. The statement must be in writing and witnessed. The advance statement should set out how a person wishes to be treated for mental disorder and the ways in which a person wishes not to be treated. Section 275 and 276 of the 2003 Act make provision for advance statements.

60. Section 19 of the Bill inserts sections 276A, 276B and 276C to the 2003 Act. Section 276A requires health boards to place a copy of any statement or document withdrawing a statement, with the person’s medical records and send a copy to the Commission.

61. Section 276B places a duty on the Commission, on receipt of an advance statement or a document withdrawing the statement, to keep a copy of the statement in a register to be maintained by the Commission.

62. Section 276C details who may inspect the register, namely the person to whom any matter in the register relates, any individual acting on the person’s behalf, and for the purposes of making decisions or taking steps with respect to the treatment of the person for mental disorder – a mental health officer dealing with the person’s case, the person’s responsible medical officer, or the relevant health board in which the person resides.
Section 22: Communication at medical examination etc.

New section 261A

63. Sections 260 and 261 of the 2003 Act place certain duties on hospital managers, known as appropriate persons for the purposes of these provisions, with regard to the provision of information to patients, and assistance to patients with communication difficulties.

64. Section 22 of the Bill inserts section 261A to the 2003 Act, which places additional duties on appropriate persons, in respect of help with communication at certain medical examinations and interviews specified in subsection (4)(a) and (b).

65. If the subject of a medical examination has difficulty in communicating or generally communicates in a language other than English, all reasonable steps must be taken to make arrangements to ensure the subject of the medical examination can communicate during the examination. A written record must be made of the steps taken to facilitate this. Section 22 concludes by defining appropriate person for the purposes of this section; namely the Scottish Ministers in respect of a medical examination under section 136(2) of the 2003 Act (which is a medical examination for medical disordered prisoners) and otherwise, for examinations or interviews held in a hospital, the managers of that hospital, for examinations held elsewhere, the medical practitioner carrying it out, or for interviews, the mental health officer.

Section 23: Services and accommodation for mothers

Amendment of section 24

66. Section 24 of the 2003 Act places a duty on health boards to provide services and accommodation for certain mothers with post-natal depression, to enable those mothers to care for their child in hospital. Section 23 of the Bill amends this provision to extend the duty to provide services for mothers with a mental disorder other than post-natal depression, in addition to provision of services for mothers with post-natal depression.

Section 24: Cross-border transfer of patients

Amendment of sections 289, 290 and 309A

67. Section 24 of the Bill makes a number of small changes to provisions relating to cross-border transfer of patients.

68. Sections 289 and 290 of the 2003 Act give the Scottish Ministers power to make regulations allowing, respectively, for the cross-border transfer of patients subject to measures other than detention, and the cross-border transfer of patients subject to detention. Section 24(2) amends section 289 of the 2003 Act by extending the power to make regulations in respect of the cross-border transfer of patients subject to requirement other than detention, to include persons subject to equivalent requirements in a member state of the European Union. Section 24(3) amends section 290 in the same way in respect of cross-border transfer for patients subject to detention requirements or otherwise in hospital.
69. Section 309A of the 2003 Act allows the Scottish Ministers to make regulations for and in connection with the keeping in charge of a person who is subject to escorted leave of absence authorised under legislation in force in another part of the UK, or in the Isle of Man or the Channel Islands. Regulations made under that section may make such provision by applying provisions of the 2003 Act dealing with absconding patients (sections 301 to 303 of the 2003 Act), with or without modification, to such patients. This enables regulations to make clear the powers of persons escorting patients under authority conferred under legislation in force in other territories, so that there is clear authority under the 2003 Act for those persons to continue to escort the patient whilst in Scotland.

70. Section 24(4) amends section 309A so that regulations made under that section can make provision for and in connection with the keeping in charge of a person who is subject to escorted leave of absence authorised under legislation in force in another member State of the European Union.

71. The effect of all of these changes is that regulations that currently make provision for the cross-border transfer of patients within the UK, under various orders, can now provide for the cross-border transfer of patients within the European Union, provided those patients are subject to equivalent requirements in their home country.

**Section 25: Dealing with absconding patients**

**Amendment of section 303**

72. Section 25 makes changes to sections 303, 309 and 310 of the 2003 Act with regard to provisions for absconding patients. Section 303 of the 2003 Act authorises certain persons to exercise powers in relation to any patient subject to an order authorising detention, where that patient has absconded. In particular, section 303(3)(a)(iii) gives a member of staff of any hospital, and where the patient liable to be taken into custody is subject to a compulsory treatment order which specifies a particular hospital, a member of staff of that establishment, the power, amongst other matters to take an absconding patient into custody.

73. Section 25(2) amends section 303(3)(a)(iii) to include a reference to a patient subject to an interim compulsory treatment order as well as a compulsory treatment order.

**Amendment of section 309 and 310**

74. Section 309 of the 2003 Act enables the Scottish Ministers to make regulations applying sections 301 to 303 of the 2003 Act to patients from England, Wales, Northern Ireland, the Isle of Man or the Channel Islands. Regulations made under section 309 allow persons who have absconded from those jurisdictions and are in Scotland to be taken into custody and returned to their own jurisdiction.

75. Section 25(3) of the Bill amends section 309 by extending the power to make regulations applying provisions in relation to absconds, to persons in Scotland subject to corresponding requirements or measures in a member State of the European Union. The section further provides that regulations made under section 309 applying section 301 to 303 to patients from other jurisdictions or member states may apply some or all of Part 16 of the 2003 Act to allow persons
These documents relate to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

held in custody by virtue of these provisions to be provided with medical treatment (but excluding persons who are subject to detention in accordance with an emergency detention certificate EDC).

76. Section 310 of the 2003 Act currently provides for regulations to provide the circumstances in which certain patients, specified in section 310(3), may be taken into custody, and the steps that can be taken by specified persons upon taking such patients into custody. Section 25(4) of the Bill provides that regulations made under that section may specify persons authorised by the patient’s RMO as persons who can take such patients into custody.

**Section 26: Agreement to transfer of prisoners**

77. Where a person who is serving a sentence of imprisonment has a mental disorder requiring treatment, section 136 of the 2003 Act allows for that person to be transferred from prison to a specified hospital under a transfer for treatment direction (TTD). Section 26 of the Bill amends section 136 to provide that such a TTD may only be made if a mental health officer has agreed to the making of the direction.

**Section 27: Compulsory treatment of prisoners**

*Amendment of schedule 2, part 2*

78. Part 2 of schedule 2 to the 2003 Act concerns the organisation and administration of the Tribunal. In particular paragraph 7(4) of schedule 2 provides that the convenor of proceedings before the Tribunal in relation to a patient subject to a compulsion order and a restriction order, a hospital direction (HD) or a transfer for treatment direction (TTD), must be the President of the Tribunal or a member of the Tribunal who serves as a sheriff convenor, unless those proceedings relate solely to the appointment of a named person in respect of the patient, under section 255 and 257 of the 2003 Act.

79. Section 27 amends paragraph 7 to provide, for proceedings relating to an application for a Compulsory Treatment order (CTO) in respect of a patient subject to a TTD or an HD, that the convenor does not have to be the President, or a member of the Tribunal who serves as a sheriff convenor. This is in addition to the existing exception for proceedings relating solely to the appointment of named persons.

80. The effect of this amendment is that the default provision in sub-paragraph (3) of paragraph 7 will apply to proceedings relating to an application for a CTO in respect of patients subject to a TTD or an HD, with the result that the convenor of the Tribunal will have to be either the President or a legal member selected from the panel mentioned in paragraph (1)(1)(a) of Schedule 2.

*New paragraph 1A, schedule 3*

81. Chapter 1 of Part 7 of the 2003 Act is concerned with the application for and making of compulsory treatment orders (CTOs). Schedule 3 to the 2003 Act makes a number of modifications to Chapter 1 of Part 7 insofar as it applies to patients who become subject to a CTO whilst already subject to a HD or TTD.
82. Section 27(3) adds a new paragraph to schedule 3, with the result that when a patient is subject to a HD or a TTD, and an application is made for a CTO, notice of the application requires to be given to the Scottish Ministers, in addition to the existing requirement to give notice to the patient, the patient’s named person and the Commission.

**PART TWO – CRIMINAL CASES**

**Section 28: Making certain orders in remand cases**

*Amendments to sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P*

83. The 1995 Act was amended by Parts 8, 9 and 10 of the 2003 Act with regard to the treatment of mentally disordered offenders. Part 2 of the Bill makes a number of minor amendments to the 1995 Act, mainly concerned with timescales, and procedure.

*Amendments to sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P*

84. Section 28 of the Bill amends the following sections of the 1995 Act: sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P, in the same way. In each of these sections, reference is made to a person being in custody. The Bill adds the words ‘remanded in’ in front of ‘in custody’, on each occasion it occurs, to clarify that the references to a person being in custody are to persons being held in prison, and do not include persons held in police custody.

**Section 29: Periods for assessment orders**

85. Section 52D of the 1995 Act makes provision for assessment orders. If a person has been charged with an offence, the case has not been concluded, and it appears to the prosecutor that the person has a mental disorder, the prosecutor may apply to the court for an assessment order to allow the appropriate examination and assessment by an approved medical practitioner of a person prior to trial or after conviction but before sentencing. The time periods for assessment orders are amended by section 29 of the Bill.

*Amendment to sections 52D, 52F, 52G and 52H*

86. Section 29(2)(a) changes the way in which timescales for removal of a person to hospital under an assessment order (AO) are calculated. At present the AO authorises the removal to and detention of a person in a specific hospital for up to 28 days, beginning with the day that the order is issued and ending 28 days after that event. This approach is different from the general rule applicable to the computation of time periods in the criminal court where time periods are calculated from the day the relevant order begins to the end of the day following the expiry of the relevant period. Section 29(2)(a) amends section 52D of the 1995 Act to align the computation of time periods under the parts of the 1995 Act amended by the 2003 Act, to the computation of time periods generally found in criminal procedure. This approach is replicated in the remainder of section 29 for the purposes of computation of time periods with regard to supplementary provision for AOs, review of AOs, and early termination of AOs in sections 52F, 52G and 52H of the 1995 Act respectively.

87. In addition, section 29(4) amends the period of extension for consideration of a case. If the court is satisfied on receipt of an assessment report under 52G(1), that further time is
necessary to consider the case, it may on one occasion only make an order extending the AO for 14 days, beginning with the day on which the order would otherwise cease to authorise the detention of the person in hospital and expiring at the end of the 14 days following that day. This is an increase of 7 days from the previous power to extend an AO.

Section 30: Periods for treatment orders

Amendment of sections 52M, 52P, 52R

88. Treatment orders can be made by a court and authorise certain measures, including, if required, the removal to hospital and detention of a person there, and the giving of specified treatment. Provision for treatment orders is made in sections 52K to 52U of the 1995 Act. Section 30 amends the timescales for treatment orders in sections 52M, 52P and 52R in the same way, and for the same purpose as the timescales for assessment orders (AOs) are amended by section 29 of the Bill.

Section 31: Periods for short term compulsion

89. Section 53 of the 1995 Act makes provision for interim compulsion orders (ICOs). These orders can be made by the court after conviction if a court is satisfied, on the written or oral evidence of two medical practitioners that the offender has a mental disorder.

Amendment of sections 53, 53A, 53B and 54

90. In the same way that section 29 of the Bill amends the timescales for assessment orders, and section 30 amends the time periods for treatment orders, section 31 amends section 53 and section 53A of the 1995 Act in respect of the timescales for ICOs. This section also amends section 53B and section 54 in respect of the timescales for the review and extension of ICOs in the same way.

Section 32: Periods for compulsion orders

Amendment of sections 57A, 57B and 57D

91. Sections 57A to 57D of the 1995 Act make provision for compulsion orders (CO), which may be made by the courts after conviction if the court is satisfied on the written or oral evidence of two medical practitioners that the offender has a mental disorder.

92. Section 32 of the Bill amends the timescales for COs to bring the computation of these timescales in line with practice in criminal procedure more generally. Section 32 amends sections 57A, 57B and 57D of the 1995 Act in the same way and for the same purposes as was the case with sections 28, 29, 30 and 31 of the Bill.

Section 33: Periods for hospital directions

Amendment of sections 59A and 59C

93. Hospital directions (HDs) are directions which allow a person to receive appropriate medical treatment for mental disorder in hospital, and then, if they become well, to be transferred to prison to complete the prison sentence imposed at the time of making the HD. In accordance
with earlier changes made in the Bill, section 33 amends sections 59A(4)(b), 59A(7)(a) and 59C to bring the computation of the relevant timescales in these sections in line with the way timescales are calculated for AOs, treatment orders and compulsion orders under the 1995 Act.

**Section 34: Variation of interim compulsion orders**

94. When an interim compulsion order (ICO) is made under section 53 of the 1995 Act, the court will specify a hospital to which the offender is to be admitted. Section 53B concerns the review and extension of ICOs. At present whilst the terms of an order can be extended, it is not possible for the court to direct that an offender be moved to a different hospital, notwithstanding the fact that it may have become apparent during the course of the initial period of the ICO that the present hospital was not suitable for the offender in question.

*Amendment of section 53B*

95. Section 34 of the Bill provides a power for the court to direct that, if it is appropriate to do so, the offender be admitted to a different hospital, specified by direction. If that is done, section 32(2)(c) provides that this is to have the same effect as if the hospital specified in the direction were the hospital specified in the ICO.

**Section 35: Transfer of patient to suitable hospital**

96. In certain situations, it becomes apparent very quickly that a person who is subject to an assessment order (AO), treatment order (TO), or interim compulsion order (ICO) and has been admitted to hospital by virtue of that order, would be more appropriately treated in another hospital.

*New section 61A*

97. Section 35 of the Bill inserts section 61A into the 1995 Act, which gives a person’s responsible medical officer (RMO) the authority to transfer a person subject to an AO, a treatment order or an interim CO, before the end of the 7 days beginning with the day on which the person is admitted to hospital by virtue of the order in question. Such a transfer can only occur once, and in making the transfer the RMO must be satisfied both that the current hospital is not suitable and that the new hospital is suitable for the purpose for which the order is made. Before carrying out the transfer, the RMO must, as far as practicable, inform the person of the reason for the transfer, notify the managers of the specified hospital and obtain the consent of the managers of the other hospital and the Scottish Ministers. After the transfer, the RMO must notify any solicitor acting for the person, and the court which made the order.

**Section 36: Compulsion orders**

*New section 57E*

98. Section 36 of the Bill inserts new section 57E into the 1995 Act, with the effect that in sections 57(2)(a), 57A, 57B and 57D of that Act, any references to a hospital may be read as references to a hospital unit and a hospital unit means any part of a hospital which is treated as a separate unit.
Section 37: Hospital directions

Amendment to section 59A

99. In similar fashion to section 36 of the Bill, section 37 amends section 59A of the 1995 Act to provide that references to hospitals in that section includes reference to hospital units and a unit is any part of a hospital which is treated as a separate unit.

Section 38: Transfer for treatment directions

Amendment to section 136 of the 2003 Act

100. Section 38 of the Bill amends section 136 of the 2003 Act to include, in the same way as achieved by sections 36 and 37 of the Bill, provision for references to hospitals in that section to include reference to hospital units and a unit is any part of a hospital which is treated as a separate unit.

Section 39: Transfer from specified unit

New section 218A

101. Section 39 inserts section 218A into the 2003 Act. Patients subject to compulsion and restriction orders (COROs), hospital directions or transfer for treatment directions, can be subject to an order or direction specifying a hospital unit rather than a hospital. New section 218A allows hospital managers to transfer a patient who is subject to an order specifying a hospital unit, to another unit within the same hospital, but only if the Scottish Ministers consent to that transfer. Again, hospital unit is defined as meaning any part of the hospital treated as a separate unit.

Section 40: Consequential repeals

102. Section 9 of the Crime and Punishment (Scotland) Act 1997, and paragraph 66 of schedule 7 to the Criminal Justice and Licensing (Scotland) Act 2010, relating to power to specify hospital units, are repealed by section 40 of the Bill.

Section 41: Information on extension of compulsion order

New section 153A

103. Section 151 of the 2003 Act sets out the steps that a responsible medical officer (RMO) must take when he or she has determined that a compulsion order (CO) is to be extended without change. In such cases, an RMO must prepare a record setting out the reasons for the determination and whether the mental health officer (MHO) agrees, disagrees or has not expressed a view, and, in the case of a disagreement, the reasons for that, the type of mental disorder suffered by the patient and whether that has changed from the disorder in the original CO. This record must be submitted to the Tribunal and a copy sent to the patient (unless the RMO considers there would be significant risk to the patient in doing so), the patient’s named person, the MHO and the Commission. The Tribunal must be informed if the RMO is sending a copy or not to the patient and, if not, the reasons for that decision. When the MHO disagrees
with the determination, or the type of mental disorder differs from that originally recorded in the CO, the RMOs decision to extend the CO must be reviewed by the Tribunal.

104. Section 41 of the Bill inserts new section 153A which sets out new duties for the MHO when the Tribunal is required by section 165(2) of the 2003 Act to review the determination. That situation occurs when (i) the determination states that there is a difference between the type of mental disorder that the patient has and that recorded in the CO; (ii) where the MHO disagrees with the determination, or has failed to comply with the duties imposed by section 151 of the 2003 Act to inform the patient of the determination, their rights in relation to this and the right to independent advocacy, and as far as practicable interview the patient; or (iii) when the Tribunal has not reviewed the CTO during the period of 2 years prior to the date on which the CO would have lapsed had it not been extended by the RMOs determination.

105. When section 165(2) applies, the MHO, must prepare and submit a record to the Tribunal with the patient’s name and address and that of the patient’s named person and primary carer, if known, details of what the MHO has done in compliance with section 151 of the 2003 Act, and so far as relevant to the extension of the CO, the details of the personal circumstances of the patient, any advance statement of the patient (if known by the MHO), the views of the MHO on the extension of the CO and any other information the MHO considers relevant in relation to the extension of the CO. A copy of this record must also be sent to the patient and the patient’s named person, RMO and the Commission. The patient need not receive a copy of the record if the MHO considers so doing would carry a significant risk of harm. The Tribunal must be told if the patient is not receiving the report, and the reasons for this decision.

Section 42: Notification of changes to compulsion orders

Amendment of section 157 and 160

106. This section makes consequential minor changes to section 157 and 160 in respect of compulsion orders.

PART THREE – VICTIMS RIGHTS

Section 43: Right to information: offender imprisoned

107. Section 16 of the Criminal Justice (Scotland) Act 2003 (the Criminal Justice Act) as amended by the Victims and Witnesses (Scotland) Act 2014, provides that victims of any offence can receive information mainly related to the circumstances in which a prisoner leaves prison. This may be information about: the first time a prisoner is entitled to be considered for temporary release, an escape, transfer to a prison outwith Scotland, release on licence or parole, death of the prisoner or the end of the custodial sentence.

108. The Bill amends the Criminal Justice Act to provide for the disclosure of information about mentally disordered offenders to their victims or their relatives, in certain circumstances. A mentally disordered offender is the term used to describe a person charged with an offence who, upon conviction or acquittal has either been given a mental health disposal by a court authorising compulsory measures of treatment and, in some cases detention in hospital, rather than being
sentenced to imprisonment, or a prisoner who has been found to be suffering from a mental disorder whilst in prison and who is thereafter transferred into the mental health system.

Amendment of section 43 of the Criminal Justice (Scotland) Act 2003

Section 43 of the Bill amends section 16 of the Criminal Justice Act to add to the information which a victim can receive under the existing scheme in cases where the offender is in hospital receiving treatment for mental disorder by virtue of a hospital direction or a transfer for treatment direction. In such cases, section 43 of the Bill amends section 16 so that victims can receive notification when the offender is unlawfully at large from a hospital, or has been returned to hospital after being unlawfully at large, and when a certificate has been granted, for the first time, allowing unescorted suspension of detention.

Section 44: Right to information: compulsion order

Section 44 makes further amendment to the Criminal Justice Act 2003 by inserting new sections 16A, 16B and 16C, which make provision regarding victims’ rights to receive certain information relating to offenders who are subject to a compulsion order and a restriction order (CORO).

New section 16A of the Criminal Justice Act 2003

New section 16A provides that where a person over 16 has been made subject to a CORO in proceedings in respect of an offence perpetrated against a natural person, the Scottish Ministers must give the information described in section 16C to the person entitled to receive that information (as determined by section 16B), provided that the person has requested to be given the information. The information may only be withheld if the Scottish Ministers consider that disclosing the information would be inappropriate due to exceptional circumstances in the case.

New section 16B

Section 16B lists those persons who are entitled to ask to be given information under section 16A, namely, the victim of the offence, or if the victim is dead, the spouse, cohabitee, child or parent of the victim, and if the victim died before reaching 16, any other person who cared for the victim before the relevant offence took place.

114. If the victim is under 12, he or she may not ask for information but someone who cares for the victim may ask instead. The section clarifies that a person who asks for information must be not be incapable, and must not be a person accused of, or reasonably suspected of being the perpetrator, or been implicated in the perpetration of the offence.
New section 16C

115. Section 16C lists the information that is to be given under section 16A; that is, whether the compulsion order has been modified or revoked, whether the restriction order has been revoked, the date of death of the offender, any transfer of the offender to a place outwith Scotland, the conditional discharge of the offender, or the recall of the offender to hospital following conditional discharge.

116. If the offender is subject to a compulsion order authorising detention in hospital, additional information may be disclosed including whether the offender is unlawfully at large from hospital, if they have been returned to hospital after having been unlawfully at large, and that detention has been suspended in respect of the offender for the first time, or that such suspension has been revoked.

Section 45: right to make representations

New section 17B

117. Section 45 of the Bill inserts new sections 17B to 17D to the Criminal Justice Act.

118. Section 17B provides for the victims of mentally disordered offenders to be given a right to make representations in certain cases. A person who has the right to be given information about the offender must, in a case where the offender is subject to a hospital direction or a transfer for treatment direction, be given the chance to make representations before a decision about suspending the offender’s detention is made. Where the offender is subject to a compulsion order and restriction order, an opportunity to make representations must be given before a decision is taken about (i) suspending the offender’s detention; (ii) revoking or varying the compulsion order in any way; (iii) conditionally discharging the offender; or (iv) varying any conditions applying to the conditional discharge of the offender which might affect the victim’s family. Any representations must be about how the decision in question might affect the victim or the victim’s family and the right to make representations only applies if the victim has intimated to the Scottish Ministers a wish to make representations.

New section 17C

119. Section 17C provides that if representations concern revoking or varying the compulsion order in any way or varying any conditions which might affect the victim’s family, representation may be made in person or in writing, but otherwise must be made in writing. Section 17C(2) makes provision for the Scottish Ministers to issue guidance as to how representations, whether written or oral, should be made.

New section 17D

120. Section 17D provides that where a decision has been made under section 17B (mentally disordered offender: victim’s right to make representation), if the victim has asked for information about a decision to be given, the Scottish Ministers must do so unless there are exceptional circumstances which make it inappropriate.
Section 46: information sharing.

New section 17E

121. Section 46 of the Bill inserts new section 17E to the Criminal Justice Act, which provides that, where the Scottish Ministers are required by section 16 or 16A to give a victim information about an offender, they must give notice to the offender’s responsible medical officer and, if the offender is subject to a compulsion order, the Tribunal.

122. Notice under subsection (1) is to request that the recipient of the notice must give the Scottish Ministers such information as they may require to fulfil their duties to give information to the victim under sections 16, 16A or 17D. The recipient of this notice must comply with the request given. If the Scottish Ministers cease to be required to give anyone information about the offender they must notify all recipients of the notice, which thereafter ceases to apply to persons in receipt of it.

Section 47: associated definitions

New section 18A

123. Section 47 inserts a new interpretation section to the Criminal Justice Act, Section 18A adds references to the 2003 Act and the Tribunal to the Criminal Justice Act.

Section 48: Power to make modifications

New section 18B

124. Section 48 inserts new section 18B to the Criminal Justice Act. Section 18B gives the Scottish Ministers the power to amend sections 16A and 16B of that Act, by substituting a different age for the ages specified in those sections, section 16C by adding descriptions of information, and section 18A by adding, amending or repealing definitions of terms used in 16C.

125. Section 18B further provides that the power to amend by order includes amending section 16A so that information may be given under that section in some or all cases where a person has been made subject to a compulsion order and either, the person has not been made subject to a restriction order or the restriction order to which the person was made subject has been revoked. Section 18B also provides that section 17B may be amended to specify types of decision in respect of which representations may be made.

126. Finally, section 18B(3) gives the Scottish Ministers power to make any necessary, or expedient amendments in consequence of amendments to 16A or 17B, to sections 16C, 17E and 18A, or to the 2003 Act.

Section 49: Amendments to the 2003 Act

Amendment to section 193

127. Section 49 amends section 193 of the 2003 Act by requiring that where a victim is entitled to make representations before the Tribunal makes a decision, and no opportunity has
been given to the victim to make representations, the Tribunal must have regard to any victim’s representations before making a decision under that section.

128. Section 49 further amends section 200 of the 2003 Act, by requiring the Scottish Ministers to have regard to any victims’ representations before varying any conditions with regard to a conditional discharge of a patient.

129. Section 49(4) of the Bill amends section 224 of the 2003 Act by requiring a responsible medical officer to consider victims’ representations before deciding what conditions should be included in any certificate suspending detention.

130. Section 329 is amended by section 49(5) of the Bill, which adds a definition of victim’s representations at the appropriate place in that interpretation section.

PART FOUR – COMMENCEMENT AND SHORT TITLE

Section 50: Commencement

131. Section 50 provides that the provisions of the Bill (except those which come into force at the beginning of the day following the day on which the Bill receives Royal Assent) will come into force on a date or dates determined by order, made by the Scottish Ministers. Such an order may include transitional, transitory or savings provisions as the Scottish Ministers consider necessary or expedient.

Section 51: Short Title

132. Section 51 gives the short title of the Bill.
These documents relate to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

FINANCIAL MEMORANDUM

INTRODUCTION

1. This Financial Memorandum relates to the Mental Health (Scotland) Bill (“the Bill”). It has been prepared by the Scottish Government to satisfy Rule 9.3.2 of the Scottish Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Scottish Parliament. The Memorandum summarises the cost implications of the Bill. It should be read in conjunction with the Bill and the other accompanying documents.

2. The Scottish Government has an overarching ambition to help the people of Scotland live longer healthier lives. The Bill seeks to improve the operation of the Mental Health (Care and Treatment) Act 2003 (“the 2003 Act”) and some related provisions in the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”). Additionally the Bill makes provision – through amendments to the Criminal Justice (Scotland) Act 2003 – as to the rights of victims of crime in the context of mental health disposals.

BACKGROUND

3. The 2003 Act was commenced in October 2005. It became apparent from the on-going monitoring to which the 2003 Act was subject that there were some aspects of the legislation which were not operating as efficiently and effectively as had been intended. The McManus Review Group was set up in 2008 to undertake a limited review of the civil provisions of the 2003 Act. The Review Group reported in Spring 2009\(^1\) and the Scottish Government published its response to the review Group’s recommendations in October 2010\(^2\) (following a further consultation exercise). [http://www.scotland.gov.uk/Publications/2013/12/1962/10](http://www.scotland.gov.uk/Publications/2013/12/1962/10). The output from these consultation exercises helped inform the consultation exercise on the draft Mental Health (Scotland) Bill\(^3\); with the key amendments to the 2003 Act relating to advance statements, named persons, multiple Tribunal hearings and suspension of detention.

4. In addition to these matters, service users and petitioners have brought to the Scottish Government’s attention a number of more minor and technical matters relating to how the mental health legislation is working in practice. The Bill therefore makes a number of amendments to both the 1995 Act and the 2003 Act to resolve these issues and as such amends the existing mental health care and treatment regime. Following a public consultation\(^4\), in 2010 the Scottish Government committed to introducing a notification scheme for victims of mentally disordered offenders. As the implementation of such a scheme requires primary legislation this Bill is an appropriate vehicle to use.

OVERVIEW OF THE BILL

5. The provisions in the Bill are set out in four parts. The following provides a brief overview of these Parts—

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\(^3\) Link to draft bill consultation [http://www.scotland.gov.uk/Publications/2013/12/1962/0](http://www.scotland.gov.uk/Publications/2013/12/1962/0)

\(^4\) Link to VNS consultation [http://www.scotland.gov.uk/Publications/2010/08/27104119/0](http://www.scotland.gov.uk/Publications/2010/08/27104119/0)
These documents relate to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

- **Part 1** makes provision for amendments to the 2003 Act relating to advance statements, appeals against excessive security, multiple tribunal hearings, named persons, suspension of detention and minor technical and drafting matters.

- **Part 2** covers mental health disposals in criminal cases. A number of mainly technical amendments are made to the 1995 Act, for example provision adjusting the manner in which the period of detention and treatment under certain orders is calculated.

- **Part 3** relates to victims’ rights and introduces a number of changes to the Criminal Justice (Scotland) Act 2003 to create a victim notification and representative scheme for victims of mentally disordered defenders.

- **Part 4** sets out general provisions on coming into force and modification of enactments.

6. The following sections of the Memorandum consider the cost implications of Parts 1 to 3. Part 4 does not have specific cost implications and so is not discussed here.

**PART 1: MENTAL HEALTH (SCOTLAND) ACT 2003**

**Costs on the Scottish Administration**

7. Part 1 of the Bill sets out a number of changes to the 2003 Act. With the exception of changes to provisions relating to named persons, advance statements and time periods for suspension of detention, the changes are technical and minor in nature. There are no significant anticipated costs to the Scottish Government associated with the changes in this part of the Bill. Costs related to bodies within the Scottish Administration are detailed at paragraphs 10 to 30. There will require to be changes made to the Code of Practice and the implications of this are detailed below.

**Scottish Government**

8. The Scottish Ministers have a statutory duty to prepare, publish and revise a Code of Practice under the 2003 Act. The current Code of Practice is in three volumes. The Code, 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 Act, are under a duty to have regard to the Code.

9. The amendments arising from Part 1 of the Bill will impact on Volumes 1 and 2 of the Code of Practice. Volume 1 deals with a range of issues relating to the general framework within which the 2003 Act operates. These subjects include, for example, the duties placed on health boards and local authorities; cross-border transfers of patients; and medical treatment. The revision of the Code of Practice will be a matter for the Scottish Government as part of the normal business of the Directorate for Health and Social Care Integration and costs are anticipated to be minimal and will be absorbed within the day to day running costs of the directorate.

Mental Welfare Commission

10. The Mental Welfare Commission (“the Commission”) was originally set up under the Mental Health Act 1960. The Commission’s duties are set out in the 2003 Act and the Adults with Incapacity (Scotland) Act 2000. The Commission aims to ensure that all care, treatment and support for persons treated under the 2003 Act is lawful and respects the rights and promotes the welfare of individuals with mental illness, learning disability and related conditions. The Commission is accountable to the Scottish Ministers for their statutory duties and how, given it is funded by the Scottish Government, it spends public money. The Commission carries out its work and produces reports independently from the Scottish Government.

11. The Commission is notified of all episodes of detention and safeguarded treatments carried out under the 2003 Act. The Scottish Government recommend the use of forms for carrying out these notifications under the 2003 Act. These forms ensure that services record the legal information required when detaining individuals under the 2003 Act or using other parts of the legislation. They also prompt services to make the appropriate notifications required under the legislation, for example to the Mental Health Tribunal for Scotland etc. Only the forms authorising safeguarded treatment under Part 16 of the 2003 Act are statutory but all of the forms are routinely used by services throughout Scotland. Changes to the form are necessitated by the changes made in Part 1 of the Act and it is these changes that will precipitate costs to the Commission.

12. There are 52 forms and they can be viewed at MWC forms. The Commission receives over 30,000 forms a year for both mental health and adult with incapacity legislation. These notifications are received from medical records departments and mental health officers. Forms are received by the Commission both electronically and in paper format. From this database the Commission produces comprehensive information on an annual basis on how the 2003 Act is being used across Scotland, comparing use and trends across health board and local authority areas.

13. Proposals to change provisions within Part 1 of the 2003 Act will require changes to those forms associated with said provisions. The changes contained in the Bill were in the draft bill consulted on between December 2013 and March 2014. The Commission has based estimated costs on the provisions in the draft bill. It is considered around half of the forms will require some changes and there may be a requirement for one or two new forms. This will not be known until the Bill completes the parliamentary process. The Commission also predict some changes to forms as the result of a limited consultation process. For example, when the forms were designed the Mental Health Tribunal Service had yet to come into operation. Some minor adjustments were made in 2007 to make the forms more efficient and effective. The Commission anticipates that there will be administrative changes to the forms to make the overall process more efficient and effective.

14. In addition to changes to the forms there will also be some programming changes required. The costs for the upgrade are detailed at Table 1 below. These estimated costs are based on the Commission’s analysis of the changes contained in the Bill, and the costs associated

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These documents relate to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

with amending the forms which will be required to accommodate the changes brought forward by part 1 of the Bill.

Table 1: Amendment to Mental Health Act: IMP Upgrade costs

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Capital</th>
<th>Revenue</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>£11,000</td>
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<td>Start Nov 2014 (0.6 WTE) Consultation with stakeholders e.g. medical records. Development of forms</td>
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<tr>
<td>Business Analyst</td>
<td>£7,000</td>
<td></td>
<td>2 days per week. Designing new forms. Finalising specification for quote for upgrade</td>
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2015-16

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<tr>
<th>CSE Servalec Quote (V1)</th>
<th>£70,000</th>
<th>Create new V7 form. Includes changes to Compulsory treatment orders forms pack, suspension of detention forms and other changes currently identified in Mental health draft bill consultation</th>
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</thead>
<tbody>
<tr>
<td>Systems testing and user acceptance</td>
<td>£10,000</td>
<td>MWC staff testing including travel</td>
</tr>
<tr>
<td>Cardiff consultancy</td>
<td>£10,000</td>
<td>Ensure forms and Imp are compatible.</td>
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<tr>
<td>Training</td>
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<td>Medical records and staff. Development of training materials and regional delivery</td>
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<tr>
<td>Contingency</td>
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<td>See paragraph 13</td>
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2016/17 – 2020/2021

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<th>Depreciation</th>
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<th>Amortise equally over 5 years (£36,000 per annum).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£182,000</td>
<td>£180,000</td>
</tr>
</tbody>
</table>
15. In terms of margins of uncertainty, there are some uncertainties within this project which is reflected in the £15,000 contingency budget line. The legislative process may result in changes to the legislation that are currently not predicted. These changes may have an impact on the mental health forms or result in additional necessary programming. But the Commission will be kept fully informed as the Bill progresses through Parliament so costs can be adjusted accordingly. The consultation on the forms may lead to a demand for bigger revisions than anticipated to make the overall system more effective. There is therefore a small margin of uncertainty as to the costs outlined here. The process will be managed tightly by the Scottish Government working jointly with the Commission and the Mental Health Tribunal for Scotland (“The Tribunal”) to ensure the costs are kept as close to these projected figures as possible.

16. Section 21 (Registering of advance statements) of the Bill places a new duty on the Commission to set up a register of advance statements. The Commission has advised that they do not envisage this resulting in any additional costs. The advance statement will not be on a form used under the 2003 Act and there is therefore no requirement to design this form.

**Mental Health Tribunal**

17. The Tribunal was established by the 2003 Act. The primary role of the Tribunal is to consider and determine applications for compulsory treatment orders under the 2003 Act and to operate in an appellate role to consider appeals against compulsory measures under the 2003 Act. The Tribunal also plays a monitoring role by periodic review of compulsory measures. The Commission is entitled to refer certain cases to the Tribunal for consideration and in certain circumstances the Scottish Ministers must refer cases to the Tribunal. A number of provisions within Part 1 of the Bill have cost implications for the Tribunal although these may be offset by some small scale efficiency savings.

**Costs associated with suspension of detention**

18. Sections 6 to 9 of the Bill amend the current provisions within the 2003 Act regarding the suspension of detention of persons detained in hospital by virtue of an order under the 2003 Act. A patient’s Responsible Medical Officer (with, where necessary, the consent of the Scottish Ministers) can grant a certificate suspending an order. During the period of suspension the order will not authorise detention in hospital. The main use of suspension of detention is providing time away from hospital as part of rehabilitation and recovery programmes.

19. The key change proposed in the Bill to the current suspension of detention provisions is that a patient’s Responsible Medical Officer is only permitted to suspend detention for a total period of 200 days in any twelve month period. Only periods of suspension of detention involving an overnight element count towards the 200 day threshold. If the Responsible Medical Officer wishes to suspend detention beyond this 200 day threshold then prior to so doing they must submit an application to the Tribunal.

20. The Tribunal will hold a hearing to consider whether the grounds for compulsion continue to be met and if in the Tribunal’s view, grounds for compulsion do continue to be met the threshold limit for the number of days where detention is suspended is rest to 100 days. This is in essence a new alternative disposal for the Tribunal. Currently every patient should have a hearing to consider whether an order should be varied to a community-based treatment order. This hearing should take place towards the end of the time limit on suspension of detention at
present. The change proposed in the Bill places this hearing on a stronger statutory footing but it is not anticipated that this will cause any increase in the numbers of hearings triggered. Therefore no additional costs are anticipated.

21. However where the Tribunal extends the time limit for suspension of detention, additional hearings will arise as there will now require to be a further hearing towards the end of the extension period to consider whether the compulsory treatment order should now be varied to being community based.

22. At this point in time it is impossible to quantify how many extra hearings will arise as a result of this change. An additional hearing will only happen when a responsible medical officer seeks to have a Tribunal extend the time limit for suspension of detention. Such decisions are made on a case by case basis, and will depend entirely on the circumstances of each individual who is subject to measures under the 2003 Act. That being said, having considered the proposed changes with the Scottish Tribunals service, and taking into account current practice of responsible medical officers, it is anticipated that the requests for extensions of the time period for suspension of detention will be very low. This is based on the fact that at present, a maximum of 9 months suspension of detention within a 12 month period is available for patients and it is only in a very small number of cases that an extension to this period would have been beneficial to the patient. Given this anticipated outcome, any additional costs to the Tribunal are expected to be minimal and will be absorbed within existing budgets.

Costs associated with conditions of excessive security appeals

23. Sections 10 to 12 of the Bill amend the existing regulatory framework to enable individuals held in medium secure facilities throughout Scotland to lodge an appeal with the Tribunal against being held in what they perceive to be conditions of excessive security. Individuals will be able to lodge one such appeal in any twelve month period.

24. As no appeal has previously be made under section 268 (detention in conditions of excessive security) of the 2003 Act there is no existing data to help formulate potential costings. To help devise indicative costings the Scottish Government has looked at the number of hearings held in 2013 by the Tribunal in relation to section 264 (detention in conditions of excessive security: state hospital) cases. Out of an average of 132 patients within the State Hospital there were 51 hearings in respect of excessive security, approximately 44%. There are currently circa 150 individuals within the medium secure estate in Scotland.

25. Whilst it could be argued that an individual in the State Hospital is more likely to appeal against their level of security than an individual held at a lower level of security, for the purposes of estimating the potential cost here, the Scottish Government has assumed that 44% of the current 150 patients in the medium secure estate will wish to appeal - which would amount to 66 appeals. The costs associated with this amount are estimated at around £80,000, based on a calculation of the approximate cost of a hearing multiplied by the approximate number of appeal hearings. These costs are subject to a significant margin of uncertainty given that we cannot, with any certainty, predict the number of appeal cases that may be brought under this new provision and the figures are based on an estimation of costs, arising from appeal provisions that have significant differences from those contained within the Bill.
26. We anticipate these costs will be incurred in the initial 12 months following the commencement of the provisions relating to appeals against excessive security. Subject to Parliamentary timetabling, and the duration of the Bill’s progress through Parliament, together with the need to consult on regulations, and the time required for Parliamentary scrutiny of such regulations, it is expected these costs will run from around November 2015 onwards. We expect, however, that in the following years, the costs arising from excessive security appeals will potentially be lower, year on year, as with any new appeal process, the first year always gives a disproportionately high figure given there will undoubtedly be a number of patients who have been waiting some time for such an appeal to be available whose hearings will be included in the initial year’s costs but not subsequently.

Savings to the Tribunal

27. A short term detention certificate, which lasts for 28 days, can be extended where an application for a compulsory treatment order is made to the Tribunal. In these circumstances, the patient’s detention in hospital continues to be authorised for a further five working days from the time when the short term detention certificate would otherwise have expired. This is to allow the hearing to take place. Section 1 of the Bill proposes extending this five working day period to ten working days to allow the patient, in particular, more time to prepare for a hearing. Although it is not possible to estimate specific savings at this point in time it is possible that some small efficiencies savings may accrue as a result of fewer hearings having to be held to determine an application which in turn will assist with the scheduling of tribunal hearings.

28. Similarly, some small efficiency savings in relation to increased flexibility with regard to the scheduling of certain cases may accrue as a result of provision made at the section 26 of the Bill. Section 26 removes the obligation for the Convenor of a Tribunal Panel to be either the Tribunal President or to be selected from the Shrieval Panel in certain cases. These are cases where a prisoner becomes unwell during their prison sentence and has to be transferred to hospital and at the expiry of their sentence are still in hospital and may need to remain subject to compulsory measures of treatment and care under the mental health legislation.

Scottish Legal Aid Board

29. Legal aid in the form of Assistance by Way of Representation (ABWOR) would be available to individuals who wish to lodge an appeal against being held in conditions of excessive security. As evidenced by the Scottish Legal Aid Board’s Annual Report 2012-2013 (Table 3.18(b) Accounts paid and average case costs – civil ABWOR) the average case cost for a Tribunal hearing was £1,041 in 2012-2013. As discussed above, it need not necessarily be the case that each of the 66 appeals would be dealt with at a separate hearing. It may be that the individual concerned lodged an appeal at a time when they were due to attend a Tribunal hearing on a separate matter and both issues are dealt with at one hearing. In cases such as this only a portion of the civil ABWOR cost for the case would be directly attributable to the section 268 appeal element of the Tribunal hearing.

30. However for the purposes of deriving some form of estimate of potential costs here, the Scottish Government, estimates that there could be an additional cost to the Scottish Legal Aid Budget in 2015/16 in the region of £70,000 (66 x £1,041 (rounded up). These figures are based on the estimated cost to the legal aid budget of £1,041 multiplied by the estimated number of appeal hearings based on the number of appeals brought under ,the existing appeal provision for
persons within the State Hospital who have appealed against being held in conditions of excessive security. Again, for the reasons highlighted at paragraph 23 above, there is a significant margin of error with these figures, given the difficulty in predicting with any certainty the number of appeals likely to be brought forward. Costs for subsequent years are difficult to predict as whilst it will be open to an individual to submit a section 268 appeal once in a twelve month period it is not possible to predict with any certainty at this juncture how many appeals are likely to be made.

**Costs on local authorities**

31. The Scottish Government has responded to consultation feedback and a number of mental health officers’ (MHO) duties and responsibilities as specified in Consultation on proposals for a draft Mental Health (Scotland) Bill have either been removed (e.g. changes to the current procedure for submitting compulsory treatment order applications) or significantly reduced (e.g. submission of MHO reports in relation to section 86).

32. Section 2 of the Bill introduces a new section 87A of the 2003 Act, which places a new requirement on mental health officers and may cause a slight increase in costs for local authorities. The section requires mental health officers to prepare a report for a hearing where a responsible medical officer requires a hearing to review a patient’s compulsion order and the mental health officer disagrees with the responsible medical officer’s assessment of the patient. This is a new duty and the preparation of such reports for hearings will incur additional administrative and staffing costs for local authorities. However, the approximate number of cases where this will apply is less than 20 for the whole of Scotland, based on recent figures for hearings provided by the Commission.

33. Based on figures verified by the Association of Directors of Social Work, it is estimated that the preparation of a report by a mental health office will cost in the region of £475. This results in an additional cost of £9,000 for the estimated 20 hearings where this will apply. This cost will be spread across all local authority areas in Scotland.

34. The Scottish Government therefore considers that the proposed legislative changes will result only in minimal costs for local authorities.

**Costs on other bodies, individuals and business**

**National Health Service**

35. There are a number of provisions within the Bill which may result in additional costs being incurred by the NHS and these are outlined below.

36. As discussed at paragraph 19, section 9 (Maximum suspension of detention provisions) of the Bill provides that if a responsible medical officer wishes to suspend detention for a patient beyond the 200 day threshold, then prior to doing so they must submit an application to the Tribunal. The Tribunal will hold a hearing to consider whether the grounds for compulsion continue to be met. Notwithstanding this, the responsible medical officer already has a duty under the 2003 Act to regularly review the appropriateness of any order their patient is subject
to. It is therefore not anticipated that these provisions will result in any substantive increase on costs to the NHS.

37. Sections 22 and 23 of the Bill propose a slight widening of the existing provisions relating to the provision of assistance with communication at medical examinations, and services and accommodation for mothers with mental health disorders.

38. At present, assistance is given to patients with communication difficulties when they are the subject of existing orders. The Bill proposes to extend this to patients with communication difficulties who are subject to an application for these orders. This obligation will rest with the Scottish Ministers, NHS or local authorities and reflects the requirements of the Equality Act 2010 which public authorities are already subject to. It is considered therefore that any costs associated with this provision will be minimal and absorbed within current budgets.

39. Section 23 extends the duty Health Boards currently have, to provide services and accommodation for certain mothers with post natal depression, to mothers with post natal depression and any other mental disorder. This will require additional provision of accommodation and services across the NHS estate. However given the number of variables involved, it is difficult to provide costings with any certainty for this proposal. In patient services for mothers with post natal depression to be accompanied by their child are currently organised on a regional basis, with specialists units in the West and East and a couple of beds in the North, served by specialist perinatal nurses and dedicated consultant time but no specialist unit. Costs to extend these provisions to women with other mental disorders are entirely dependent on estimate of need and level of services required together with the timetable to deliver. It is proposed that these changes will require to be met within a 2 year timetable, during which period of time the level of service required will be clarified and costings determined accordingly.

40. As discussed above the proposed legislative changes to section 268 (detention in conditions of excessive security: hospitals other than state hospitals) of the 2003 Act will provide a right of appeal against being held in conditions of excessive security, for persons within a medium secure setting. There will be some additional work for medical staff in terms of preparing for and attending these hearings but it is not anticipated that these costs will be significant as the information required for these hearings is already required for hearings under the present regime.

41. However, as these changes build on existing provision within the NHS, overall the Scottish Government considers that the proposed legislative changes will result in only minimal costs to the NHS.

Savings

42. Section 8 of the Bill amends the 2003 Act to remove the need for responsible medical officers to seek the prior approval of the Scottish Ministers before granting a certificate suspending detention in the case of assessment orders, treatment orders, interim compulsion orders and temporary compulsion orders to enable a patient to attend a court hearing or necessary medical (including dental) appointment. This amendment will give rise to some small efficiency

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7 Equality Act 2010, c15
savings as responsible medical officers will no longer having to liaise with Health and Social Care Integration Directorate staff to obtain the prior approval of the Scottish Ministers. There are too many variables to enable the Scottish Government to devise a meaningful estimate of what these potential savings might be.

**Individuals**

43. The Scottish Government considers that the provisions in Part 1 of the Bill have no direct financial implications on individuals or businesses.

**PART 2: CRIMINAL CASES**

44. The 1995 Act was amended by Parts 8, 9 and 10 of the 2003 Act with regard to the treatment of mentally disordered offenders. Part 2 of the Bill makes a number of minor amendments to the 1995 Act, mainly concerned with timescales and procedure.

**Costs on the Scottish Administration**

**Codes of Practice**

45. The amendments arising from Part 2 of the Bill will impact on Volume 3 of the Code of Practice. This Volume of the Code of Practice for the 2003 Act covers a range of issues relating to mentally disordered offenders including procedures for the disposal of cases of persons with mental disorder who are involved in criminal proceedings which are set out in Part VI and sections 200 and 230 of the 1995 Act. Provisions in the 2003 Act have replaced or made amendments to some of these procedures.

46. The revision of the Code of Practice will be a matter for the Scottish Government as part of the normal business of the Directorate for Health and Social Care Integration. Costs will be minimal and absorbed accordingly.

**Costs on local authorities**

47. Section 41 of the Bill proposes a new section 153A of the 2003 Act, which places a new requirement on mental health officers. This may cause a slight increase in costs for local authorities. The section requires mental health officers to prepare a report for a hearing where a responsible medical officer is requiring a hearing to review a patient’s compulsion order and the mental health officer disagrees with the responsible medical officer’s assessment of the patient. This is a new duty and the preparation of such reports for hearings will incur additional administrative and staffing costs for local authorities. However, the approximate number of cases where this will apply is less than 20 for the whole of Scotland, based on recent figures for hearings from the Commission. From figures verified by the Association of Directors of Social Work, it is estimated that the preparation of a report by a mental health office will cost in the region of £475. This results in an additional cost of £9,000 for the estimated 20 hearings where this will apply. This cost will be spread across all local authority areas in Scotland.

48. The Scottish Government therefore considers that costs to local authorities from these provisions will be minimal.
Costs on other bodies, individuals and business

49. The Scottish Government considers that the provisions in Part 2 of the Bill have no direct financial implications on other bodies, individuals or businesses.

PART 3: VICTIMS’ RIGHTS

Costs on the Scottish Administration

50. The preparation of the guidance in relation to the Victim Notification Scheme for mentally disordered offenders will be a matter for the Scottish Government as part of the normal business of the Directorate for Health and Social Care Integration.

The Tribunal

51. The provisions in Part 3 of the Bill could have minimal financial implications for the Tribunal. At present victims who wish to make representations to the Tribunal are heard on a different day and in a different location from the hearing to which the representation relates. The current number of victim representations is not statistically significant, but this may well increase once the new victim notification scheme is delivered and publicised in the financial year 2016/17. We are mindful of the potential for a small increase in costs with regard to this and it will be included in budget determinations for the financial year 2016/17.

Costs on local authorities

52. The provisions in Part 3 of the Bill have no direct financial implications on local authorities.

Costs on other bodies, individuals and business

53. The Scottish Governments considers that the provisions in Part 3 of the Bill have no direct financial implications on individuals or businesses.
SCOTTISH GOVERNMENT STATEMENT ON LEGISLATIVE COMPETENCE

On 19 June 2014, the Cabinet Secretary for Health and Wellbeing (Alex Neil MSP) made the following statement:

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

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

On 19 June 2014, the Presiding Officer (Rt Hon Tricia Marwick MSP) made the following statement:

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

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Mental Health (Scotland) Bill introduced in the Scottish Parliament on 19 June 2014. It has been prepared by the Scottish Government to satisfy Rule 9.3.3 of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 53–EN.

BACKGROUND

2. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the "2003 Act") came into force in October 2005. The 2003 Act, introduced a different mechanism for deciding on compulsory treatment, making use of a tribunal system rather than the sheriff court; it also allowed compulsory treatment in the community, which had not previously been allowed. A new legal entity, called a named person, was created, to attempt to overcome problems experienced with next of kin having automatic rights when a person became mentally ill. The possibility of making advance statements, detailing treatment wanted or not wanted in the event of a person becoming mentally ill, was created. These were among the most radical of the changes introduced.

3. In the two years following commencement of the 2003 Act, there were many bodies monitoring the situation, from user and carer groups, service providers, the Tribunal Service and the Mental Welfare Commission ("the Commission"). Each had kept the Scottish Government informed of areas which did not appear to be functioning as well as had been anticipated. Although there was no strong feeling that there was anything fundamentally wrong with the 2003 Act, the Scottish Government decided that a "light touch" review should be undertaken.


5. As the Scottish Government response to the McManus Review noted some recommendations would require primary legislation to amend the 2003 Act before they could be implemented. These recommendations related to advance statements, named persons,
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

medical examinations, suspension of detention and multiple hearings at Mental Health Tribunal (“the Tribunal”).

6. The Bill also contains provision allowing victims of crime committed by mentally disordered offenders to receive certain information and to make representations about the release of the offender. Improving the provision of information, including case specific information, for victims has long been a policy objective of the Scottish Government. Evidence suggests that victims of crime require information for a number of reasons: a perception that it is a victim's right to receive case progress information; it helps to control anger and the desire for retribution; and to reduce fears of repeat victimisation. These information needs may be more pronounced for victims of serious violent and sexual crimes. Provision of information therefore meets a legitimate need, and can help to alleviate, at least to some degree, the sometimes severe effect that a crime can have on an individual.

7. The Criminal Justice (Scotland) Act 2003 (“CJ Act 2003”) gives all victims or an eligible family member the right to receive information about the release from prison of the offender, who committed the crime against them, and to receive information from and to make representations to the Parole Board for Scotland. The scheme is formally referred to as the "Victim Notification Scheme" (VNS) for Scotland. Although victims of an offender sentenced to imprisonment have a right to receive information about an offender, victims of a mentally disordered offender have no similar rights.

8. In 2010 the Scottish Government publicly consulted³ on whether a scheme similar to that in place for other offenders in the criminal justice system should be introduced for victims of mentally disordered offenders. The Scottish Government’s analysis of responses report⁴ published in March 2011 (following a public consultation discussed below) stated the Scottish Government’s intention to implement a statutory scheme but noted that primary legislation would be required to progress this matter.

CONSULTATION

9. The provisions in the Bill have been extensively consulted on.

10. The recommendations of the McManus Review, which form the bulk of the Bill, were consulted on between August and November 2009. The recommendations from this consultation exercise helped inform the Scottish Government’s formal response to the McManus review which was published in October 2010. This is referred to throughout this Memorandum as the McManus consultation.

11. The Scottish Government consulted on whether there should be a victim notification scheme for the victims of mentally disordered offenders between August and November 2010. This is referred to as the VNS consultation throughout this Memorandum.

³ SG consultation http://www.scotland.gov.uk/Publications/2010/08/27104119/0
⁴ SG analysis report http://www.scotland.gov.uk/Publications/2011/03/21112101/0
12. The provisions relating to appeals against excessive security were the subject of a public consultation between June and September 2013\(^5\). This consultation is referred to as the excessive security consultation throughout this Memorandum.

13. The whole of the Bill was published in draft on 23 December 2013, as part of a public consultation which ran until 25 March 2013\(^6\). This consultation generated over 100 responses. This is referred to throughout this Memorandum as the draft bill consultation. Therefore all changes proposed in the Bill have been based on best available evidence and subject to thorough consultation with stakeholders.

**POLICY OBJECTIVES OF THE BILL**

14. The overarching approach of the 2003 Act is to ensure that the law and practice relating to mental health should be driven by a set of principles, particularly minimum interference in peoples’ liberty and the maximum involvement of service users in any treatment. The Bill, which amends the 2003 Act, seeks to reinforce this approach by making a number of changes to practice and procedures to ensure that people with a mental disorder can access effective treatment timeously by providing improvements to the legislative framework.

15. The policy objectives of the Bill are as outlined below—

- **Part 1:** to improve the efficiency and effectiveness of the mental health system in Scotland by implementing the changes the Scottish Government said it would bring forward following on from the McManus Review; to provide a better system for the review of conditions of security to which patients are subject by adjusting the provisions which allow the Tribunal to consider, on application, whether a patient is being detained in conditions of excessive security, and make a number of technical and drafting amendments to improve the legislative framework.

- **Part 2:** to make a number of minor technical amendments to Part VI (Mental Disorder) of the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”) to assist in providing greater clarity of meaning as well as improving operational efficiency.

- **Part 3:** to implement a victim notification and representation scheme for victims of mentally disordered offenders subject to a hospital direction, transfer for treatment direction or a compulsion and restriction order. This will place victims of mentally disordered offenders subject to these orders on the same footing as victims who are currently eligible to be part of the Criminal Justice Victim Notification Scheme. The proposed scheme is also intended to implement the recent EU Directive\(^7\) establishing minimum standards on the rights, support and protection of victims of crime.

16. A glossary of frequently used terms is attached at Annex A to this document.

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\(^5\) Excessive Security Consultation: http://www.scotland.gov.uk/Publications/2013/08/7455/0

\(^6\) Mental Health (Scotland) Bill Consultation: http://www.scotland.gov.uk/Publications/2013/12/1962

PART 1 – THE 2003 ACT

Procedure for compulsory treatment

Policy objectives

17. The policy intention behind the changes discussed below is to ensure patients have sufficient time to prepare for hearings, even those requiring to be held at short notice, and that the Tribunal has all the information needed, including reports from Mental Health officers where they currently do not receive such reports.

Measures until application determined

Current position

18. Currently where an application for a compulsory treatment order is made in relation to a patient who is liable to detention under a short term detention certificate, the period of detention is automatically extended for a period of five working days beyond the date on which authority to detain under the certificate is due to expire. The Tribunal must determine the application for the compulsory treatment order or grant an interim compulsory treatment order under section 65 of the 2003 Act within this five day period.

19. Applications for compulsory treatment orders are regularly received by the Tribunal immediately prior to the expiry period of the short term detention certificate. This results in the Tribunal facing a significant logistical and administrative burden to ensure that the necessary arrangements are put in place to enable a hearing to be held and all relevant parties are notified in effect within five working days. This short timeframe adversely impacts on the patient who has limited opportunity to instruct legal representation if they so wish or to instruct an independent medical report prior to the first hearing of the compulsory treatment order application.

Proposed change

20. The Scottish Government considers increasing the five working day period to ten working days will have a number of benefits, amongst which are: enabling Convenors of the Tribunal to make use of existing powers to review and proactively manage cases in advance of setting a date to ensure, as far as possible, only one full hearing needs to be held; providing service users, carers and named persons with significantly more opportunity to prepare for the hearing. The Bill provides for the increase from five to ten working days. In order to preserve the principle of least restriction, provision is also made within the Bill to ensure that the proposed extension to the period of detention will not increase the continuous period of detention of fifty six days provided for by section 65(3) of the 2003 Act nor the six month period provided for in section 64.

Information where order extended

Current position

21. Currently, where an individual’s responsible medical officer is proposing to extend a compulsory treatment order, the responsible medical officer is required to seek the views of certain persons, including the individual’s mental health officer, before making a
determination. Section 101(2) of the 2003 Act provides that when (i) the type of mental disorder recorded in the determination by the responsible medical officer to extend the compulsory treatment order is different to that which was recorded in the original compulsory treatment order or (ii) when the mental health officer disagrees with the extension of the compulsory treatment order or (iii) where the Tribunal has not reviewed the compulsory treatment order during the two year period prior to which the compulsory treatment order would have lapsed had it not been extended by the responsible medical officer, then the Tribunal must review that determination.

Proposed change

22. The Scottish Government considers that in certain specific cases – namely where the Tribunal is required to review a determination by virtue of section 101(2) of the 2003 Act - then the mental health officer should submit a written report to the Tribunal containing the information set out at new section 87A(4) to aid the Tribunal’s consideration of this matter. Section 2 of the Bill makes provision for this.

Consultation

23. These proposals in sections 1 and 2 of the Bill were welcomed by respondents to the draft Bill consultation.

Alternative approaches

24. No alternative approaches were considered.

Emergency, short term and temporary steps

Policy objective

25. The broad policy objective behind the provisions discussed below is to ensure a patient is subject as far as is possible to the appropriate order for his or her condition and that any changes required to the order can be made as quickly and fairly as possible.

Emergency detention in hospital

Current position

26. Section 36 of the 2003 Act provides for the granting of an emergency detention certificate by a medical practitioner in respect of a patient. An emergency detention certificate authorises the removal of a patient to a hospital (if not already in hospital) or to a different hospital and the detention of the patient for a period of 72 hours. Any medical practitioner can grant the emergency detention certificate. Section 36(1) provides the conditions which must be met for the medical practitioner to grant the emergency detention certificate.

27. One of these conditions is that the patient does not fall within section 36(2). Section 36(2) provides that the patient falls within that subsection if, immediately before the medical examination the patient is subject to specified measures which authorise the detention of the patient. So, if a patient is subject to any of these measures (for example a short term detention
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

certificate) immediately before the examination then an emergency detention certificate cannot be granted in respect of that patient.

28. Section 113 of the 2003 Act applies to patients who are subject to a compulsory treatment order. These orders authorise certain measures to be taken in respect of the patient. Section 113 applies where the patient fails to comply with any of these measures and the order does not authorise detention of the patient in a hospital, i.e. it is a community based order.

29. Section 113(4) empowers the patient’s responsible medical officer to take or make arrangements to take the patient into custody and convey the patient to a hospital. Section 113(5) provides that where that power is exercised the patient may be detained in hospital for a period of 72 hours. Section 113(4) and (5) are not specified in section 36(2). This means that a patient who is subject to detention in hospital under section 113(5) by virtue of the power in section 113(4) having been exercised will not be excluded from the operation of the power in section 36(1) to grant an emergency detention certificate.

30. The provisions in Part 5 of the 2003 Act are intended to apply to emergency situations. The granting of an emergency detention certificate is appropriate where a patient urgently needs to be detained in hospital and there is insufficient time to make arrangements for the usual procedures leading to short term detention (Part 6 of the 2003 Act) or long term detention (Part 7 of the 2003 Act). The provision in section 36(2) is consistent with the policy behind these provisions and is intended to prevent inappropriate use of the emergency detention provisions.

Proposed change

31. A patient subject to detention under section 113(5) is already within a detention regime and the Scottish Government considers it is that regime which should govern any subsequent detention which follows immediately on that detention – not the emergency provisions set out in Part 5 of the 2003 Act. The Scottish Government therefore considers it appropriate to extend the list of specified measures in section 36(2) to include a reference to section 113(5). The Bill makes provision for this at section 3.

Notification of emergency detention

Current position

32. Section 38 of the 2003 Act (duties on hospital managers: examination, notification etc.) applies where a patient is detained in hospital under the authority of an emergency detention certificate granted under section 36(1). The managers of the hospital in which the person is detained must arrange for the person to be medically examined by an approved medical practitioner, who will be a psychiatrist, to determine whether the detention criteria continue to be met. If not, the approved medical practitioner must revoke the emergency detention certificate. If the detention criteria are met then it is likely to be appropriate to grant a short term detention certificate under section 44(1).

33. The managers of the hospital must within 12 hours of the emergency detention certificate being given to them, inform the persons specified in section 38(4) of the 2003 Act
of the granting of a certificate (section 38(3)(a)). The hospital managers are also required, within 7 days of receiving notice from the medical practitioner of the additional information under section 37, to notify the persons listed in section 38(4) of that information (section 38(3)(b)(i)).

**Proposed change**

34. The Commission is currently one of the persons specified in Section 38(4) of the 2003 Act. The Commission has advised that because emergency detention certificates can be granted at any time, frequently the notification under section 38(3)(a) amounts to a message being left on an answering machine and serves little purpose. The Scottish Government concurs with the Commission’s view on this matter. In the interests of streamlining procedures and as the hospital managers will still require to notify the Commission in terms of section 38(3)(b)(i), the Bill at section 3(4) removes the need for the Commission to be notified additionally in respect of the same circumstances, under section 38(3)(a).

35. As some of the additional information provided by the medical practitioner under section 37 of the 2003 Act to the hospital managers may be of an unduly sensitive nature, the Bill provides that hospital managers can exercise discretion as to whether or not to give notice of certain matters to the persons listed in section 38(4) at section 3(3) of the Bill.

**Short term detention**

**Current position**

36. Section 44 of the 2003 Act is in similar terms to section 36 (discussed above). Section 44 provides for the granting of a short term detention certificate by an approved medical practitioner in respect of a patient. This certificate authorises the removal of a patient to a hospital (if not already in hospital) or to a different hospital and the detention of the patient for a period of 28 days. It also authorises the giving of medical treatment to the patient in accordance with Part 16 of the 2003 Act. Part 16 sets out a framework of powers, restrictions and safeguards for the giving of medical treatment for mental disorder. Only an approved medical practitioner who will be a psychiatrist can grant a short term detention certificate.

37. Section 36(1) of the 2003 Act provides the conditions which must be met for the approved medical practitioner to grant the short term detention certificate. One of these conditions is that the patient does not fall within section 44(2). Section 44(2) provides that the patient falls within that subsection if, immediately before the medical examination, the patient is subject to specified measures which authorise the detention of the patient. So, if a patient is subject to any of these measures (for example an extension certificate under section 47(1)) immediately before the examination then a short term detention certificate cannot be granted in respect of that patient.

**Proposed change**

38. As discussed above in relation to emergency detention certificates, a patient subject to detention under section 113(5) of the 2003 Act is already within a detention regime and the Scottish Government considers it is that regime which should govern any subsequent
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

detention which follows immediately on that detention – not the short term provisions set out in Part 5 of the 2003 Act. The Scottish Government therefore considers it appropriate to extend the list of specified measures in section 44(2) of the 2003 Act to include a reference to section 113(5). The Bill provides for this at section 4.

**Consultation**

39. The changes were included in the draft Bill consultation and were welcomed by those respondents who answered questions in relation to these proposed changes.

**Alternative approaches**

40. No alternative approaches were considered.

**Suspension of orders and measures etc.**

**Policy objectives**

41. The policy intention behind these provisions is twofold. Firstly, with regard to the suspension of orders on emergency and short term detention, to ensure that in circumstances where the health of a patient subject to an order in the community deteriorates very quickly such that emergency detention is required, that the patient is only subject to that emergency order, rather than subject to duplicate orders.

42. Secondly, with regard to suspension of a patient’s detention in hospital by the patient’s responsible medical officer, suspension of detention allows patients to attend court hearings, clinical appointments and facilitates the gradual testing out of a patient’s response to increasing freedoms and the assessment of risk associated with their eventual return to the community. However, the McManus review found that the current time limits and processes required to grant suspension of detention were complicated, arbitrary and difficult to operate in practice. The intention behind these provisions in the Bill therefore is to ensure the regime for suspending a patient’s detention is improved so that suspension of detention can be carried out in a manner which is clearly understood by all parties and provides the flexibility needed for an effective suspension of detention system.

**Suspension of orders on emergency detention**

**Current position**

43. A compulsory treatment order under Part 7 of the 2003 Act may or may not authorise detention in hospital. A patient’s condition may suddenly deteriorate to such an extent that urgent hospital treatment is necessary and the patient may require to be admitted to hospital as an emergency. In such cases there is unlikely to be time for an application to be made to the Tribunal to vary the compulsory treatment order to provide for detention in hospital and it may be necessary to grant an emergency detention certificate. Section 43 of the 2003 Act provides that with one exception (giving of treatment under Part 16 of the 2003 Act) if a patient is subject to a compulsory treatment order and then an emergency detention certificate

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8 Part 16 of the 2003 Act sets out a framework of powers, restrictions and safeguards for the giving of medical treatment.
is granted, any measures authorised by a compulsory treatment order cease to have effect for the period of time the patient is subject to the emergency detention certificate.

**Proposed change**

44. As it would be possible for a patient subject to either an interim compulsory treatment order or a compulsion order to be given an emergency detention certificate, the Scottish Government considers that section 43 of the 2003 Act should also apply to patients subject to those orders. The Bill provides for this at section 6.

**Suspension of orders on short term detention**

**Current position**

45. In a similar vein, section 56 of the 2003 Act provides that if a patient is subject to a compulsory treatment order and is subsequently given a short term detention certificate, the compulsory treatment order ceases to authorise the measures specified in the order during the period of the short term detention certificate.

**Proposed change**

46. As it would be possible for a patient subject to either an interim compulsory treatment order or a compulsion order to be given a short term detention certificate, the Scottish Government considers that section 56 should also apply to patients subject to those orders and the Bill provides for this at section 7.

**Suspension of detention for certain purposes**

**Current position**

47. Section 221 of the 2003 Act allows a patient’s responsible medical officer to grant a certificate suspending an assessment order made by the criminal courts. Section 224 makes similar provision in relation to a treatment order, and an interim compulsion order. In addition it is noted that section 8(4) of the Bill adds a temporary compulsion order to the list of orders at section 224 of the 2003 Act. Before a detained patient leaves hospital, for example for attendance at court hearings, a certificate authorising suspension of detention is required. The patient remains liable to be detained and subject to the other measures authorised by the order under which the patient is detained. Ministerial control of remand patients (which is what individuals subject to the orders mentioned above are) was introduced under the 2003 Act.

**Proposed change**

48. With the benefit of over eight years of working with the 2003 Act, the Scottish Government considers that in certain specific circumstances, Ministerial involvement is both unnecessary and inefficient. For example, when a patient requires to attend a court hearing relating to their case, the responsible medical officer currently requires to obtain the Scottish Ministers’ prior consent to the suspension of detention. Clearly in circumstances such as these, that consent is not going to be withheld.
49. In the interests of streamlining procedures, the Scottish Government considers that it should no longer be necessary for a responsible medical officer to seek the prior approval of the Scottish Ministers before granting a certificate suspending detention in the case of assessment orders, treatment orders, interim compulsion orders and temporary compulsion orders to enable a patient to attend a court hearing or necessary medical (including dental) appointment. The Bill provides for this revised policy position at section 8.

**Maximum suspension of detention measures**

**Current position**

50. The Scottish Government recognises that suspension of detention is an essential tool in the treatment of mentally disordered offenders. This is provided for at chapter 7, sections 127 to 129 of the 2003 Act. In many cases this will be a vital part of the rehabilitation and recovery programme as it allows the patient extended time out of the hospital in the community subject to conditions imposed by the responsible medical officer, whilst still being liable to detention under the Act. This may include periods of time at home or in a community-based care setting. Suspension of detention in practice is often used as a precursor to an application for a variation of a compulsory treatment order to make it community based.

**Proposed change**

51. The Scottish Government is aware that the current arrangements for suspension of detention are perceived by some as inflexible and difficult to manage and have resulted in the development of excessively bureaucratic systems to count up the number of days a patient has had their detention requirement suspended. The Scottish Government therefore considers the revised arrangements outlined below should result in a system that is flexible enough to respond to practical issues of day to day care and treatment whilst at the same time provide safeguards against suspension of detention being used in situations where an application for variation of the order would be more appropriate.

52. Under the revised procedures, at section 9 of the Bill, the responsible medical officer of a patient who is subject to a compulsory treatment order can authorise the suspension of detention for a period of no more than 200 days in any 12 month period. This only applies to periods of suspension of detention incorporating an overnight element. The responsible medical officer will be given the power to grant a certificate suspending detention for an individual period not incorporating an overnight element and there is no limit to the number of times the power can be exercised. The responsible medical officer should record the suspension of detention in the patient’s case notes.

53. The responsible medical officer will not be able to authorise any overnight periods of suspended detention beyond the 200 day limit unless he or she first makes an application to the Tribunal. The responsible medical officer can make an application for increasing the 200 days at any point during or after the 200 days. In addition the responsible medical officer must notify the Commission when the application is submitted to the Tribunal and also notify the Commission of the outcome of the application. This will give the Commission the opportunity to consider whether to exercise their powers under the Act to make a reference to the Tribunal for review of the order to which the patient is subject.
54. Where the Tribunal approves an application to increase the maximum number of overnight periods of suspension of detention, the responsible medical officer will be able to authorise a further 100 overnight stays within the original 12 month period.

Consultation

55. The provisions on suspension of certain orders were fully consulted on in the draft Bill consultation. They build on recommendations from the McManus consultation. The proposals with regard to suspension of orders on emergency and short term detention were welcomed by respondents. However, the proposals with regard to suspension of detention by responsible medical officers differ from those in the draft Bill consultation. The proposal in the consultation draft was that the current 9 month limit on suspension of detention should be removed altogether, and no limit placed on the amount of suspension of detention afforded to a patient. This was criticised by the majority of responses to the consultation, the general view being that removing the limit on the length of time for detention to be suspended could lead to patients being detained on a hospital based order inappropriately.

56. In response to this, the Bill now reflects the position proposed in the McManus consultation, whereby a clearer approach is taken to the calculation of time periods for detention. In addition it will be necessary for the Tribunal to approve any increase of the 200 day maximum for overnight periods of suspension of detention and any application made for such an increase must be notified to the Commission.

Alternative approaches

57. As mentioned above, an alternative approach whereby the time limit on suspension of detention was removed altogether was considered but was changed to the current position in the Bill for the reasons outlined at paragraph 55.

Orders regarding level of security

Policy objective

58. The policy objective behind these proposals is to provide an effective right of appeal against a perceived level of excessive security for certain patients who are held out with the state hospital, to ensure as far as possible the principle of least restriction is upheld.

Current position

59. At present, section 268 of the 2003 Act gives qualifying patients in qualifying hospitals the right to apply to the Tribunal for a declaration that the patient is being held in conditions of excessive security. If the Tribunal is so satisfied that the patient is subject to conditions of excessive security then it may make an order to that effect and specify a period of time, up to 3 months, within which the Health board for the area in which the patient normally resides shall identify a suitable hospital, not being a state hospital, which the Board and the Scottish Ministers agree would not involve the patient being subject to levels of excessive security.
60. The definition of qualifying patient and qualifying hospital for the purposes of section 268 were to be made by regulations but to date no regulations have been made under this section. Therefore, there is at present in reality no provision for an appeal against levels of excessive security for patients other than patients detained within the state hospital under section 264 of the 2003 Act.

61. There is an inherent difficulty with the existing provision in that if the Tribunal finds that a patient is subject to a level of security that is excessive then that patient can be moved to a different hospital under the powers in section 268, but not to a different part of the same hospital operating a lower level of security. This does not reflect the reality of the secure estate in Scotland today where a number of hospitals have differing levels of security on the same site, and it is far preferable for a patient to be able to remain within the same overall site, that he or she may be familiar with, with a reduction in the level of security as appropriate, rather than be required to move to another hospital altogether, simply to meet a reduction in security levels.

Proposed changes

62. The Scottish Government acknowledges that in so far as patients held within medium secure settings are concerned, the lack of provision for appeals against excessive security for patients out with the state hospital is not appropriate. As regards patients in low secure settings, the Scottish Government does not consider there to be a problem with patients being held in conditions of excessive security (particularly since the next step in progressing such patients onward from a low secure setting would be to release them into the community, which it is open to the Tribunal to order as part of the on-going review procedures available elsewhere in the 2003 Act).

63. Amendments have therefore been made to section 268 of the 2003 Act, by sections 11 and 12 of the Bill, to provide that patients who are subject to a compulsion and restriction order, a hospital direction or a transfer for treatment direction, and are within a qualifying hospital may apply to the Tribunal for a declaration that they are being held in conditions of excessive security. Regulations will provide for a definition of qualifying hospital (by identifying those hospitals, or hospital units which operate a medium level of security) and the power to move a patient, on a successful appeal, includes the power to move a patient to a lower level of security within the same hospital. The Scottish Government considers that these changes to the appeal provisions in section 268 will result in an effective appeal process against levels of excessive security for patients out with the state hospital that fits within the way the secure estate is provided in Scotland.

Consultation

64. The proposals relating to appeals against excessive security were the subject of a separate consultation from June to September 2013. This was the excessive security consultation, which followed the Supreme Court case RM v Scottish Ministers⁹, wherein the Supreme Court held that the Scottish Ministers had acted unlawfully in failing to bring forward regulations under section 268 of the Act as outlined above. The consultation sought views on bringing forward a set of regulations under the existing power, or repealing the

existing section 268 and looking at alternative ways of considering whether an individual was being held in conditions of excessive security or not.

65. The consultation did not bring forward any conclusive answers, save for consensus on the point that section 268 of the Act was not fit for purpose as outlined above, given it does not permit the movement of patients between different levels of security within the same hospital. The Bill therefore amends the current excessive security provisions in the 2003 Act to resolve this issue and adjusts the regulation making power in order to determine which patients the right will apply to. These changes provide a right of appeal that can be exercised appropriately within the current and anticipated Scottish secure estate.

**Alternative approaches**

66. As mentioned above, the excessive security consultation proposed as an alternative way forward, repeal of section 268 altogether and consideration of a different method of assessing whether an individual was being held at an appropriate level of security. However, any new method of assessment would require extensive analysis of the secure estate in Scotland at present, and any proposals for change would require to be fully consulted upon. This work would take two to three years to complete and such a delay was not welcomed. Therefore the Scottish Government considered the most appropriate way forward was to create an effective appeal process, as outlined in the Bill and consider a new approach to assessing whether a patient is being held at an appropriate level of security or not, over the longer term.

**Removal and detention of patients**

**Policy objective**

67. The broad policy objective behind these provisions is to ensure that the Commission is notified when a removal order is made, thus giving those persons subject to such orders, the same opportunity for support from the Commission as persons subject to similar types of order.

**Current position**

68. Sections 293 to 296 of the 2003 Act make provision to allow a mental health officer to apply to the sheriff (or, in certain circumstances, a Justice of the Peace under section 294) for a removal order. Such an application can be made in relation to a persons over 16 who have a mental disorder and where any of the circumstances in section 293(2) apply (for example, the person lives alone and is unable to look after themselves). Section 293(3) enables a mental health officer, any police constable and any other specified person to enter the premises and remove the person subject to the order to a place of safety and to detain that person for a period not exceeding 7 days. Section 300 defines “place of safety” to mean a hospital, premises used for the purposes of providing a care home service, or any other suitable place (other than a police station).

69. Where a removal order is made, section 295 allows the person subject to the order, or any person claiming an interest in the welfare of that person to apply to the sheriff for an order recalling the removal order or varying it (for example, by specifying a different place of
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

safety). Currently there is no provision for the Commission to be notified when an application is made for a removal order, or when such an order is made. This is at odds with other provisions in the 2003 Act dealing with similar situations. For example, there is a duty placed on a mental health officer to notify the Commission where a warrant is obtained under section 35 seeking authority to carry out inquiries under section 33 of the 2003 Act.

Proposed change

70. The Scottish Government is of the view that the making of a removal order is a significant event as it can authorise detention for up to 7 days. The absence of a duty to notify the Commission means that the Commission cannot consider whether to apply to make an application to the sheriff under section 295 as outlined above. The Scottish Government therefore considers that where an application for a removal order is made under Part 19 of the 2003 Act, a duty should be placed on the mental health officer to notify the Commission. The Bill makes provision for this at section 13.

Consultation

71. This proposal was contained within the draft Bill consultation and was welcomed. The Commission is content with the proposal.

Alternative approach

72. No alternative approach was considered.

Detention pending medical examination

Policy objective

73. The broad policy objective of the proposed changes discussed below is to ensure a patient in urgent need of attention can be detained for an appropriate length of time to ensure initial examination takes place.

Current position

74. Section 299 of the 2003 Act empowers certain nurses (a mental health or learning disabilities nurse registered in Sub-Part 1 of the Nurses’ Part of the register kept in accordance with the Nursing and Midwifery Order 2001) to detain a patient who is in hospital receiving treatment but who is not subject to compulsory treatment for mental disorder for a period of two hours.

Proposed change

75. Section 14 of the Bill provides for an amendment to section 299 whereby a patient can now be detained for up to three hours, for the purpose of enabling the examination of a patient to be carried out by a medical practitioner. This additional time seeks to balance the need for flexibility to arrange for a medical examination with maintaining the need for minimum restriction on patients.
Consultation

76. This proposal was contained in the draft Bill consultation and was welcomed by the majority of respondents. A small number of respondents were concerned that the extension of the maximum length of detention from 2 to 3 hours, was an infringement on a person’s liberty. But, on balance, given the short increase in length of time of detention, the fact that this is a permissive power and that 3 hours is the maximum length of detention possible, it was considered that it was appropriate to proceed with this change.

Alternative approach

77. No alternative approaches were considered.

Time for appeal referral or disposal

Policy objectives

78. The policy objective of the provisions discussed below is to ensure the appeal process under section 220 of the Act is brought into line with similar appeals in other parts of the Act, thereby ensuring the matter is resolved within a reasonable time to allow patients to get the treatment they need timeously.

Current position

79. The power of managers of a hospital to transfer a patient detained in a hospital, subject to a compulsion and restriction order, a hospital direction, or a transfer for treatment direction, from one hospital to another include the power to transfer the patient to a state hospital even when the state hospital is not specified in the order. A patient who is notified of an intention to transfer, or who has been transferred to a state hospital has a right of appeal against this decision and has 12 weeks within which to lodge an appeal.

Proposed change

80. The proposed change in the Bill, brings the appeal period down from 12 weeks to 28 days. The current 12 week period has caused significant problems as where an appeal has been lodged prior to a transfer, the transfer cannot take place until the appeal is considered, which can delay a patient’s treatment for up to 12 weeks. This change will ensure appeals are made within a reasonable time so that patients are appropriately placed and treated with the minimum of disruption.

Consultation

81. This proposal was contained within the draft Bill consultation and was welcomed by the majority of respondents. A small minority were concerned by the reduction in the length of the appeal period, offering the view that this was a reduction in the rights of a patient. However, given the delays caused by the current length of appeal process, and the fact that the new provision mirrors the time limits for similar appeals under other sections of the 2003 Act, it was felt appropriate to proceed with the changes in line with the majority of respondents.
Alternative approaches
82. No alternative approaches were considered.

Periodical referral of cases and recording where late disposal

Policy objective
83. The policy objective behind the provisions discussed below is to ensure the Tribunal deals with cases in a timely and appropriate manner.

Current position
84. At present, the time limits for review of certain types of orders are calculated by the date when an application is made to the Tribunal. This means however that it could be some weeks between the making of an application and the Tribunal determining the case.

Proposed changes
85. The Bill proposes changes whereby the time limits for review of certain orders are calculated by the date when a case has been determined by the Tribunal rather than an application made. This has the effect of shortening the length of time before a case is considered, which is beneficial to the patient. The Bill also proposes a change whereby the Tribunal must record in its record of proceedings if it has failed to consider a case by the correct deadline, thus ensuring a record is kept of all such delays so that they can minimised in the future.

Consultation
86. These changes were contained in the draft Bill consultation and were welcomed by respondents.

Alternative approaches
87. No alternative approaches were considered.

Representations by named persons

Policy objective
88. The policy objective for the provisions discussed below is to ensure that a person can be reassured that their named person is an individual that they are content to have protect their interests, and that a named person will take on that role only if they are content to do so.

Current position
89. If an individual needs treatment under the 2003 Act then the person can choose someone to help protect their interests. This person is called a named person and anyone aged 16 or over can choose a named person. The 2003 Act also provides that if a person does not choose a named person then a carer or nearest relative may become a named person by default.
**Proposed changes**

90. The Scottish Government considers that an individual should only have a named person if they chose to have one. The Scottish Government also considers it is important that an individual should give their written and witnessed consent to acting as a named person. The rationale for this is that this will enable the named person to discuss matters with the individual and obtain information about the role and responsibilities of a named person prior to their accepting the nomination. The Bill makes provision for this and also repeals the Tribunal’s power upon application to appoint a named person where no such person exists. The Tribunal retains the power on application to remove a named person where that person is considered to be inappropriate, and where, in such a case the patient is under 16, the Tribunal will be able to appoint another person as the named person.

**Consultation**

91. These changes were contained within the draft Bill consultation subject to one change which was that the draft Bill retained the power the Tribunal had under the 2003 Act, to appoint a named person for an individual if they considered that was appropriate. All the changes to the named persons policy were welcomed with the exception of the retention of the Tribunal’s power to appoint a named person. This was considered to breach the policy intention that a person should only have a named person if he or she wanted one and had appointed one as the need for trust between a person and his or her named person was considered an essential element of the role by virtually all respondents. The Scottish Government, having considered all consultation responses, therefore amended the proposals for introduction to reflect the preferred option.

**Alternative approaches**

92. An alternative approach whereby retention of the Tribunal’s power to appoint a named person was considered but, for the reasons outlined in paragraph 91 above, the Scottish Government has decided not to proceed with that approach.

**Advance statements**

**Policy objective**

93. The policy objective for these provisions is to ensure where an advance statement exists, it is used as appropriate, thus underpinning the principle of maximum involvement of service users in proceedings and treatment.

**Current position**

94. An advance statement sets out the way a person wishes to be treated, or not treated, for mental disorder in the event of becoming mentally unwell and unable to make decisions about treatment. It should be considered by medical staff and the Tribunal when decisions are being taken about a patient.
Proposed changes

95. The Scottish Government considers it is important that where an individual has completed an advance statement and thus shown a willingness to participate in their treatment then it is important that the relevant parties are aware of the existence of this document.

96. The Bill at section 21 places a duty on Hospital Boards to ensure that where they receive a copy of an individual’s advance statement this must be placed in the person’s medical records and a copy must be sent to the Commission. In turn, the Bill places a duty on the Commission to maintain a central register of advance statements. The register will only be available for inspection to the persons specified at new section 276C(2).

Consultation

97. These proposals were contained in the draft Bill consultation and were strongly supported by respondents.

Alternative approach

98. No alternative approaches were considered.

Support and services

Policy objective

99. The policy objective behind the proposals set out below is to ensure patients are able to participate as fully as possible with their treatment. The Bill requires assistance to be given to aid communication at examinations as well as to patients detained in hospital. By requiring additional support for mothers who have a mental disorder, the welfare of both a mother and her children are being prioritised.

Communication at medical examination

Current provision

100. Section 261 of the 2003 Act (Provision of assistance to patient with communication difficulties) applies in relation to patients detained in hospital by virtue of the 2003 Act or to the 1995 Act and to patients not detained in hospital but subject to an order or direction listed in this section.

Proposed change

101. The Scottish Government considers it is appropriate to extend the existing provision of assistance to patients with communications difficulties to, not only those who are the subject of certain orders, but also to those who are subject to an application for these orders. Section 23 of the Bill provides for this.
Services and accommodation for mothers

Current provisions
102. Section 24 of the 2003 Act requires Health Boards to make provision to allow a mother to care for a young child, under the age of one, in hospital where the mother is admitted to hospital for treatment for post-natal depression, cares for the child and is not likely to endanger the child’s health or welfare. The purpose is to ensure that the mother and baby are not separated in the child’s first year of life, recognising the importance of maintaining and supporting this relationship.

Proposed change
103. Mothers are frequently admitted to hospital according to their need for inpatient care, not necessarily according to diagnosis. Women may be affected by a variety of conditions, including for example, psychosis and schizophrenia in the months leading up to and following a birth. The Scottish Government therefore considers it is appropriate that the services and accommodation mentioned in section 24 should be available to all such women and the Bill at section 23 extends the scope of section 24 of the 2003 Act to provide for women admitted to hospital for any type of mental disorder (including post-natal depression).

Consultation
104. Both the provisions relating to help with communication at medical examinations and to support for mothers with mental disorders, beyond post-natal depression were contained in the draft Bill consultation and were strongly welcomed.

Alternative approaches
105. No alternative approaches were considered.

Cross-border and absconding patients

Policy objective
106. The policy objective behind these provisions is to ensure parity of treatment for patients in other EU member states in respect of cross border transfers and absconding patients with patient in the rest of the UK.

Current position
107. Using enabling powers available to them under section 289 of the 2003 Act the Scottish Ministers have made regulations which allow for the cross-border transfer of patients subject to a community based compulsory treatment order or compulsion order from Scotland to England or Wales, and for the reception in Scotland of persons subject to a corresponding requirement in England and Wales. Regulations have been made under section 290 which allow for (i) the transfer of patients whose detention in hospital in Scotland is authorised by virtue of the 1995 Act or the 2003 Act from Scotland to a place outwith Scotland (whether or not a place in the UK); (ii) the removal of a patient who is in hospital for the purpose of receiving treatment for mental disorder, other than by virtue of the 1995 Act or the 2003 Act from Scotland to a place outwith the UK; and (iii) the reception in Scotland of persons
subject to corresponding measures in England, Wales, Northern Ireland, the Isle of Man or the Channel Islands. Sections 289 and 290 do not allow regulations made under those sections to authorise the reception of patients from outwith the United Kingdom – i.e. from other member States of the European Union into Scotland in order to provide treatment for mental disorder.

*Proposed changes*

108. Where a patient absconds from a hospital or other such place in Scotland, the patient will be taken back to the hospital or other address in accordance with section 303 of the 2003 Act and the order or certificate to which they are subject continues to run. Accordingly, authority to treat the patient continues under the original order or certificate and Part 16 of the 2003 (refer to paragraph 43) Act will apply to the giving of such treatment. However, there is no provision to authorise the giving of treatment to patients who abscond from detention in another jurisdiction and are taken into custody in accordance with section 309 of the 2003 Act and associated Regulations. The Bill makes provision to allow this to happen in sections 24 and 25.

*Consultation*

109. These provisions were included within the draft Bill consultation and though few respondents commented on the provisions, those that did were in favour of the changes.

*Alternative approaches*

110. No alternative approaches were considered.

*Arrangements for treatment of prisoners*

*Policy objective*

111. The policy objective behind the provisions discussed below is to ensure firstly, with regard to the additional requirement placed on mental health officers, in respect of persons transferring to hospital, those persons are afforded the same support from mental health officers as individuals subject to similar orders under the 2003 Act receive, and secondly, to ensure the Tribunal can operate as efficiently as possible with the minimum of delay to patients.

*Agreement to transfer of prisoners*

*Current position*

112. A person who is serving a prison sentence and who has a mental disorder requiring treatment can be transferred from prison to a specified hospital under a transfer for treatment directions. There is no requirement for involvement of a mental health officer at present, in such transfers.

*Proposed change*

113. The Scottish Government considers that as mental health officers are involved in other contexts such as the making of a compulsory treatment order, where their contribution
is invaluable, it would be beneficial to patients for mental health officers to be involved in the
decisions to transfer a person from prison to hospital under a transfer for treatment direction.
The Bill makes provision for this at section 26 wherein the agreement of a mental health
officer is required before such a transfer from prison to hospital can take place.

Compulsory treatment of prisoners

Current position

114. Where the Tribunal is dealing with cases relating to certain restricted patients, namely
those subject to compulsion orders with restriction orders, transfer for treatment direction,
and hospital directions, the panel must be led by the President of the Tribunal or a Shrieval
Convener. This is provided for in paragraph 7, schedule 2 to the 2003 Act.

Proposed change

115. The Scottish Government considers that removing the obligation for the Convenor of
a Tribunal Panel to be either the Tribunal President or to be selected from the Shrieval Panel
in certain cases will result in in some small efficiencies in relation to the scheduling of such
cases. These are cases where a prisoner becomes unwell during their prison sentence and has
to be transferred to hospital and at the expiry of their sentence are still in hospital and may
need to remain subject to compulsory measures of treatment and care under the mental health
legislation.

Consultation

116. These provisions were included in the draft bill consultation and were commented on
by very few respondents. Those that did respond were content with the proposal.

Alternative approach

117. No alternative approaches were considered.

PART 2 – CRIMINAL CASES

Policy objective

118. The provision for the disposal by the criminal courts of persons with mental disorders
who are involved in criminal proceedings is made by Part VI of the 1995 Act. This Act was
amended by the 2003 Act to provide for, amongst other matters, two new pre-sentencing
disposals (assessment orders and treatment orders) and to replace old interim hospital orders
and hospital orders with interim compulsion orders and compulsion orders. Given the
technical nature of these changes, with the exception of changes to section 52G of the CJ Act
2003, no alternative approaches were considered.

119. Since the 2003 Act commenced, a number of minor and technical amendments have
been identified. The implementation of these amendments will assist in providing greater
clarity of meaning as well as improving operational efficiency.
Calculating time periods

Current position

120. At present the time periods for assessment orders, treatment orders, interim compulsion orders, compulsion orders and hospital directions are calculated starting with the day on which the order is made and running to the end of the last day of the relevant time period. For example a 7 day order begins on the day it is made until the end of 7 days after that day. This approach to calculating a period of detention differs from the computation of time periods in the criminal courts more generally.

Proposed changes

121. Sections 29 to 33 of the Bill amend the relevant time periods for assessment orders, treatment orders, interim compulsion orders, compulsion orders and hospital directions. The time periods for these orders are calculated starting with the day on which the order is made and ending at the end of the day following the expiry of the relevant period. In the case of a seven day order, this will now mean that the order starts on the day it is made and ends at the end of the day following the expiry of the seven days. This reflects the approach taken in criminal cases and should minimise the miscalculation of time periods.

Extension of Assessment Order

Current position

122. Where an assessment order is made by the court under sections 52D or 52E of the 1995 Act, the period of detention in hospital authorised by the order is 28 days. Before the end of this period the patient's responsible medical officer must submit a report to the court in accordance with section 52G. Currently, if following receipt of that report, the court thinks that further time is required to complete the assessment then the court may extend the assessment order, on one occasion only, for a further period of 7 days.

Proposed changes

123. Section 29(4) of the Bill amends section 52G (review of assessment order) of the 1995 Act so that if the court considers that further time is required to complete an assessment, the court may extend the assessment order on one occasion only, for a further period of 14 days.

Variation of interim compulsion order

Current position

124. A court can make an interim compulsion order under section 53 of the 1995 Act after conviction and before final disposal. This order is intended to be used in cases where the offender may present a high risk to the public and a compulsion order and restriction order or a 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 final disposal may be appropriate. It would be open to the responsible medical officer to state in their report to the court that the treatment that the patient requires is no longer available in the hospital specified in the order and to recommend a change of hospital. However, the current legislation does not provide for this.
Proposed changes

125. Section 34 of the Bill provides a power for the court to direct, if it is appropriate to do so, that the offender be admitted to a different hospital, specified by direction. If that is done, section 32(2)(c) provides that this is to have the same effect as if the hospital specified in the direction were the hospital specified in the interim compulsion order. Furthermore, section 35 (through the insertion of a new section 61A of the 1995 Act enables a responsible medical officer, subject to the consent of the Scottish Ministers, to move a patient within the first seven days of that patient having been admitted to the hospital specified in the order. The order in question might be an assessment order, a treatment order or an interim compulsion order. The rationale being that the first seven day period is the time when a patient is being fully assessed and it can often become apparent very quickly in that assessment period that the hospital specified in the order is not the most suitable environment for the patient and any delay could potentially be very damaging to the patient’s short and longer term health.

Consultation

126. The draft Bill consultation set out the Government’s proposals with regard to the proposed amendments to the 1995 Act. Very few respondents commented on these proposals but the majority of those who did respond supported these mainly minor and technical refinements. The one more substantive amendment in relation to the extension of an assessment order did generate some comments outlined at paragraph 126 below.

Alternative approach

127. In relation to section 52G (review of assessment order) of the 1995 Act, the Scottish Government considered enabling the court to extend the assessment order on one occasion only, for a further period of 21 days. Those who responded to the consultation expressed concern at this proposal. Respondents commented that, whilst they could appreciate the need for an extension, an increase from 7 to 21 days was too big a leap when talking about a person’s liberty and appeared to be more for the benefit of court programming than being about ensuring a person-centred approach to change. The Scottish Government reflected on these comments and considered a pragmatic approach here would be to allow the court to extend the assessment order for a period of up to 14 days (as opposed to 21 days) rather than 7 days, on one occasion only.

PART 3 - VICTIMS’ RIGHTS

Policy objective

128. The policy objective of these proposals is to introduce a statutory notification and representation scheme for victims of mentally disordered offenders, who are subject to certain orders (hospital direction, transfer for treatment direction or a compulsion and restriction order) akin to the scheme available to offenders under the CJ Act 2003. The scheme is to be administered by officials within the Scottish Government Health and Social Care Integration Directorate. The Scottish Ministers consider that the implementation of such a scheme will bring the rights of victims of mentally disordered offenders into line with victims of other offenders thereby promoting victims’ rights.
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

Information and representation

Current position

129. Section 16 of the CJ Act 2003 introduced a statutory scheme for the provision of information to certain victims, or to their relatives in certain circumstances, about the offender who perpetrated the offence against them. This statutory scheme does not apply to victims of mentally disordered offenders. The CJ Act 2003 also introduced a statutory right for victims to make representations about the release of the offender and any conditions with which they ought to comply on release, prior to any decision being taken by the Parole Board to release the convicted person on licence. This right does not extend to victims of mentally disordered offenders.

Proposed changes

130. Sections 43 to 49 of the Bill make provision for victims’ rights. These sections insert provisions into the existing victim notification scheme in Part 2 of the CJ Act 2003 so as to extend the scheme to the victims of mentally disordered offenders.

131. The proposals will allow qualifying victims to receive limited information about the status of the patient who perpetrated the crime against them, as well as the right to make representations to the Tribunal, the Scottish Ministers or the patient’s responsible medical officer, as the case may be, in connection with the conditions which might apply to the patient upon being released from detention. The intention behind the provisions is to provide victims with the opportunity to receive information and make representations regardless of whether the offender happens to be given a prison sentence or a mental health disposal (or else is subsequently transferred into the mental health system from prison) thereby producing a comprehensive and consistent scheme. However, in recognition of the fact that mentally disordered offenders are themselves vulnerable, the proposals do not require Scottish Ministers to disclose information to victims where there are exceptional circumstances which would make doing so inappropriate: this could, for example, apply if the mentally disordered offender is particularly vulnerable and release of the information would cause them harm.

132. Section 16 of the CJ Act 2003 currently applies to victims of a prescribed offence where the offender is convicted and sentenced to imprisonment or detention for a period of at least 18 months, to imprisonment or detention for life, or to detention without limit of time. In such a case, section 16 requires the Scottish Ministers to give the victim information regarding the offender’s date of release, date of death, transfer out of Scotland, eligibility for temporary release, recall to custody following release, and any period that the offender is unlawfully at large.

Right to information: offender imprisoned

Current position

133. At present there is no provision in law for victims of mentally disordered offenders to be notified of changes to that offenders detention
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

Proposed change

134. Amendments are made to section 16 of the CJ Act 2003 by section 43 of the Bill to deal with cases where an offender is subject either to a hospital direction (made by a court under section 59A of the 1995 Act) or a transfer for treatment direction (made by the Scottish Ministers under section 136 of the 2003 Act). In such a case, a victim who has intimated a desire to receive information under the scheme will be notified if the offender has for the first time been granted unescorted suspension of detention under the 2003 Act.

135. The nature of the information which is to be made available to victims of convicted persons is intended to—

- assist the victim and/or their close family members in coping with the longer term effects of the offence by giving them notice of the offender’s release (rather than them learning this through media sources or by seeing them in the community);
- give victims and/or their close family members peace of mind by informing them of the offender’s death or transfer out of Scotland;
- warn victims and/or their close family members of any periods during which the offender is unlawfully at large so they can take whatever precautions they consider necessary.

Right to information: compulsion order

Current position

136. At present there is no provision for victims of mentally disordered offenders to receive any information about that offender’s period of detention.

Proposed change

137. New sections 16A to 16C are added (by section 44 of the Bill) to the CJ Act 2003 to deal with victims of mentally disordered offenders who are not sentenced to imprisonment but instead receive a mental health disposal. Section 16A provides that the Scottish Ministers must give certain information which relates to an offender who has perpetrated an offence against a natural person and who has been made subject to a compulsion order and a restriction order under the 1995 Act to persons who are, by virtue of section 16B, entitled to receive the information.

138. A person’s entitlement to receive information under the scheme is determined by section 16B, which provides that the victim is to receive the information, unless certain specified circumstances persist. If a person would otherwise be entitled to receive the information but they are aged under 12, the person’s carer is entitled to receive the information instead. The information which is to be provided to victims or such other persons is set out in section 16C and includes revocation of the compulsion order or restriction order to which the patient is subject, the offender’s date of death, release of the patient on conditional discharge and any periods in which the offender is unlawfully at large.
Right to make representations

Current position

139. Section 17 of the CJ Act 2003 currently provides a right to make representations to victims who are entitled to receive information under section 16 of that Act. The entitlement available to victims under section 17 is to make representations to Scottish Ministers as regards the release of the offender on licence and as to the conditions which might be specified in the release licence.

Proposed change

140. The amendments made to section 16 in the Bill to extend that provision to victims of persons subject to a hospital direction or transfer for treatment direction also have the effect of extending the right to make representatioin in section 17 to such persons.

141. In addition, section 17B (added by section 45 of the Bill) gives victims of offenders subject to a hospital direction or transfer for treatment direction the right to make representations to the patient’s responsible medical officer before a decision is taken to suspend the offender’s detention without imposing a supervision requirement.

142. Section 17B also provides victims of offenders subject to a compulsion order and restriction order with the right to make representations prior to certain decisions being taken relating to the discharge of the patient or the unescorted suspension of the patient’s detention. It is made clear in section 17B that any representations made must be about how the decision in question might affect the victim or members of their family.

Consultation

143. The majority of the 34 responses received to the VNS consultation were in favour of procedures being introduced to enable information to be routinely given to victims of mentally disordered offenders in the same or similar way in which information is made available to victims of crime under the Criminal Justice Victim Notification Scheme.

144. The draft Bill consultation set out the Government’s proposals in this regard and provision was made in the draft Bill (which issued with the consultation document) to reflect said proposals.

145. The views of the respondents who offered comments on these provisions ranged from those who welcomed the proposals, to those who were in favour of the proposals but only in the case of patients subject to a compulsion order with a restriction order (i.e. not for patients subject to just a compulsion order), through to those who were opposed to the proposals. A number of respondents commented that individuals subject to a compulsion order have often committed only minor offences and that to allow the proposed notification in such cases may be an unnecessary and disproportionate limitation of their rights to private and family life. A number of respondents who are service users raised concerns that the implementation of such a scheme would result in people who suffer from a mental disorder facing even more discrimination.
Alternative approaches

146. As highlighted at paragraph 15 (third bullet point) the victim notification scheme implements the recent EU Directive, which does not differentiate between offenders who suffer from mental disorder and those who do not in respect of the information to be given to victims. As such, alternative approaches were limited. Consideration had been given to a totally separate, standalone service for victims of mentally disordered offenders but it was considered for ease of use for both practitioners and victims, that incorporating the provisions for victims of mentally disordered offenders within the existing scheme was the most pragmatic and effective approach to take.

EFFECTS ON EQUAL OPPORTUNITIES

147. The Scottish Government does not consider that the measures in the Mental Health (Scotland) Bill will adversely impact on equal opportunities. An Equalities Impact Assessment will be published separately by the Scottish Government in due course.

148. The provisions in the Bill apply equally to all persons regardless of age, sex, race, gender reassignment, pregnancy and maternity, disability, marital or civil partnership status, religion or belief or sexual orientation; accordingly, the Government considers that they do not have any effect on equal opportunities. The only exception to this is section 23 of the Bill which amends section 24 of the 2003 Act; that section requires Health Boards to make provision to allow a mother to care for a young child, under the age of one, in hospital where the mother is admitted to hospital for treatment for post-natal depression. Section 23 extends the scope of section 24 of the 2003 Act to cover women admitted to hospital for any type of mental disorder (including post natal depression). The purpose of this amendment is to ensure that a mother and her baby are not separated in the child’s first year of life, recognising the importance of maintaining and supporting this relationship. In that regard, the provision has a positive effect on equal opportunities on the basis of pregnancy and maternity.

EFFECTS ON HUMAN RIGHTS

149. The measures in the Bill are compatible with rights under the European Convention on Human Rights (ECHR).

150. The 2003 Act and the 1995 Act contain provision allowing for the compulsory detention and treatment of persons suffering from mental disorder in certain circumstances. Given that these provisions allow for compulsory treatment and detention, they have an effect on the human rights of the persons subject to such measures.

151. The compulsory detention of persons suffering from mental disorder is permitted under Article 5(e) of ECHR if it amounts to the ‘lawful detention’ of persons of ‘unsound mind’. Orders or directions made under the 2003 Act (by doctors or by the Tribunal) authorising such detention and treatment, or by the court under the 1995 Act, amount to lawful detention for the purposes of Article 5(e).
152. By virtue of Article 5(4), persons detained on this basis are entitled to have the lawfulness of that detention reviewed by a court and their release ordered if that detention is not lawful.

153. All orders or directions authorising compulsory detention and or treatment for mental disorder under the 2003 Act or the 1995 Act are subject to regular review by the Tribunal in accordance with the 2003 Act (the Tribunal satisfies the definition of a “court” for the purposes of article 5(4)).

154. A number of provisions in the Bill make technical and procedural amendments to the provisions of the 2003 Act relating to the process for obtaining certain orders authorising compulsory treatment and related matters and these do not have any additional effect on the human rights of patients. Examples of such provisions are section 2 of the Bill which requires mental health officers to submit a record to the Tribunal in certain cases where a patient’s responsible medical officer makes a determination extending a compulsory treatment order, and sections 3 and 4 which adjust the requirement to notify certain persons when an emergency detention certificate is made.

Sections 10 to 12 of the Bill

155. Sections 10 to 12 of the Bill make a number of changes to the provisions of the 2003 Act which allow a patient to make an application to the Tribunal regarding the conditions of security to which they are subject, particularly as regards section 268 of the 2003 Act which relates to patients detained in hospitals other than a state hospital. The excessive security provisions in the 2003 Act are intended to ensure that patients are appropriately managed during the period of their detention in hospital and can progress on to lower levels of security and eventual discharge from hospital if that is considered appropriate.

156. The Bill does not give all patients subject to detention the right to apply to the Tribunal for an order declaring that the conditions to which they are subject are excessive; instead, section 12 of the Bill adds provision to the 2003 Act allowing Scottish Ministers to make regulations determining which patients will be able to exercise the right. The fact that the Bill does not apply this right to all patients is not considered to have a negative impact on the Article 5 rights of patients as the requirements of Article 5(4) are satisfied by the provisions in the 2003 Act allowing for the order or direction to which the patient is subject to be reviewed by the Tribunal (for example, under sections 193 and 215 of the 2003 Act in respect of patients subject to a compulsion order and restriction order or a transfer for treatment/ hospital direction).

157. Both domestic and Strasbourg case law supports the view that Article 5 is concerned with the fact, rather than the conditions, of detention. Accordingly, a patient already lawfully detained in Article 5 terms is not deprived of his liberty on account of being placed in more restrictive conditions: see, for example, Ashingdane v United Kingdom, Aerts v Belgium and R (Munjaz) v Mersey Care NHS Trust.
Section 15 of the Bill

158. Article 6 of ECHR guarantees practical and effective access for the determination of civil rights (and criminal liability) to an independent and impartial court or tribunal established by law. Currently, where it is proposed to transfer a patient subject to compulsory detention in hospital to a state hospital, section 220 of the 2003 Act allows the patient to appeal against the transfer within 12 weeks. Section 15 of the Bill reduces that period to 28 days to bring it into line with the time period in s.219 for appeals against transfers to hospitals other than a state hospital, and to seek to ensure that the matter is resolved within a reasonable time to allow patients to get the appropriate treatment they require as soon as possible with as little disruption as possible.

159. Transfer of a patient to the State Hospital amounts to a determination of the patient’s civil rights (on the basis that the patient will be subject to special measures of security at the State Hospital and there may be an impact on the patient’s ability to progress towards discharge) and Article 6 is therefore engaged by section 15. As far as criminal proceedings are concerned, Article 6 requires persons charged with a criminal offence to have adequate time and facilities for the preparation of his defence. Applying this to the context of appeals against transfer to the state hospital, it is considered that 28 days from the date that notice is given of a proposed transfer (or from the date of transfer if no notice is given) is sufficient time to allow patients to appeal to the Tribunal against the transfer. This is consistent with the period allowed for appealing to the Tribunal under section 219 as regards transfers to hospitals other than a state hospital. It is noted that all that a patient, or the patient’s named person, need do to initiate an appeal under both sections 219 and 220 is to submit the appeal in writing stating the matter which is being appealed and a brief statement of the reasons for the appeal (rule 23 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 (SSI 2005/519).

160. In the light of the above, the reduction of the period within which a patient can submit an appeal against a transfer to the State Hospital to the Tribunal in section 15 of the Bill is not considered to breach a patient’s Article 6 rights.

Part 3 – Victims’ rights

161. The Bill makes provision allowing certain information to be provided to victims of mentally disordered offenders subject to a hospital direction, transfer for treatment direction or a compulsion order and restriction order. The proposals also allow for the right to make representations in certain circumstances in connection with the release of the patient from detention.

162. Whilst the information which falls to be disclosed under the scheme does not, as such, amount to medical information it is nevertheless private information in which the patient has a reasonable expectation of privacy. On that basis, the statutory scheme set out in the Bill engages Article 8(1) of ECHR (which protects the right to respect for private and family life) and falls to be justified under Article 8(2).
163. Disclosure of the information provided under the scheme can be justified under Article 8(2) on the basis that it is necessary for the protection of health (as victims suffer tremendous stress and anxiety wondering whether an offender has escaped from detention and if or when they might encounter the offender in public) and protection of the rights and freedoms of others. The information which falls to be provided to victims is restricted to information which will provide support and protection to them in terms of knowing whether the offender is due to be released, if the offender is being transferred out of Scotland, if the offender has escaped/been returned to hospital, if the offender has died and so on. This type of information can help victims to recover from the offence and deal with the stress and anxiety of wondering whether they are likely to encounter the offender in a public place, or indeed near their home.

164. In striking the right balance between the rights of victims to receive information under the proposed scheme and the rights of offenders in protecting their privacy, different considerations apply where the offender suffers from mental disorder and are themselves vulnerable. The provisions in the Bill allow a higher level of protection to be afforded to vulnerable patients in individual cases as section 16A(3) (inserted by s.44 of the Bill) will allow Ministers not to give information under the scheme if they consider there to be ‘exceptional circumstances’ which make it inappropriate. This provision can be relied on in individual cases if it is considered that disclosure of the information under the scheme would cause harm to the patient, for example, in terms of having a negative impact on their mental health. Section 16(1) of the CJ Act 2003 already contains similar provision which, following amendment of the scheme, will apply in relation to patients who are subject to a transfer for treatment direction or a hospital direction.

165. Similarly, the provisions which allow victims to make representations in relation to certain decisions relating to the release of an offender must, by virtue of s.17B(2) (as inserted by s.45(2) of the Bill) be about how the decision in question might affect the victim or the victim’s family. In other words, the representations must be about the impact of the decision to release the patient on the victim, not whether the patient is released.

166. In the light of the above, whilst the Bill provisions have an effect on the Article 8 rights of certain patients, any infringement of their rights under Article 8(1) can be justified under Article 8(2) on the basis that the provisions pursue legitimate aims and go no further than is necessary to achieve those aims.

**EFFECTS ON ISLAND COMMUNITIES**

167. The provisions of the Bill apply equally to all communities. The Bill has no disproportionate effect on island communities. The increase in the period from 5 to 10 days for a Tribunal to determine an application for a compulsory treatment order, where such an application is made in relation to a patient who is liable to detention under a short term detention certificate, will benefit island and rural communities generally as it provides a longer period of time for the patient to prepare for the Tribunal, access legal representation etc., all of which can take more time to arrange in rural areas.
EFFECTS ON LOCAL GOVERNMENT

168. The Scottish Government does not consider that the measures in the Bill have any disproportionate effect on local government. The implications for local authorities relate to the services provided by mental health officers, who are officers of the local authority.

169. Mental health officers are affected by the terms of the Bill, in particular, sections 2, (further information where a compulsory treatment order is extended), section 26 (agreement to transfer of prisoners) and section 41 (information on extension of compulsion order). In both section 2 and section 41, a mental health officer will now be required to provide a report where a Tribunal is considering the extension of a compulsion order or a compulsion and treatment order. However the report by the mental health officer will only be required in the situation where the mental health officer disagrees with the approach taken by the patient’s responsible medical officer, in any given case. On the basis of current figures, that situation arises in less than 20 cases per year.

170. Similarly, a new duty is placed on mental health officers under section 26 of the Bill, to provide a report for a Tribunal in cases where a transfer for treatment direction (TTD) is being considered in respect of a patient. A TTD is considered where a person is in prison and the person’s health deteriorates to the extent that transfer for treatment in hospital is required. On the basis of current figures there are approximately 85 hearings of this type each year.

EFFECTS ON SUSTAINABLE DEVELOPMENT ETC.

171. The Bill will have no impact on sustainable development.
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

Annex A

GLOSSARY REVIEW

A
Advance Statement – A signed and witnessed document written by a person setting out their preferences for how they wish to be treated, or not treated, when they are unwell.

Assessment Order – an granted by a criminal court under section 52D of the 1995 Act which authorises detention in hospital for 28 days, used as the starting point of investigation into mental disorder. Can be extended once for a period of seven days. Requires one medical report.

Approved Medical Practitioner – a medical practitioner who has been approved under section 22 of the 2003 Act by a Health Board or by the State Hospitals Board for Scotland as having specialist training experience in the diagnosis and treatment of mental disorder

C
Compulsion Order – a final disposal made under section 57A of the 1995 Act by a criminal court which authorises detention and treatment in a hospital or community setting for six months, then reviewed annually. Requires two medical reports and an MHO report. Applications for variation and revocation are made to the Tribunal.

Compulsion Order with Restriction Order – same as Compulsion Order but without limit of time. Reserved for the most serious and high risk offenders.

Compulsory Treatment Order – a civil equivalent to the compulsion order. Granted by a Tribunal under section 66 of the 2003 Act, authorises detention and treatment in hospital or community for an initial period of six months, then annual review. Requires two medical reports and an MHO report. Applications for variation and revocation are made to the Tribunal.

Cross Border Transfer – the transfer of patient to or from Scotland from another jurisdiction to enable care and treatment which cannot be provided for in Scotland, or for repatriation.

E
Emergency Detention Certificate – an order granted by a medical practitioner which lasts for 72 hours and is used to detain a person in hospital for making urgent inquiries into their mental health.

H
Hospital Direction – an order granted under section 59A the 1995 Act which authorises detention of a patient in hospital until they are well enough to be transferred to prison to complete their sentence.

I
Independent Advocate – a person who helps patients express their views in relation to their care and treatment. Advocacy is provided free of charge under section 259 to all persons with a mental disorder.
This document relates to the Mental Health (Scotland) Bill (SP Bill 53) as introduced in the Scottish Parliament on 19 June 2014

**Interim Compulsion Order** – an order which may be made whilst further medical reports have been requested before a full compulsion order can be imposed by the Court. Lasts 12 weeks and be renewed by further periods of 12 weeks for up to one year.

**Interim Compulsory Treatment Order** – an order which may be made whilst further medical reports have been requested before a full compulsory treatment order can be imposed by the Tribunal. Lasts up to 28 days, and can be renewed repeatedly so long as total detention does not exceed 56 days.

**Mental Health Officer** – a social worker with specialist training and skills in relation to mental health.

**Mental Health Tribunal** – an independent judicial body which deals with applications for review, variation and recall for civil orders and compulsion orders, including those with restriction.

**Mental Welfare Commission** – an independent regulatory body which provides on-going monitoring of the 2003 Act to Scottish Ministers. Provides advice to professionals and service users, and also has powers to investigate cases where there are concerns of care standards.

**Named Person** – someone appointed by the patient to look after their interests. They are entitled to receive information about the patient and in certain circumstances can make applications on their behalf.

**Place of Safety** – defined by section 300 of the of the 2003 Act as a hospital; place used as a care home; or other accommodation where the owner is willing to temporarily receive the patient. A police station may be used if none of the above are available. Normally used to facilitate medical examination when someone has become the subject of a Removal Order from premises or public.

**Removal Order** – an order granted by a sheriff where a person with a mental disorder is suspected to need immediate care and treatment, unable to look after themselves or for protection from ill-treatment or neglect is removed to a place of safety.

**Responsible Medical Officer** – the lead medical practitioner who has overall responsibility for a patient’s care and treatment.

**Short Term Detention Certificate** - granted by an approved medical practitioner which enables a patient to be detained in hospital for a period of 28 days for the purposes of assessment or treatment of the patient’s mental condition.
**Suspension of Detention** – a period(s) of authorised absence from hospital to help prepare a patient for a managed return into the community. Also used to facilitate attendance at court, routine medical appointments, or compassionate leave.

**Transfer for Treatment Direction** – issued by Scottish Ministers under section 136 of the 2003 Act where a serving prisoner requires hospital treatment for mental disorder.

**Treatment Order** – an order granted by a court under section 52M of the 1995 Act which authorises detention and treatment in hospital until certain conditions have been met. Used to facilitate treatment whilst the patient is undergoing court process.
MENTAL HEALTH (SCOTLAND) BILL

DELEGATED POWERS MEMORANDUM

PURPOSE
1. This memorandum has been prepared by the Scottish Government in accordance with Rule 9.4A of the Parliament’s Standing Orders, in relation to the Mental Health (Scotland) Bill. It describes the purpose of each of the subordinate legislation provisions in the Bill and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes and Policy Memorandum for the Bill.

2. The contents of this Memorandum are entirely the responsibility of the Scottish Government and have not been endorsed by the Scottish Parliament.

BACKGROUND
3. The Mental Health (Scotland) Bill “(the Bill”) is part of the Scottish Government’s programme to streamline, simplify and clarify the systems for efficient and effective treatment for people with a mental disorder. The Bill seeks to improve the operation of the Mental Health (Care and Treatment) Scotland Act 2003 (“the 2003 Act”) and some related provisions in the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”). Additionally the Bill makes provision through amendments to the Criminal Justice (Scotland) Act 2003, as to the rights of victims of crime in the context of mental health disposals.

OUTLINE OF BILL PROVISIONS

4. The Bill is structured in the following parts
   - **Part 1** amends the 2003 Act in respect of a number of issues relating to compulsory treatment for patients including procedures for compulsory treatment, suspension of detention, removal of patients and timescales for referrals and disposals. Part 1 also amends provisions relating to representation by named persons and advance statements.
   - **Part 2** amends the 1995 Act in respect of treatment for mentally disordered offenders. It amends timescales for assessment and treatment orders for such patients and provides for variation of certain orders.
   - **Part 3** creates a new notification scheme for victims of mentally disordered offenders.
   - **Part 4** sets out general provisions on coming into force and modification of enactments.
APPROACH TO USE OF DELEGATED POWERS

5. The Bill contains a number of delegated powers. The Government has had regard, when deciding where and how provision should be set out in subordinate legislation rather than on the face of the Bill, to the need to:

- strike the right balance between the importance of the issue and providing flexibility to respond to changing circumstances without the need for primary legislation;
- anticipate the unexpected, which might otherwise impact on the purpose of the legislation;
- the need to make proper use of valuable Parliamentary time; and
- allow detailed administrative arrangements to be kept up to date within the basic structure and principles set out in the primary legislation.

6. The delegated powers provisions are listed below, with a short explanation of what each power allows, why the power has been taken in the Bill and why the selected form of Parliamentary procedure has been considered appropriate.

DELEGATED POWERS

Section 11(2)(f): Orders relating to non-state hospitals

7. Chapter 3 of Part 17 of the 2003 Act allows certain persons to make an application to the Mental Health Tribunal for Scotland (the Tribunal”) for an order declaring that a patient is being held in conditions of excessive security. Sections 264 to 267 apply to patients detained in a state hospital, whilst sections 268 to 270 apply to ‘qualifying patients’ detained in other ‘qualifying hospitals’.

8. Section 11(2)(f) of the Bill repeals the existing powers in section 268 of the 2003 Act to (i) specify a description of “qualifying patient” in regulations for the purposes of sections 268 to 271 of that Act; (ii) specify a description of “qualifying hospital” in regulations for the purposes of sections 268 to 271; and (iii) make provision in regulations as to when for the purposes of sections 268 to 271 a patient's detention in a hospital is to be taken as involving the patient being subject to a level of security that is excessive in the patient's case.

9. No regulations have been made under section 268 of the 2003 Act.

10. The regulation making powers repealed in section 11(2)(f) of the Bill appear in a revised form in section 12(3). Repealing and re-enacting the regulation making power in a new section (section 272A) is intended to improve the readability of sections 268 to 271 as a whole by dealing with the meaning of ‘qualifying hospital’, ‘hospital’ and ‘hospital unit’ in the one place. The vires of the power has also been adjusted to make it clear that the meaning ascribed to ‘qualifying hospital’ in regulations can refer to a particular hospital unit or to particular measures of security or containment; this will allow, for example, hospitals adopting particular security measures to be specified as ‘qualifying hospitals’ for the purpose of sections 268 to 271.
Section 12(3): Qualifying non-state hospitals and units

Power conferred on: The Scottish Ministers
Power exercised by: Regulation made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

11. This provision inserts a new section 272A into the 2003 Act which enables the Scottish Ministers to (i) further define the expression “qualifying hospital” for the purposes of sections 268 to 271 (subsection (1)); (ii) make provision for the purposes of those sections to assist in the determination of whether the patient’s detention in hospital involves the patient being subject to a level of security which is excessive in a patient’s case; and (iii) make further provision regarding the operation of those sections in particular circumstances. It is noted that subsection (4) of the new section 272A provides that regulations made under that section may make provision by reference to a specified hospital or hospital unit (or a type or description of hospital or hospital unit) or to measures of security or containment under which a patient is detained.

Reason for taking power

12. The power in subsection (1) of section 272A is taken to allow the Scottish Ministers to specify the patients, or groups of patients, to whom the right in section 268 will apply by reference to the hospital, or hospital unit in which those patients are detained. This is a reformulation of the existing power in section 268(12) to define “qualifying hospital”.

13. The power in subsection (2) of section 272A is a reformulation of the existing power in section 268(14) and is retained to ensure that the circumstances in which a patient will be regarded as being subject to a level of security that is excessive can be specified in order to assist the Tribunal in the determination of an application under section 268.

14. The power in subsection (3) of section 272A is included to provide the Scottish Ministers with sufficient flexibility to make additional provision in order to ensure that sections 268 to 271 operate effectively in relation to particular circumstances. A wide power is required to ensure that the Scottish Ministers are able to react quickly to ensure the legislative framework supports the ever-changing nature of the secure estate for mental health patients and ensure that as this develops to meet the changing needs of patients, so the legislation can be amended to reflect these developments.

15. The nature of the secure estate in Scotland is such that resources need to adapt to the changing needs of patients quickly. The flexibility of regulations rather than primary legislation is needed to ensure the legislative framework can adapt to the changes in the secure estate.

Choice of procedure

16. Section 12(4) of the Bill amends section 326(4) of the 2003 Act so that regulations made under the new section 272A will be subject to affirmative procedure. Affirmative procedure is considered appropriate here given that the exercise of the powers will determine which patients outwith a state hospital are eligible to make an application under section 268 (or to have an application made which relates to them by their named person, etc.).
consistent with the existing regulation making powers under section 268 and will ensure that the appropriate level of scrutiny is given to the exercise of the power.

Section 19(2) Consent to being named person

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Provision

17. Chapter 1 of Part 17 of the 2003 Act makes provision for patients to have a “named person”. Section 250 makes provision for the nomination of a named person. Section 19(2) of the Bill provides that a nomination made under section 250(1) of the 2003 Act will only be valid if a docket to the nomination states that the person nominated has consented to the nomination and the docket has been signed by the nominated person and witnessed by a ‘prescribed person’. This is achieved by the amendments made to section 250(1) in section 19(2) of the Bill.

18. Subsection (7) of section 250 confirms that references to ‘prescribed person’ in that section means a person of a class prescribed by regulations. Accordingly, the power conferred by section 19(2) of the Bill enables the Scottish Ministers to prescribe the class of person who can witness a nominated person’s signature, on a docket, consenting to act as an individual’s named person. Regulations made under section 250 of the 2003 Act are subject to negative resolution procedure (see section 326(1) and (3) of the 2003 Act).

Reason for taking power

19. The reason for taking this regulation making power is to provide the Scottish Ministers with the flexibility to change the prescribed class of person. It would not be an effective use of either the Parliament’s or the Government’s resources for this detailed administrative matter to have to be dealt with through subsequent primary legislation. This is consistent with the approach adopted in the existing section 250(2) and (7) for prescribing persons for the purpose of witnessing the signing of a nomination of a named person under that section.

Choice of procedure

20. Negative procedure is considered appropriate for an administrative matter and is in line with the procedure in place for other situations, including in the existing section 250(2) itself, where the Scottish Ministers are required to “prescribe the class of person” (negative procedure applies to the existing power in section 250(2) to prescribe persons to witness a nomination made under that section by virtue of section 326(3) of the 2003 Act).

Section 24 Cross border transfer of patients

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Provision

21. Section 24 of the Bill makes a number of small changes to provisions relating to cross border transfer of patients. Section 24(2) amends section 289 of the 2003 Act by extending the power to make regulations in respect of the cross border transfer of patients subject to requirement other than detention, to include persons subject to equivalent requirements in a member state of the European Union. Section 24(3) amends section 290 in the same way in respect of cross border transfer for patients subject to detention requirements or otherwise in hospital and section 23(4) amends section 309A in a similar fashion as regards the power to make regulations in relation patients who are in Scotland on an escorted leave of absence from another jurisdiction with the UK.

Reason for taking power

22. The current powers to make regulations under sections 289 and 290 of the 2003 Act do not allow Scottish Ministers to make regulations to authorise the reception of patients from outwith the United Kingdom – i.e. from other member States of the European into Scotland to provide treatment for mental disorder. The changes to these provisions in section 24(2) and (3) will allow such regulations to be made (or rather, amendments to be made to the existing regulations made under these sections) which will enable patients from other Member States to be transferred to Scotland to receive treatment for mental disorder.

23. Similarly, the power in section 309A to make provision by way of regulations allowing patients from another jurisdiction, but who are in Scotland on an escorted leave of absence, to be kept in charge of an authorised person does not apply to patients from other Member States of the EU. The amendment to section 309A will allow such regulations to be made (or rather, amendments to be made to the existing regulations made under this section, including provision applying sections 301 to 303 of the 2003 Act (provisions relating to absconds) to such patients. These changes are being made by way of the delegated powers, rather than on the face of the Bill, because it is consistent with the approach adopted in the existing provisions of the 2003 Act.

Choice of procedure

24. Section 24 amends the regulation making powers in sections 289, 290 and 309A which already attract affirmative resolution procedure by virtue of section 326(4)(c). Affirmative procedure is considered appropriate as this is an extension to an existing regulatory power subject to affirmative procedure and this is the normal procedure for this type of power.

Section 25(3) Dealing with absconding patients

Power conferred on: The Scottish Ministers
Power exercised by: Regulation made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

25. Section 25 of the Bill makes a number of changes to the provisions of the 2003 Act relating to patients who have absconded, or who are treated as having absconded from detention in hospital.
26. Section 25(3)(a) amends section 309 by extending the power to make regulations applying sections 301 to 303 of the 2003 Act to patients from other jurisdictions so as to include patients who have absconded from another member state of the European Union.

27. Section 25(3)(c) amends section 309 of the 2003 Act further by extending the power to make regulations applying sections 301 to 303 to patients from other jurisdictions or, following the amendment in section 25(3)(a), member states, so that some or all of Part 16 of the 2003 Act may also be applied. This will allow persons held in custody by virtue of these provisions to be provided with medical treatment for mental disorder in accordance with Part 16 of the 2003 Act (Part 16 specifies the circumstances in which particular types of treatment, for example, medicine and artificial nutrition, may be given). However, this will not apply to persons who have been taken into custody and who are subject to the equivalent of an emergency detention certificate (which only authorises detention for 72 hours for the purpose of determining what medical treatment requires to be given to the patient); treatment will still be given to such patients if it is necessary as a matter of urgency.

Reason for taking power

28. The current power to make regulations under section 309 of the 2003 Act does not permit Scottish Ministers to make provision allowing patients who have absconded from another member state of the EU to be taken into custody in Scotland. The changes made to section 309 in section 25(3)(a) of the Bill will allow such regulations to be made (or rather, amendments to be made to the existing regulations made under this section).

29. Where a patient absconds from a hospital or other such place in Scotland, the patient will be taken back to the hospital or other address in accordance with section 303 and the order or certificate to which they are subject continues to run. Accordingly, authority to treat the patient continues under the original order or certificate and Part 16 of the 2003 Act will apply to the giving of such treatment. However, there is currently no provision to authorise the giving of treatment to patients who abscond from detention in another jurisdiction and are taken into custody in accordance with section 309 and The Mental Health (Absconding Patients from Other Jurisdictions) Regulations 2008. The power in section 309, and the 2008 Regulations, only authorise the taking into custody of the patient and returning them to the place from which they absconded.

30. Where a patient absconds from another jurisdiction, including from another member state, and is taken into custody in Scotland, their return to the original jurisdiction may not be immediate as it could take a day or so for the hospitals to organise transport. In the interim, the patient may be unwell and require treatment, but the hospital would have no authority to treat the patient other than providing emergency treatment under section 243 of the 2003 Act. The changes made to section 309 in section 25(3)(b) and (c) will allow regulations to be made which will permit treatment to be given to such patients for their mental disorder. These changes are being made by way of the delegated powers, rather than on the face of the Bill, because it is consistent with the approach adopted in the existing provisions of the 2003 Act.

Choice of procedure

31. Section 25 amends the regulation making power in section 309 which already attracts affirmative resolution procedure by virtue of section 326(4)(c). Affirmative procedure is considered appropriate as regulations made under this power will determine the nature of compulsory medical treatment given to patients who have been taken into custody under
These provisions. Affirmative procedure is also considered appropriate as this is an extension to an existing regulatory power which attracts affirmative resolution procedures.

Section 25(4) Dealing with absconding patients

Power conferred on: The Scottish Ministers
Power exercised by: Regulation made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

32. Section 25(4) extends the scope of the regulation making power in section 310(1) to make it clear that the reference to ‘specified persons’ in section 310(1) includes persons authorised by the patient’s responsible medical officer.

Reason for taking power

33. Where a patient absconds from a hospital or other such place in Scotland, the patient will be taken back to the hospital or other address in accordance with section 303 and the order or certificate to which they are subject continues to run. The 2003 Act provides a list of persons who are, or may be, authorised to take patients that have absconded, or failed to comply with a condition in their order, into custody and return them to their place of residence. Section 303(3)(a) sets out the list of people who can take an absconding patient subject to a civil order back into custody. That list includes “any other person authorised for the purposes of that subsection by the patient’s responsible medical officer”. As regards absconding patients who are subject to a mental health order as a result of criminal proceedings, section 310 allows provision to be made by regulations authorising the taking into custody of such patients by ‘specified persons’. Regulations have been made in exercise of this power specifying the persons who can take such patients into custody (see regulation 3 of SSI 2005/463), but it is doubtful whether the power would allow any other person authorised by the patient’s responsible medical officer to be specified. The amendment to section 310 in section 25(4) clarifies that such provision can be made.

Choice of procedure

34. Section 25 amends the regulation making power in section 309 which already attracts affirmative resolution procedure by virtue of section 326(4)(c). Affirmative procedure is considered appropriate as regulations made under this power will allow certain persons to be taken into custody by persons authorised by a doctor. Affirmative procedure is also considered appropriate as this is an extension to an existing regulatory power which attracts affirmative resolution procedures.

Section 43(3)(b) Right to information: offender imprisoned

Power conferred on: The Scottish Ministers
Power exercised by: Order made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

35. Part 3 of the Bill makes a number of amendments to the Criminal Justice (Scotland) Act 2003 (“the CJ Act 2003”) to create a victim notification and representation scheme for victims of mentally disordered offenders. The current victim notification and representation scheme set out in sections 16 to 18 of the CJ Act 2003 does not apply to victims of offenders
who are made subject to a mental health order. Section 43 amends section 16 of the CJ Act 2003 by adding to the list of information to be provided to victims under the scheme as regards offenders who are made subject to a hospital direction under the 1995 Act or a transfer for treatment direction under the 2003 Act. Section 43(3)(b) amends section 16(4) of the CJ Act 2003 by adding power (in paragraph (c) of that subsection) to modify section 18A (inserted by section 47 of the Bill) by adding, amending or repealing definitions of terms used in the descriptions of information in section 16(3).

Reason for taking power

36. The reason for taking this order making power is to provide the Scottish Ministers with the flexibility to add, amend or repeal definitions of terms used in the descriptions of information in section 16(3). It would not be an effective use of either the Parliament’s or the Government’s resources for an administrative matter to have to be dealt with through subsequent primary legislation.

Choice of procedure

37. Section 43 amends the existing order making power in section 16(4) of the CJ Act 2003 which is already subject to affirmative procedure by virtue of section 88(2) of that Act. Affirmative procedure is considered appropriate as this is an extension to an existing order making power which attracts affirmative resolution procedures. This is also considered appropriate as this power can be used to modify primary legislation.

Section 45(2) Right to make representations

Power conferred on: The Scottish Ministers
Power exercised by: Guidance
Parliamentary procedure: None

Provision

38. Section 45(2) of the Bill inserts sections 17B to 17D into the CJ Act 2003 to allow victims who are entitled to receive information under the victim notification scheme to also have the opportunity to make written and oral representations in relation to certain decisions about the offender. Subsection (2) of new section 17C (Making representations under section 17B) makes provision requiring Scottish Ministers to issue guidance setting out how such representations should be framed.

Reason for taking power

39. Guidance issued in accordance with this provision will be designed to assist victims, or as the case may be their carers or family members, with framing representations and may be revised and updated following feedback from those using the new system.

Choice of procedure

40. The issuing of guidance does not attract any Parliamentary scrutiny; this is considered appropriate here as the guidance will simply explain how representations are to be framed (for example by focusing on the potential impact on the victim encountering the offender when they are conditionally discharged from hospital) and inform victims where to turn if they need assistance to make such representations. The guidance will be published on the Scottish Government and Scottish Tribunals Service websites in due course.
Section 48 Power to make modifications

Power conferred on: The Scottish Ministers
Power exercised by: Order made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

41. Section 48 of the Bill inserts new section 18B (Power to modify Part) of the CJ Act 2003. This is a power to modify aspects of the victim notification scheme as it pertains to mentally disordered offenders, for example the power to amend sections 16A and 16B by substituting a different age for the ages specified in those sections.

Reason for taking power

42. The reason for taking this order making power is to provide the Scottish Ministers with the flexibility to change the scheme. It would not be an effective use of either the Parliament’s or the Government’s resources for this detailed administrative matter to have to be dealt with through subsequent primary legislation.

Choice of procedure

43. Affirmative procedure is considered appropriate as section 48(3) inserts “18B” in section 88(2) of the Criminal Justice (Scotland) Act 2003 which deems this order making power should be subject to the affirmative procedure. This is appropriate given that this power can be used to amend primary legislation and use of the affirmative procedure is normal in such cases.

Section 50 Power to commence Bill

Power conferred on: The Scottish Ministers
Power exercised by: Order made by Scottish statutory instrument
Parliamentary procedure: laid only

Provision

44. This provision enables the Scottish Ministers to commence the Bill by conferring a power on Ministers to bring the provisions of the Bill into force, by order, on such day as the Scottish Ministers appoint. Transitional, transitory or saving provision may be made to ensure the smooth implementation of the amendments (for example by preserving existing rules for on-going pre-commencement cases/proceedings; this may be relevant, for example, as regards the provisions in Part 2 of the Bill relating to the timings of certain remand orders).

Reason for taking power

45. It is standard for Ministers to have control over the commencement of Bills. It is considered appropriate for the substantive provisions of the Bill to be commenced at such a time as the Scottish Ministers consider to be suitable.

Choice of procedure

46. As is now usual for commencement orders, the default laying requirement applies (as provided for by section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010).
Health and Sport Committee

Stage 1 Report on Mental Health (Scotland) Bill
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Background to the Bill</td>
<td>1</td>
</tr>
<tr>
<td>Main provisions</td>
<td>2</td>
</tr>
<tr>
<td>Overall views on the Bill</td>
<td>3</td>
</tr>
<tr>
<td><strong>Committee's evidence and analysis</strong></td>
<td>3</td>
</tr>
<tr>
<td>Measures until application determined</td>
<td>3</td>
</tr>
<tr>
<td>Repeat hearings</td>
<td>4</td>
</tr>
<tr>
<td>European Convention on Human Rights</td>
<td>5</td>
</tr>
<tr>
<td>Continuous period of detention</td>
<td>5</td>
</tr>
<tr>
<td>Scottish Government response</td>
<td>6</td>
</tr>
<tr>
<td>New duties for Mental Health Officers</td>
<td>7</td>
</tr>
<tr>
<td>Resources</td>
<td>8</td>
</tr>
<tr>
<td>Transfer treatment decisions</td>
<td>8</td>
</tr>
<tr>
<td>Reports to the Tribunal</td>
<td>9</td>
</tr>
<tr>
<td>Suspension of detention</td>
<td>11</td>
</tr>
<tr>
<td>Orders regarding level of security</td>
<td>11</td>
</tr>
<tr>
<td>Nurse holding powers</td>
<td>13</td>
</tr>
<tr>
<td>Time for appeal, referral or disposal</td>
<td>15</td>
</tr>
<tr>
<td>Representation by named persons</td>
<td>17</td>
</tr>
<tr>
<td>Opt-in versus opt-out</td>
<td>17</td>
</tr>
<tr>
<td>Consent to acting as a named person</td>
<td>18</td>
</tr>
<tr>
<td>Awareness of role of named person</td>
<td>19</td>
</tr>
<tr>
<td>Young people</td>
<td>19</td>
</tr>
<tr>
<td>Advance statements</td>
<td>20</td>
</tr>
<tr>
<td>Register of advance statements</td>
<td>21</td>
</tr>
<tr>
<td>Barriers to usage</td>
<td>22</td>
</tr>
<tr>
<td>Scottish Government response</td>
<td>23</td>
</tr>
<tr>
<td>Care for a child under the age of one</td>
<td>24</td>
</tr>
<tr>
<td>Cross-border transfer of patients and dealing with absconding patients</td>
<td>24</td>
</tr>
<tr>
<td>Mental health dispositions in criminal cases</td>
<td>26</td>
</tr>
<tr>
<td>Victim Notification Scheme</td>
<td>27</td>
</tr>
</tbody>
</table>
Victim Notification Scheme for victims of mentally disordered offenders subject to certain orders 27

Stigma and potential impact on offender 28

Other issues 29

Right of access to advocacy 29

Learning disabilities, autistic spectrum disorders and wider review of legislation 31

The use of force, covert medication and restraint 33

Consideration by other committees 34

Delegated Powers and Law Reform Committee 34

Finance Committee 34

Concluding remarks 35

Annexe A 40

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence 40

List of other written evidence 44

Annexe B 46

Letter from the Finance Committee, Report from the Delegated Powers and Law Reform Committee 46
Health and Sport Committee

To consider and report on health policy, the NHS in Scotland, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Sport, and measures against child poverty.

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## Committee Membership

<table>
<thead>
<tr>
<th>Convener</th>
<th>Deputy Convener</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duncan McNeil</td>
<td>Bob Doris</td>
</tr>
<tr>
<td>Scottish Labour</td>
<td>Scottish National Party</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhoda Grant</td>
<td>Colin Keir</td>
</tr>
<tr>
<td>Scottish Labour</td>
<td>Scottish National Party</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard Lyle</td>
<td>Mike MacKenzie</td>
</tr>
<tr>
<td>Scottish National Party</td>
<td>Scottish National Party</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Nanette Milne</td>
<td>Dennis Robertson</td>
</tr>
<tr>
<td>Scottish Conservative and Unionist Party</td>
<td>Scottish National Party</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard Simpson</td>
<td></td>
</tr>
<tr>
<td>Scottish Labour</td>
<td></td>
</tr>
</tbody>
</table>

### Note

The membership of the Committee changed during the period covered by this report, as follows:

Mike MacKenzie and Dennis Robertson replaced Aileen McLeod and Gil Paterson on 21 November 2014.
Introduction

1. The Mental Health (Scotland) Bill (“the Bill”) was introduced into the Scottish Parliament on 19 June 2014 by Alex Neil, then Cabinet Secretary for Health and Wellbeing. The Health and Sport Committee was designated as the lead committee by the Parliament on a motion of the Parliamentary Bureau on 25 June. The lead committee is required, under Rule 9.6.1 of the Parliament’s Standing Orders, to report to the Parliament on the general principles of the Bill.

2. Following the Bill’s introduction, the Committee issued a call for evidence, which ran from 27 June 2014 to 22 August 2014. The Committee received 50 submissions, with nine further submissions after the closing date.

3. The Committee took evidence on the Bill at its meeting on 30 September, 7 October, 11 and 18 November and 2 December 2014. The Committee would like to thank everyone who provided written and oral evidence as part of its consideration of the general principles of the Bill.

4. The Committee conducted a fact-finding visit on 2 June to Evergreen in Kirkcaldy, a Scottish Association for Mental Health (SAMH) training service which provides work experience opportunities in horticulture for people with mental health problems.

5. The Bill was also considered by the Delegated Powers and Law Reform Committee and the Finance Committee.

Background to the Bill

6. The Mental Health (Care and Treatment) Scotland Act 2003 (“the 2003 Act”) came into force in October 2005. It followed the 2001 report of the Millan Committee, which reviewed the previous mental health legislation for Scotland. The Millan Committee made recommendations based around the central idea that both the law and practice relating to mental health should be driven by a set of ten principles. These principles relate to minimising interference in peoples’ liberty and maximising the involvement of service users in any treatment.¹

7. The 2003 Act is a rights-based piece of legislation that gives individuals the right to express their views about their care and treatment. It provides for the right to independent advocacy, the right to submit an advance statement which states an individual’s wishes and the right to choose a named person who can make decisions on an individual’s behalf.²

8. The 2003 Act redefined the role and functions of the Mental Welfare Commission for Scotland (“the Commission”) and established the Mental Health Tribunal (“the Tribunal”) as the principal forum for approving and reviewing...
compulsory measures for the detention, care and treatment of mentally disordered persons.  

9. In 2008 the Scottish Government commissioned a limited review of the civil provisions of the 2003 Act. The McManus Review identified areas for improvement including those in relation to advance statements, independent advocacy, named persons, medical examinations and tribunals. The Scottish Government’s response to the McManus Review noted that some recommendations would require primary legislation. These recommendations related to advance statements, named persons, medical examinations, suspensions of detention and multiple hearings at Mental Health Tribunal.

10. The Scottish Government’s response to the McManus Report forms the basis of the changes set out in the Bill. The Scottish Government undertook a number of consultations regarding this legislation.

Main provisions

11. In evidence to the Committee Jamie Hepburn Minister for Sport, Health Improvement and Mental Health summarised the key objective of the Bill—

“The overarching purpose of this amending bill – it amends the Mental Health (Care and Treatment) (Scotland) Act 2003 – is to make a number of changes to current practice and procedures to ensure that people with a mental disorder can access effective treatment in good time. In doing so it seeks to build on the principles of the 2003 act.”

12. The key provisions of the Bill relate to recommendations made in the McManus Report. In addition, the Bill makes provision for the introduction of a notification scheme for victims of some mentally disordered offenders.

13. Part 1 of the Bill makes provision about the operation of the Bill.


15. Part 3 of the Bill creates a new notification scheme for victims of some mentally disordered offenders. This will allow certain information to be provided to victims of offenders subject to certain orders and will also allow victims to make representations in certain circumstances in connection with the release of the patient from detention.
Overall views on the Bill

16. The Committee found that responses to the call for written views and witnesses who gave oral evidence to the Committee were broadly supportive of the policy intentions behind the Bill.

17. Dr Joe Morrow of the Mental Health Tribunal for Scotland commented positively on the Bill’s provisions—

“I think that some of the amendments that it makes will make the legislative framework much more efficient and effective and hence more focused on assisting the patient in the process”

18. The Mental Welfare Commission raised a number of points which were also mentioned by other witnesses. These included a suggestion that the Bill was “relatively modest” in its scope but it contained a number of provisions which sought to improve the efficiency and operation of mental health legislation.

19. Recurring themes during the Committee’s consideration of the Bill were the rights of patients and ensuring administrative efficiency. In oral evidence, Colin McKay of the Mental Welfare Commission for Scotland suggested that there were concerns about a number of areas where timescales were being extended for statutory bodies to perform their function and timescales in relation to patients and their rights were being contracted.

20. SAMH shared a similar view, and suggested that proposals which appeared to restrict patients’ rights in the interests of making the overall system run more smoothly were not in the spirit of the Millan principles.

21. The report discusses the key provisions in the Bill which were raised by witnesses during the evidence taking process.

Committee’s evidence and analysis

Measures until application determined

22. Section 1 of the Bill makes provision to increase the time that a period of detention is automatically extended beyond the date at which the short-term detention certificate is due to expire, from five to ten working days. This was recommended in the McManus Review as a way of overcoming the problem of people being required to attend multiple hearings. The Bill also makes provision that the proposed extension would not increase the continuous period of detention.

23. There were mixed responses to this provision. Joe Morrow welcomed the proposed increase in the extension period. He told the Committee that the
Tribunal’s support for the provision was not for the administrative convenience of the Tribunal but to “help us focus on the patient’s involvement”\textsuperscript{14}.

24. In its written submission, the Tribunal explained that the policy intention was to ensure that patients had the best opportunity to be represented and to have instructed a psychiatric report if they so wished. The aim was to ensure that patients were ready and prepared to proceed at the first Tribunal hearing.\textsuperscript{15}

25. However, in contrast, whilst Colin McKay supported the desire to reduce the need for interim and repeat hearings for the benefit of the service user, he expressed “some nervousness” regarding the proposed extension being automatic.\textsuperscript{16}

26. A concern shared by several witnesses, including Colin McKay, was that because the change in extension period would in principle apply to all cases, there was a risk that those involved would tend to work to the new, relaxed deadline, resulting overall in a longer period of pre-hearing detention.\textsuperscript{17}

27. Joe Morrow responded to this point and sought to assure the Committee that this would not be the case. He told the Committee that the Tribunal had achieved “radical” results in reducing the number of multiple hearings, interim hearings or adjournments in the last six years. He stated that there had been a reduction to around 20-30 per cent of cases now going to a second hearing.\textsuperscript{18} He said that should there be a change in extension period he would “work extremely hard and focus on making sure that a decision is delivered for the patient as soon as possible.”\textsuperscript{19}

Repeat hearings

28. A number of witnesses raised concerns regarding the introduction of the increased extension period related to whether there was still such an acute need to reduce the number of repeat hearings.

29. Several witnesses, including Jan Todd of the Law Society and Convener of Tribunals, referred to the drop in the number of repeat hearings since the McManus report as evidence that there was no longer a particular need to increase the extension to the detention period.\textsuperscript{20}

30. The impact this provision would have on the number of multiple hearings was also raised by SAMH in its written submission. It called for the Scottish Government to provide information on its estimates in relation to the reduction in multiple hearings which could be expected as a result of these changes, and what the average number of days detained would be likely to be following its introduction.\textsuperscript{21}

31. Karen Kirk of Legal Services Agency offered a note of caution regarding whether a further reduction in the number of hearings was the appropriate
ambition. She explained that there may be instances where two hearings for a case did not necessarily disadvantage or cause upset to the patient.  

**European Convention on Human Rights**

32. Several witnesses, including Karen Kirk, raised concerns that the provision as it was currently drafted may not be compliant with Article 5 (right to liberty and security) of the European Convention on Human Rights.

33. She explained that the increase in the detention extension period from five to ten days could result in a person being detained for more than seven weeks before appearing before a mental health tribunal. Jan Todd of the Law Society of Scotland told the Committee that it was likely to be less compliant with the ECHR to have a later hearing rather than an earlier one.

34. Cathy Asante of the SHRC queried whether there was sufficient and proportionate justification for applying to everyone a blanket extension of the period of the short-term detention certificate.

35. One suggestion explored with witnesses to address the concern regarding the provision being ECHR compliant was whether the extension could be applied only in ‘exceptional circumstances’. Jan Todd suggested that there could be practical difficulties with this approach, including how the circumstances would be described and who would determine when to have a hearing within 10 days as opposed to five.

36. Kenneth Campbell QC of the Faculty of Advocates offered a slightly different view from other representatives of the legal professions on the provision’s compliance with ECHR. He told the Committee that a blanket extension to the time period “probably would not be unduly problematic”. He highlighted that this was because the whole aim of involving the tribunal in the procedure was to ensure, as far as possible, that patients’ convention rights were properly addressed.

**Continuous period of detention**

37. The Committee also received evidence on the proposed extension time not increasing the continuous period of detention. Joe Morrow welcomed the provision and told the Committee he had no desire for a patient to be detained for any longer than necessary.

38. However, Colin Fraser of Glasgow City Council expressed some concerns with the provision. He felt that deducting the additional days at the end of the detention period—

> “would be to treat the detention period almost as though it were a prison sentence, whereas the point of someone being detained is for them to get treatment.”
39. Concern was also raised regarding how deducting the proposed extension time from the continuous period of detention would be calculated. Jan Todd felt that it could cause additional confusion and uncertainty in any potential review, if the length of the extension had to be worked out and then deducted from a certain period.

40. The Mental Health Tribunal for Scotland (“the Tribunal”) believed that it was unclear whether the period which would be deducted would be calculated in days, days and hours, or days and hours and minutes. It suggested that such a difficulty could be avoided by providing that, where a Compulsory Treatment Order (CTO) is made in such circumstances, it is deemed to commence on the day immediately succeeding the expiry of the Short Term Detention Certificate.

Scottish Government response

41. In oral evidence to the Committee, the Minister responded to the evidence the Committee had received on the proposed increase in the extension period. He told the Committee that he believed that it was an effective provision aimed at minimising the number of repeat, delayed and rearranged tribunals, as these situations could exacerbate the circumstances and the stress for the service user.

42. He emphasised that the provision was not about administrative convenience but about ensuring the best provision of service for the service user.

43. The Scottish Government told the Committee that usage of the provision would be monitored and that the code of practice for RMO and MHOs would be strengthened in regard to applications being submitted at the earliest opportunity.

44. The Minister acknowledged that there had been an overall reduction in the number of hearings. However, he felt that because rearranged hearings were still occurring, steps should still be taken to minimise their number. Following the Minister's oral evidence session, further written information was provided by the Scottish Government detailing the range of reasons why a further hearing might be required before a Compulsory Treatment Order was determined.

45. The points raised by witnesses regarding compliance with ECHR were put to the Minister. He stated: “We are convinced that the provision is ECHR compliant”. He told the Committee it would be a proportionate change aimed at benefiting the service user. The Scottish Government commented that applying the extension only to those in exceptional circumstance would be unwarranted as the extension would be relatively short. Additionally, he said that such a change might “overcomplicate the system”.
46. The Committee welcomes the reduction, since the McManus report, in the number of cases requiring more than one hearing, and the Committee recognises the key role the Tribunal has played in improving its performance in this regard.

47. The Committee recognises that it is important that measures are taken to ensure tribunals do not exacerbate the circumstances and the stress for the service user.

48. The Committee notes the response from the Minister to concerns raised regarding whether this provision would be compliant with Article 5 of the ECHR. To ensure this is the case the Committee believes that it is important that the Scottish Government assesses the implementation of this provision closely.

49. The Committee recommends that, in response to this report, the Scottish Government provides a detailed plan of the estimates in relation to the reduction in multiple hearings which could be expected as a result of these changes, and what the average number of days detained is likely to be following its introduction.

50. The Committee recommends that this provision be supported by a clear monitoring regime which records the reasons for delayed, rearranged and repeat tribunals and the length of pre-hearing detention for service users. The aim in gathering this information is to identify whether there are particular types of case or specific issues causing the delay. This approach would seek to ensure that the policy aim of improving the experience for those in short term detention was delivered and it did not result in an overall longer period of pre-hearing detention.

51. The Committee asks the Scottish Government to respond to the concerns raised regarding how deducting the proposed extension time from the continuous period of detention would be calculated. The Committee believes that it would be beneficial if further clarification was provided regarding how this provision would operate in conjunction with certain detention orders.

New duties for Mental Health Officers

52. Three sections in the Bill would place new duties on Mental Health Officers (“MHOs”). Section 2 and 41 of the Bill would provide for new duties for MHOs, including submitting written reports to the Mental Health Tribunal when the Tribunal is required to review a determination about compulsory treatment or a compulsion order. Section 26 would make provision for the involvement of a MHO in decisions regarding the transfer of people from prison to hospital.
Resources

53. The main concern raised in relation to these provisions was their impact on the workload and capacity of MHOs.

54. Beth Hall of COSLA believed that there was a need to consider the resource implications of the provisions for MHOs.\(^{40}\)

55. The Mental Welfare Commission for Scotland stated that the MHOs played a vital role in the delivery of provisions in the 2003 Act, but the service was increasingly under pressure due to a rise in workload, an ageing workforce and difficulties in attracting new social workers into the role. This was resulting, in some cases, in a degradation of the services, with statutory reports produced late or not provided, and a reduction in the fulfilment of the duty to monitor guardianship cases.\(^{41}\)

56. The Commission’s statistical monitoring report on the Mental Health Act 2013-14 includes data relating to the provision of services by MHOs. One of the duties required of an MHO under the 2003 Act is to produce a Social Circumstance Report (SCR).\(^{42}\) According to the Commission’s report in 2013-14, following a Short Term Detention Certificate, a social circumstance report was not returned to the Commission in 52% of cases.\(^{43}\)

57. The Commission’s statistical monitoring report also highlights that an emergency detention certificate (EDC) can be issued by any registered medical practitioner. However, there should, if possible, be consent from a Mental Health Officer. The Commission’s report states that in 2013-14, 42% of EDCs were issued without MHO consent.\(^{44}\)

58. Colin Fraser also raised concerns regarding the provision of MHOs within the context of the experience of Glasgow City Council. He told the Committee that the workload for MHOs had dramatically increased, particularly in relation to adults with incapacity requirements. However, numbers of MHOs were falling, from 120 in Glasgow City Council in 2011 to 94 in 2013.\(^{45}\)

59. A suggestion made to the Committee by Colin Mckay of the Mental Welfare Commission for Scotland was for a strategic review to improve the recruitment, training and retention of MHOs to ensure there was the appropriate MHO provision for the 2003 Act to work effectively.\(^{46}\)

60. Beth Hall supported the request for a strategic review and called for it to consider projected demand, the implications this would have on long-term capacity requirements and how this would be resourced.\(^{47}\)

Transfer treatment decisions

61. Concerns regarding MHO resources were discussed with the Committee in relation to specific provisions. In regard to section 26, many witnesses were supportive of MHOs being involved in the transfer treatment decision. However,
the Mental Welfare Commission and others indicated that, due to the pressures on MHOs, they were not persuaded that it should be a mandatory requirement for the agreement of an MHO before a transfer from prison to hospital could take place.\textsuperscript{48}

62. The Royal College of Psychiatrists in Scotland held a similar view and raised concern that “this measure may create unnecessary delay in treating acutely unwell prisoners”. \textsuperscript{49}

63. The Mental Welfare Commission for Scotland suggested an amendment to the provision in which MHO consent should be obtained “where practicable” with appropriate guidance in the code of practice.\textsuperscript{50}

Reports to the Tribunal

64. Sections 2 and 41 include provisions for MHOs to submit written reports to the Mental Welfare Tribunal when the Tribunal is required to review a determination about compulsory treatment or a compulsion order. The Committee received evidence from a number of witnesses, including COSLA and the Mental Health Tribunal for Scotland (“the Tribunal”), which raised concern that the information provided in the Explanatory Notes for the Bill did not reconcile with what was outlined in the Financial Memorandum.

65. COSLA commented “that MHO reports would be triggered in far more circumstance that the financial memorandum anticipates”\textsuperscript{51}. In supplementary written evidence to the Committee COSLA noted that it was—

“concerned that the scope of new duties on MHOs is unclear at this stage...However, it is clear that the additional cost set out in the financial memorandum is an underestimation of the costs associated with the measures contained in the actual Bill”. \textsuperscript{52}

66. This was also highlighted by the Finance Committee in its consideration of the Financial Memorandum (“FM”). The Finance Committee, in its letter to the Health and Sport Committee, made reference to the submission from COSLA which—

“suggested that the total number of hearings requiring a report could be in the region of 563 as opposed to 20 and 40 as stated in the FM. As the FM estimates a cost of £475 per report this suggests an overall annual cost to local authorities of over £281,000 instead of the £18,000 noted in the FM”. \textsuperscript{53}

67. The points raised by COSLA were put to the Minister by the Committee. His reply acknowledged that COSLA’s assessment was correct and there was a discrepancy between what was present in the Policy Memorandum and the FM. \textsuperscript{54} The Minister added—
“I apologise to the Committee and to COSLA for the understandable confusion that the error caused.”

68. The Minister explained that the policy intention was that the MHO would be required to produce a report when the tribunal was required to review a responsible MHO’s determination to extend a compulsory treatment order or a compulsion order in two specific situations and that a third situation had been included “erroneously”.

69. The Minister clarified that the two specific circumstances would be when there was a difference between the type of mental disorder that the patient had at the time and that which had been recorded in the original compulsory treatment order or compulsion order; and when the mental health officer disagreed with the responsible medical officer’s determination to extend the compulsory treatment order or compulsion order.

70. He estimated that, under these circumstances, an MHO would be required to produce a report in fewer than 15 cases a year in Scotland. This would result in an annual cost to local authorities of £7,125 a year. The Minister noted that this was a slight revision to the costings in the FM, as the figures on the number of hearings from the Mental Welfare Commission had been slightly higher in the previous year.

71. The Committee notes that an error has been made in the drafting of the Bill’s accompanying documents, resulting in a discrepancy between what is presented in the Policy Memorandum and the FM. This has caused some confusion and concern from interested parties, including COSLA. The Committee welcomes the clarification provided by the Minister on the circumstances in which an MHO report would be required and the assurance that provisions in the Bill would not result in a large increase in the number and costs of reports needed to be produced by MHOs.

72. Whilst the Committee notes the clarification provided by the Minister that there would only be a minimal increase in the number of reports required to be produced by MHOs, concerns remain regarding the capacity of the MHO workforce to deliver further duties under the Bill’s proposals. MHOs are already under pressure due to an increased workload, an ageing workforce and difficulties in attracting new social workers into the role.

73. The Committee seeks further assurances from the Scottish Government that the funding to support MHOs is adequate to ensure that the provisions relating to MHO duties in the Bill could be delivered effectively. The Committee asks the Scottish Government to respond to requests for a strategic review of MHO provision to improve the recruitment, training and retention of MHOs.
Suspension of detention

74. Section 9 of the Bill makes provision that a Responsible Medical Officer (RMO) can authorise the suspension of detention for a period of no more than 200 days (incorporating an overnight element) in any 12 month period and that the RMO will only be able to authorise additional overnight periods of suspended detention following application to the Mental Health Tribunal (the Tribunal).

75. In written evidence to the Committee, the Mental Welfare Commission (“the Commission”) for Scotland welcomed the move to 200 days. However, it did not agree with the provision to allow the tribunal to extend suspension by 100 days. The Commission argued—

“if a patient has been in the community for over six months, and it is felt that he or she should remain in the community but subject to compulsion, the appropriate next step should be to invite the Tribunal to vary the order to a community-based compulsory treatment order”.

76. The Tribunal also questioned the provision and considered that it may “add unnecessary complexity into the systems when the very intention was to reduce complexity”.

77. The Law Society of Scotland held a similar view to the Commission. It supported the move to 200 days but did not support the power for the Tribunal to extend suspension by 100 days. The Law Society also did not support Section 9(2) to exclude periods less than 12 hours between 9pm and 8am. It detailed in its written submission that it did not believe that the Scottish Government had consulted on these provisions.

78. The Committee asks the Scottish Government to respond to the specific concerns, raised in written evidence, relating to the suspension of detention provisions regarding allowing the tribunal to extend suspension by 100 days and to exclude periods less than 12 hours between 9pm and 8am.

Orders regarding level of security

79. Sections 10, 11 and 12 of the Bill seek to make amendments to existing provisions to give patients held in medium secure settings a right of appeal against being held in conditions of excessive security. Section 268 of the 2003 Act gives qualifying patients in qualifying hospitals the right to appeal to the Tribunal if they are being held in conditions of excessive security.

80. As highlighted in the SPICe briefing, the definition of qualifying patient and qualifying hospital was to be made by regulation and to date no regulations have been made. Therefore, currently only patients detained in the state hospital have a right of appeal against levels of excessive security. This was
the subject of the Supreme Court case RM vs the Scottish Ministers (The Supreme Court of the United Kingdom 2012).63

81. The Policy Memorandum explains that the current situation is that if a person is found to be held in conditions of excessive security they can be moved to a different hospital but not to a different part of the same hospital that operates at a lower level of security.64 The Policy Memorandum notes that this did not reflect the current secure estate in Scotland, whereby a number of hospitals have different levels of security on the same site.65

82. The Committee received evidence regarding two key issues relating to this provision; the timetable for its introduction; and the scope of the provision being extended. Colin McKay said “we will be looking for some clarity and some clear timescales around improving appeal rights in relation to excessive security”.66

83. Cathy Asante commented on the Supreme Court case relating to this provision and told the Committee that the ruling found that there had been a failure by the Scottish Government to bring forward regulations, and the Bill still required regulations to be brought forward. She encouraged the Committee to ask for a timetable for when those regulations would be introduced, so that it could be implemented as soon as possible.67

84. The Committee also received evidence calling for the right to appeal to be extended to low-secure units. In oral evidence Carolyn Roberts of SAMH stated—

“We agree that the provision to appeal against excessive security should apply to people in low security, and we absolutely agree that the intention of Millan was for the principle of least restrictive security to apply.”68

85. Carolyn Roberts told the Committee that an appeal against low-secure accommodation was not necessarily an appeal against detention, as the next step was not always a move into the community. She argued that there was a possibility that someone could move from one level of security to another and still be in low-secure accommodation. Carolyn Roberts believed that the right of appeal should apply as widely as possible.69

86. This view was also supported by Cathy Asante who commented—

“It is worth noting that the individual in the case that has led to the provisions was in a low-secure setting but would still not be able to bring an appeal under the current provisions in the bill.”70

She called for the provision to be constructed more widely and to include those individuals on civil orders in medium secure settings to be given the right to appeal.71
87. The Minister clarified that under the scope of the 2003 act, it was not possible to introduce subordinate legislation to address the issue of transfer to a different setting within the same hospital. He told the Committee that there was a petition before the Court of Session on the matter and that there was a need to act swiftly following the Supreme Court ruling.72

88. The Minister responded to comments regarding extending the appeal process to those in low-secure settings. He said that he was not convinced that low-secure settings fell under the definition of “excessive security”, particularly as the next step in progressing patients in low-secure settings was getting them back into the community. It was open to the Tribunal to order that as part of its on-going review of procedures.73

89. The Committee supports the comments made by witnesses and the Minister for a need to act swiftly to bring the right of appeal against being held in conditions of excessive security into force. The Committee therefore, recommends that the Scottish Government, in its response to this report, provide a proposed timetable for bringing regulations forward on these provisions.

90. The Committee notes the comments made by the Minister regarding the appeal process not being extended to those in low secure settings. The Committee is however mindful of the comments made by some witnesses that there may be occasions where an individual in a low secure setting could appeal and move from one level of security to another and still remain in low-secure accommodation. The Committee asks the Minister to respond to whether he considers this scenario to be an appropriate one to merit the inclusion of the right of appeal for individuals in low secure settings.

91. The Committee also asks the Minister to comment on the SHRC suggestions that individuals on civil orders in medium secure settings should also have the right to appeal.

**Nurse holding powers**

92. Section 14 of the Bill makes provision for certain nurses to detain a person for up to three hours pending medical examination by a Responsible Medical Officer (RMO). This is currently set at two hours, plus an additional period of one hour should the RMO not arrive in the first hour.

93. The Policy Memorandum states that this change is required to balance the need for flexibility to arrange for a medical examination with maintaining the need for minimum restriction of patients.74

94. The Committee heard some views that welcomed the extension to the time for the nurse holding power. Karin Campbell of Social Work Scotland believed that
it would provide extra time for the nurse to contact the MHO and the RMO, which could result in more individuals being detained on a short-term detention certificate rather than an emergency detention certificate, which she noted was better practice.\textsuperscript{75}

95. However, the majority of views received by the Committee were critical of this provision. Derek Barron of the Royal College of Nursing (RCN) and Chair of the Mental Health Nursing Forum Scotland believed that there was no evidence that the extension of the time period would have any impact whatsoever. He felt that there would be no advantage in an extension, adding, “We do not even know where the proposal came from; it certainly did not come from nursing”.\textsuperscript{76} He told the Committee that in relation to individuals subject to detention “our duty is to protect their human rights, not to make things easier for our workload.”\textsuperscript{77}

96. Colin McKay held a similar view to the RCN. He discussed the provision in relation to consideration of the impact on MHOs. Whilst he was supportive of MHO consent being sought where possible, he commented that extending the time period would not result in an increase in MHO involvement sufficient to justify the change.\textsuperscript{78} This was due to the pressures on MHOs and the likelihood that they would prioritise cases where the patient was vulnerable in the community. He also felt that there was not a huge concern regarding doctors attending within the current timescale.\textsuperscript{79}

97. The Mental Welfare Commission commented that the current use of the nurse holding power was probably being under-reported to the Commission. The data currently collected only recorded if the MHO had been contacted but not whether the MHO had any further involvement or was able to attend within the time limits.\textsuperscript{80}

98. In evidence regarding the nurse holding power, the Minister sought to assure the Committee that the provision aimed to improve the experience for service users. He told the Committee that it would provide clarity for service users on the maximum period of time for which they could be detained under the nurse’s holding power, rather than the current process of it being for a two-hour period with the possibility of it being extended to three hours. It would also make it clear that they were being detained to enable a medical examination to be conducted.\textsuperscript{81}

99. The Minister also explained that whilst there could be concerns that the changes to the nurses holding power could result in the restriction of a service user’s liberty, the Scottish Government had emphasised that the provision referred to a time period ‘up to’ three hours. A code of practice would be put in place which would emphasise that the nurse must take all reasonable steps to contact a doctor and a Mental Health Officer right at the start of the period and, equally, that hospital managers should impress upon their medical staff the
need to make themselves available to examine the patient as soon as possible.\textsuperscript{82}

100. The Minister told the Committee that he hoped this provision would reduce the number of occasions on which doctors have to apply for what could be an unnecessary 72-hour emergency detention certification in order to complete a medical examination.\textsuperscript{83}

101. In relation to extending the timescales for nurses to detain an individual for up to three hours pending medical examination, the Committee notes the comments from the RCN, the professional body whose members would be directly affected by this provision, that it does not believe there is any evidence that there would be any advantage in an extension.

102. While the Committee understands the rationale set out by the Minister on the reasons for this provision, it also believes that any provision which could lead to the restriction of a service user’s liberty must be fully justified by robust evidence. The Committee therefore asks the Scottish Government to provide further information on the number of occasions on which an emergency detention order has been necessary because of delays in the attendance of a RMO.

103. The Committee also notes the comments from the Mental Welfare Commission that the current use of the power may be being under-reported to the Commission and that the data currently collected was limited. The Committee asks the Scottish Government what steps can be taken to increase the accuracy and detail of the data recorded on nurse holding powers.

\textbf{Time for appeal, referral or disposal}

104. Managers of a hospital have a power to transfer a patient from one hospital to another or to the state hospital. Currently a patient who is notified of an intention to transfer or who has been transferred to the state hospital has 12 weeks to lodge an appeal. Under section 15 of the Bill this period would reduce to 28 days.

105. The Policy Memorandum notes that the current 12-week period has caused significant problems. In cases where an appeal is lodged prior to transfer, the transfer cannot take place until the appeal has been considered, which can result in a delay in a patient’s treatment. This change would also ensure that the appeal process was brought into line with similar appeals in other parts of the 2003 Act.\textsuperscript{84}

106. Colin McKay of the Mental Welfare Commission summed up the factors which needed to be taken into account to establish an appropriate appeal time—
“The balance that we must strike is to allow the person to move quickly to an appropriate care regime, when there is evidence that they really need to be in a different place, while maintaining the right of appeal for long enough to ensure a reasonable chance that the patient will be able to exercise it effectively.”

107. A number of witnesses commented that what was proposed in this provision was a substantial reduction of rights and the reasons for the change needed to be justified. Carolyn Roberts said—

“The argument is that the time for appeal delays treatment that might be required urgently, but we neither understand that nor think that it has any substance. After all, the existing mental health legislation allows the tribunal to order a person to be transferred immediately, pending their appeal.”

108. There was also a lack of support from some witnesses, including the Legal Services Agency Mental Health Representation Project, to the policy objective to bring these types of appeals into line with similar appeals in other parts of the 2003 Act. Cathy Asante argued that the current longer timescale for these appeals was justified, as it reflected the serious consequences of a move to the state hospital and the complexity of cases in which the person was very unwell.

109. One amendment to the provision was proposed by Colin McKay. He suggested that whilst there may be cases where a patient’s transfer is required to enable them to receive appropriate care, concern lay with the loss of the patient’s bed in the establishment in which they had been housed. He told the Committee that there should be a guarantee that the place that the patient had come from would be held until the appeal had been determined.

110. The Committee notes the concerns of witnesses regarding the proposed reduction of the appeal period for people transferred from one hospital to another from 12 weeks to 28 days.

111. As with other provisions in the Bill, there needs to be clear justification that this provision is for the benefit of the patient. The Committee asks the Scottish Government to provide further information on the rationale and evidence which has informed its decision to include this provision in the Bill.

112. The Committee recognises the importance of protecting the patient’s rights. The Committee therefore asks the Scottish Government to respond to the suggestion that there be a guarantee for the patient that, should a transfer take place before the outcome of an appeal has been determined, the place that the patient had come from would be held until the appeal had been determined.
Representation by named persons

113. Sections 18, 19 and 20 of the Bill make provisions about named persons. Currently a person over the age of 16, subject to treatment under the 2003 Act, can nominate a named person to help protect their interests. If a person does not choose a named person then a carer or their nearest relative may become a named person by default.

114. The Policy Memorandum states that “the Scottish Government considers that an individual should only have a named person if they choose to have one” and an individual should give their written and witnessed consent to acting as a named person. The Policy Memorandum also explains that the Bill makes provision for this and also repeals the Tribunal’s power upon application to appoint a named person where no such person exists. The Tribunal retains the power on application to remove a named person where that person is considered to be inappropriate, and where, in such a case the patient is under 16, the Tribunal will be able to appoint another person as the named person.

Opt-in versus opt-out

115. Most witnesses were supportive of the proposed changes to named persons provisions. However there were some areas of concern raised during evidence on this provision.

116. One of the main issues regarded the Bill’s proposals that if an individual had neither nominated a named person nor chosen to opt out, the role reverted back to the person’s primary carer or nearest relative. A view shared by several witnesses, including the Mental Health Tribunal, was that this did not “deliver the Scottish Government’s stated policy objective”, that an individual should only have a named person if they chose to have one.

117. SAMH highlighted its support for the McManus Review recommendation that the default named person role should be abolished. SAMH suggested that concern lay with individuals’ lack of awareness of their rights—

“there will still be a default named person for individuals who do not state that they do not want one. The problem with that is that, as we all know from people’s experience of the 2003 act, people do not have good awareness of their rights…. there is no reason to think that people will be any more aware of that right than they are of any other right.”

118. The Committee received evidence from Karen Martin of the Carers Trust, who argued that the default named person provision should be removed from the Bill. She told the Committee, “I have not met any service users or carers who like the idea.” She explained that it should be the responsibility of the service user to decide whether they wanted a named person and, if they did, who it should be.
119. The Minister responded to concerns regarding the default named person provision—

“...I understand the strong view that has been expressed by stakeholders who have engaged with the Committee that service users should have a named person only if they want one. The Government is generally very supportive of that. Provision has been made for service users to opt out of having a named person.”

120. The Minister appeared to suggest to the Committee that the Scottish Government may reconsider its view on this provision—

“The Government wishes to retain the provision in the best interest of service users, as a form of protection for people who lack capacity. To be fair, however and having reflected on what has been said to the Committee, we have perhaps not struck the right balance, so we will be happy to reconsider the matter.”

121. The Committee notes the Scottish Government’s policy intention that an individual should only have a named person if they choose to have one. However, the Committee believes that as currently drafted ‘the opt out’ approach to provision of a named person may not deliver this policy aim.

122. The Committee recognises the importance of protecting individuals who lack capacity, but notes the possibility that the approach currently proposed in the Bill could result in individuals having a named person whom they do not want or with whom they are not comfortable. The Committee therefore welcomes both the comments from the Minister that the right balance has perhaps not been struck in regard to this provision and the commitment to reconsider the matter. The Committee looks forward to hearing the Scottish Government’s revised proposals and to the possibility of these proposals being taken forward by amendment at stage 2.

Consent to acting as a named person

123. A number of witnesses welcomed the inclusion of the need for consent to being a named person. Joe Morrow believed that it promoted the idea that the individual who is chosen to be the named person has to buy into the process.

124. The Committee received evidence regarding the challenges faced by the individual who chose to be the named person. Gordon McInnes of Mental Health Network highlighted that being a named person was a demanding role which included being effective in a tribunal process and understanding complex medical treatments.

125. Carolyn Roberts believed that the named person needed to be provided with more support to be able to carry out the role. There was also a call from the
126. Another issue raised by witnesses was that there was a need for recognition that, even if a family member or carer of a patient were not the named person, there should still be scope for them to be engaged in the process. Colin McKay told the Committee—

“We need to strike the right balance that allows the nearest and dearest to have a say – particularly when people cannot make the decisions for themselves – but without all the baggage that goes with the named person.”

127. Joe Morrow highlighted the difference a family’s engagement could make to patients’ care and in delivering good outcomes for the patient.

128. The importance of ensuring a role for carers was also emphasised. Carolyn Roberts told the Committee that it agreed with McManus that carers should be given limited automatic rights to ensure that abolishing the default named person role did not reduce carer involvement, which it believed was important. The Mental Welfare Commission called for consideration to be given to carers being granted a right of appeal, particularly if an individual was unable to do it themselves.

129. The Minister discussed the role of carers and next of kin in evidence to the Committee. He said that unless there were exceptional circumstances in which a carer or next of kin should not be involved, they should have a role in the process without being the named person. The Minister explained that currently a tribunal could hear from persons of interest, which would include a carer or next of kin.

Awareness of role of named person

130. A number of witnesses reflected on a low level of general awareness of the role of named persons and highlighted the need to promote and publicise the role of the named person. The Carers Trust Scotland believed that there should be a nationwide publicity campaign to highlight the role of the named person.

131. The Minister, however, told the Committee that the impact of awareness-raising campaigns could be short lived and argued instead that the focus should be placed on raising awareness from the grass-roots level. He told the Committee that the NHS, local authorities and Scottish Government all had a role to play in promoting the use of named persons.

Young people

132. The Carers Trust Scotland, Scottish Independent Advocacy Alliance and the Scottish Young Carers Service Alliance noted their support for the McManus recommendation that young people under the age of 16 who have adequate
understanding of the consequences of appointing a named person should be able to do so.

133. The Minister did not support the proposals for lowering the age at which young people could nominate a named person. He said—

> “Although it is important to allow a young person to express a view on matters that will directly impact on them, it is equally important to protect those who are most vulnerable, and it could be felt that young people are particularly vulnerable in that regard.”[^111]

134. The Committee welcomes and supports the improvements proposed for individuals taking on the role of named person. The role of named person can be a challenging and demanding one. The Committee asks the Scottish Government to consider whether there is scope for provision of further training and information resources for named persons to ensure they are well supported in their role.

135. Whilst families and carers may not wish to take on the role of named person, they can make an important contribution to ensuring the delivery of good outcomes for the patient. The Committee welcomes the comments by the Minister that there should be a role for next of kin and carers who are not named persons. The Committee asks the Scottish Government to consider whether any of the current provisions in the Bill could be strengthened to give individuals in this situation a clearer role in the process.

136. The Committee agrees with the Minister that the NHS, local authorities and Scottish Government all have a role to play in promoting the use of named persons. The Committee asks the Scottish Government to consider whether further guidance can be issued to NHS boards and local authorities regarding how the named person role could be promoted by them.

137. The Committee notes the arguments from a number of witnesses that young people under the age of 16 should be able to nominate a named person. However, the Committee accepts the explanation given by the Minister that, while it is important that a young person be allowed to express a view on matters that will directly affect them, this needs to be balanced with the need to protect those who are most vulnerable. The Committee does not, therefore, support the calls for the right to nominate a named person to be extended to children and young people under the age of 16.

Advance statements

138. Sections 21 and 22 of the Bill relate to the provision of advance statements. An advance statement sets out the way an individual would like to be treated, or not treated, when they are unwell.
139. The Bill would place a duty on health boards to ensure that a copy of an individual’s advance statement is placed in their medical record and that a copy is sent to the Mental Welfare Commission. It would also place a duty on the Commission to maintain a central register of advance statements. Only certain people would be able to have access to the advance statements (the individual, a person acting on the individual’s behalf, a MHO dealing with the individual’s case, the individual’s RMO and the health board responsible for the individual’s treatment).

140. These provisions were broadly welcomed by witnesses, with several commenting on the positive role advance statements could play in ensuring a service user’s greater involvement in their mental health treatment and in improving their outcomes. Dr Jill Stavert of Edinburgh Napier University told the Committee that advance statements were an important form of supported decision making, which was an underlying principle of the 2003 Act.112

Register of advance statements

141. In relation to a central register of advance statements, there were concerns raised regarding balancing the need for access to advance statements and the privacy of the register.

142. Derek Barron told the Committee that there was a potential need for access to advance statements to be available “24/7” but he had a “huge concern” about the proposal for a central repository for advance statements—

“...The NHS in general does not have a fabulous track record of having massive, centralised systems that work in terms of who is allowed to access the data and when they can access it.”113

143. Colin McKay sought to assure the Committee that the Mental Welfare Commission already held sensitive information about patients.114 However, the Scottish Human Rights Commission proposed that people should be able to choose the level of information held on them by the Commission.115

144. A similar point was made by Carolyn Roberts, who raised concerns regarding the inclusion of the entire advance statement in the register.116 SAMH proposed that the register should simply note that a person had made an advance statement, the date on which it had last been updated and where it was kept.117

145. Carolyn Roberts told the Committee if these proposals were not to be adopted, the provisions regarding who could access an advance statement would need to be tightened up. SAMH highlighted that, as drafted, the provisions enabled access to anyone acting on the person’s behalf, as well as their health board. SAMH considered this to be an “incredibly broad provision”.118
Barriers to usage

146. Several witnesses highlighted that, currently, use of advance statements was rare. Colin Fraser of Glasgow City Council told the Committee that in relation to advance statements—

“They are an aspect of the legislation that did not take off as much as people had hoped and anticipated. It is always a bit of a treat when we come across one. We are often asked at tribunals whether there is an advance statements and more often than not, the answer is no. It is an area of work that, perhaps, merits revisiting in terms of guidance and training.”\(^{119}\)

147. Some witnesses, including Colin McKay, told the Committee that the creation of a register of advance statements was “a modest and perfectly sensible provision”.\(^{120}\) However, he questioned whether the provisions would lead to a much greater use of advance statements.

148. The Committee also received evidence regarding the low level of awareness about advance statements amongst service users, next-of-kin, carers and the general public.

149. SAMH noted that in its response to the McManus review, the Scottish Government had undertaken to place a statutory duty on NHS boards and local authorities to promote advance statements. SAMH stated that there was currently no provision in the Bill regarding a statutory duty and it would welcome such an inclusion.\(^{121}\) This suggestion was supported by the Scottish Human Rights Commission, SIAA and Inclusion Scotland.\(^{122}\)

150. Written submissions from the Centre for Mental Health and Incapacity Law, Rights and Policy at Edinburgh Napier University suggested that if there were to be a statutory duty it should be placed on specified medical staff who would be required to discuss with patients the making of an advance statement and to explain the potential effectiveness of such statements as part of the patient’s after care plan.\(^{123}\)

151. In addition to proposals for a statutory duty, the Committee received evidence regarding the ways in which the content of advance statements could be improved to encourage uptake.

152. Derek Barron recommended the inclusion of a pro-forma for advance statements that would incorporate an advisory note and be reviewed annually.\(^{124}\) SAMH suggested that the forms relating to advance statements and named persons could be simplified and combined.\(^{125}\) There was also a request made for advance statements to be more closely aligned to care plans and for them to become a ‘living document’ which could be kept up-to-date.\(^{126}\)
153. The Alliance suggested that research be carried out into the barriers to completing advance statements, the number of advance statements, how many are overturned, and the actions that would encourage take up. Both Colin McKay and Joe Morrow supported proposals for a review of the barriers to usage.

Scottish Government response

154. The Minister told the Committee that the aim of the provision on advance statements was to improve the patient experience. He explained holding the advance statements centrally, would make it easier to access a statement quickly.

155. The Scottish Government told the Committee that it did not have any current plans to undertake research specifically on whether advance statements were underutilised and whether there were barriers to making them. However, he explained that the register of statements held by the Mental Welfare Commission would provide data on the number of advance statements that were made in Scotland and their geographical spread by NHS board. This information would be used to build up a better picture of how widely used advance statements were.

156. The Scottish Government explained that the aim was to raise awareness of the effectiveness of advance statements as a tool “from the grassroots up”. The Scottish Government also explained that the facility to override the advance statement could present a barrier to people considering using them and there was a role to highlight that this only occurred in a small number of cases.

157. The Committee believes that advance statements are a useful tool for ensuring greater involvement of the service user in their mental health treatment. However, they are currently underutilised.

158. The Committee recognises that there are several potential barriers to their usage, including lack of engagement by the service user in the system, concern that the advance statement will be overturned and the quality and currency of the information contained in an advance statement. Whilst the Committee notes the comments from the Scottish Government regarding the importance of raising awareness of advance statements from the grassroots, it notes that there is no direct provision in the Bill to assist with that improvement. The Committee believes that more work needs to be done to promote advance statements amongst service users and professionals and to identify and overcome the barriers to their usage. The Committee recommends that the Scottish Government consider placing a statutory duty on health boards and local authorities to promote advance statements.
159. The Committee supports the comments made by the Minister that a central depository for advance statements will be useful in enabling statements to be accessed more quickly. The Committee recognises that there is a need to balance privacy and confidentiality with ensuring that the advance statement can be accessed when it is required. The Committee seeks further assurances from the Scottish Government on how it will ensure the approach proposed achieves that balance.

Care for a child under the age of one

160. Section 23 of the Bill seeks to extend the scope of Section 24 of the 2003 Act. Section 24 requires health boards to make provision to allow mothers to care for a child under the age of one in hospital where the mother is admitted for treatment for post-natal depression. Section 23 of the Bill seeks to extend this to all women admitted to hospital for any type of mental disorder.

161. This provision was broadly welcomed. The East Lothian Health and Social Care Partnership suggested that consideration should be given to extending support beyond the first year of a child’s life to two years. It noted that the onset of postnatal depression did not always happen immediately after birth and the impact of separation on both mother and child beyond the first year was significant.132

162. As well as suggesting that consideration be given to extending the provision to mothers of older children, the Mental Health Foundation (“the Foundation”) suggested that it should also be extended to fathers. The Foundation commented that it was possible that a father might be the primary caregiver and that the provision should reflect this by referring to parents.133

163. The Committee asks the Scottish Government to respond to the suggestions made in written evidence that the provision allowing mothers to care for their child in hospital should be extended to include fathers and mothers of children aged up to two years old.

Cross-border transfer of patients and dealing with absconding patients

164. The Policy Memorandum states that the objective behind the provisions relating to cross-border transfer of patients and dealing with absconding patients is to ensure parity of treatment for people in other EU member states in respect of cross border transfers and absconding patients from the rest of the UK.134 Currently, should a patient abscond from hospital in another jurisdiction and be taken into custody in Scotland, there is no provision to authorise treatment. The Bill makes provision to allow treatment to be authorised.
165. The Mental Welfare Commission for Scotland, in its written submission, stated that it was content with these provisions. However, the Commission noted that two issues it had raised in response to the Scottish Government’s consultation had not been addressed. The first related to the loss of a right of appeal—

“A patient transferred from, e.g. England may lose a right of appeal because the Act specifies that no appeal can be made within three months of the order being granted. But in this case, the order is granted by reports from two medical practitioners and an approved social worker. There would be an immediate right of appeal to a Tribunal. The right of appeal is lost if the patient is soon transferred to Scotland. The provision in the 2003 Act assumed that the order had been granted by a tribunal in Scotland. We recommend an amendment to the Act or the Cross-Border regulations to allow an earlier appeal to the Tribunal in this situation.”  

135

166. The second issue related to the right of appeal for a named person. The Commission noted that the regulations in respect of removing a patient from Scotland gave a right of appeal to the patient but not to the named person. The Commission considered this to be “an anomaly” as the named person could appeal a decision to transfer a patient between hospitals in Scotland.  

136

167. Some witnesses did not support the provision relation to dealing with absconding patients. This included the Scottish Independent Advocacy Alliance, who were concerned about the treatment of a patient who had absconded, especially if they did not have access to independent advocacy.  

137

168. SAMH was also opposed to the provision, noting that the 2003 Act allowed for emergency treatment to be provided. SAMH commented that—

“The consequences of these powers being extended could be the approval of quite invasive treatment without the individual's consent, something which may be required in their home jurisdiction.[…] Any treatment beyond emergency care requires a proper assessment of whether the individual meets the criteria for compulsory treatment in Scotland: it cannot be assumed that they would do so, simply because they meet the criteria elsewhere”  

138

169. The Committee notes the concerns raised regarding cross-border transfer of patients and dealing with absconding patients. The Committee asks the Scottish Government to respond to these issues and seeks assurances that patients will not be disadvantaged as a result of these provisions.
Mental health disposals in criminal cases

170. Part 2 of the Bill covers mental health disposals in criminal cases. The provision for disposal of people by the criminal courts for people with mental disorders is set out in the Criminal Procedures (Scotland) Act 1995.

171. In cases where an assessment order is made by a court, the period of detention authorised in hospital for examination by an RMO is 28 days. This can be extended for a period of seven days if the court believes that further time is needed to complete the assessment. Under the Bill, this permissible extension time in would change from to seven to 14 days.

172. Currently, time periods for assessment orders, treatment orders, interim compulsion orders, compulsion orders and hospital direction are calculated to include the day on which the order is made and to run to the end of the last day of the relevant period. The Policy Memorandum notes that this approach is different from the calculation of time periods in the criminal courts more generally.\[139\]

173. Section 29 to 33 of the Bill, if passed, would amend the time periods so that they were calculated from the day on which the order was made and run until the day following the expiry of the relevant period. It is hoped by the Scottish Government that this would minimise the number of miscalculations of time periods.\[140\]

174. The State Hospital Board for Scotland considered that the proposed extension was helpful. It noted that aligning the calculation of the start of an assessment order to match criminal proceedings would, it hoped, “prevent the confusion that had arisen to date”.\[141\] The Royal College of Psychiatrists also welcomed the proposed extension.\[142\] However the majority of evidence received by the Committee was not supportive of the provision.

175. The Centre for Mental Health and Incapacity Law, Rights and Policy at Edinburgh Napier University commented that it was questionable whether this amendment was necessary and proportionate.\[143\] The Mental Welfare Commission for Scotland stated that it was “still not convinced that the case has been made for increasing the period of extension form the current 7 day period”.\[144\] SAMH and the Scottish Independent Advocacy Alliance did not support the proposal on the grounds that they believed no justification for the change had been provided.\[145\]

176. The Committee asks the Scottish Government to respond to the comments it received questioning the necessity and justification for the provision which would enable the court to extend an assessment order to 14 days.
Victim Notification Scheme

177. Part 3 of the Bill creates a new notification scheme for victims of mentally disordered offenders, subject to certain orders (hospital direction, transfer for treatment direction or a compulsion order and restriction order)\(^{146}\). As stated in the Policy Memorandum, this brings it into line with the scheme available to victims of other offenders under the Criminal Justice (Scotland) Act 2003.\(^{147}\)

178. The majority of witnesses supported the introduction of the Victim Notification Scheme (VNS) for victims of some Mentally Disordered Offenders (MDOs). Joe Morrow told the Committee that he “greatly welcomed the creation of the VNS” and, as President of the Tribunal service, he had sat on a large number of compulsion and restriction order cases that involved victims, and had been “quite moved by the effectiveness of the process with regard to the involvement of victims at tribunals.”\(^{148}\)

179. Social Work Scotland and Midlothian Council welcomed the changes and, in a view reiterated in many of the written submissions,\(^{149}\) noted that clear guidance would be required on definitions, entry and exit points, roles and responsibilities.

Victim Notification Scheme for victims of mentally disordered offenders subject to certain orders

180. One issue discussed in evidence to the Committee was whether the provision should be extended not only to those subject to a compulsion order with a restriction order but also to patients subject to only a compulsion order.

181. The Mental Health Tribunal commented that it would be preferable if all patients subject to a mental disposal by the criminal courts (i.e. Compulsion Order alone or Compulsion Order and Restriction Order) were subject to the statutory VNS.\(^{150}\)

182. Sarah Crombie of Victim Support Scotland held a similar view and believed that victims should be notified on all occasions on the release of the offender back into the community. She told the Committee that if compulsion orders were included this would bring the scheme into line with Article 6 of the 2012 EU directive establishing minimum standards on the rights, support and protection of victims of crime, as victims of crime would all receive information.\(^{151}\)

183. In contrast, a number of witnesses supported the approach taken in the Bill for exceptions to apply to those subject to the scheme.\(^{152}\) Cathy Asante, for example, highlighted that a person on a compulsion order might have committed only a minor offence.

184. The State Hospital Board also supported the view that compulsion orders alone should not be subject to the scheme, as there was no time limit on compulsion
orders as there was on sentences. It said that this would bring individuals into the VNS who would otherwise not be included had they received a sentence.\textsuperscript{153}

185. The Committee received evidence which emphasised the importance of ensuring that mentally disordered offenders were not discriminated against relative to other offenders. Dr Jill Stavert of Edinburgh University explained to the Committee that, in certain situations, informing a person where the offender lived in a case that involved a minor crime would not be a proportionate response.\textsuperscript{154}

186. Cathy Asante raised a concern regarding the power the Bill would give Scottish Ministers to amend the provision so that it could be applied to people who were subject to compulsion orders only, if Ministers so wished. In light of the concerns raised regarding the VNS applying to those patients, the Scottish Human Rights Commission was not certain why the power was needed.\textsuperscript{155}

**Stigma and potential impact on offender**

187. Colin Fraser suggested that, whilst the majority of people on the MHO Forum in Glasgow were in favour of the introduction of the VNS, those who did not support it raised concerns that there should be “a more nuanced and stratified approach to different types of mental disordered offender”.\textsuperscript{156} Concern lay with the vulnerability of people with mental health difficulties and the risk of them being exposed post-discharge.

188. The Alliance (Health and Social Care Alliance Scotland) raised concerns that these changes would result in the “perpetuation of the stigma that already exists about mentally disordered offenders”.\textsuperscript{157}

189. The Commission noted in its written submission that it was “not persuaded that the Bill yet strikes the right balance in cases where the offender is vulnerable”.\textsuperscript{158}

190. The Commission questioned the provision in section 16A of the Criminal Justice Act 2003, which would allow Scottish Ministers to withhold information relating to offenders who were subject to a compulsion order and a restriction order in ‘exceptional circumstances’. The Commission considered this to be a narrow test and argued that there should be more clarity that Ministers should not release information where there is a significant harm to the mental or physical health to the offender.\textsuperscript{159}

191. Jan Todd of Law Society of Scotland discussed the provision of guidance on exceptional circumstances in which the notification would not be made. She told the Committee that personal circumstance would need to be taken into account “If giving out information was going to endanger someone that might outweigh the need to give victims information.”\textsuperscript{160}
192. Karen Kirk of Legal Service Agency suggested that there needed to be a proportionate response and that if the release of information was likely to have a negative impact on an individual’s care plan and treatment, there should be an opportunity to try to prevent that information from being released.  

193. The Committee welcomes the introduction of a Victim Notification Scheme for victims of MDOs. The Committee recognises that a balance needs to be struck between the rights of the patient and of the victim and it supports the approach taken in the Bill to apply the scheme to victims of MDOs subject to certain orders.

194. The Committee notes concerns raised by SHRC regarding the Ministerial power to amend the provision so that it would apply to people who were subject only to a compulsion order. The Committee asks for further information on why the Scottish Government has included this provision in light of concerns raised by witnesses that this could result in it being applied to a person who had only committed a minor offence.

195. The Committee recognises the importance of ensuring that the VNS would not operate in a way that would discriminate against mentally disordered offenders. The Committee supports the view that the implementation of the scheme would need to be monitored closely. The Committee asks the Scottish Government for further information on how it will monitor the delivery of the scheme, including its uptake and the assessment of whether it has had any impact on an offender’s recovery.

196. In light of the comments made by witnesses on the provision regarding withholding information relating to offenders who were subject to a compulsion order and a restriction order in exceptional circumstances, the Committee seeks further clarification from the Scottish Government on what would constitute ‘exceptional circumstances’.

Other issues

Right of access to advocacy

197. An issue raised repeatedly during the Committee’s evidence sessions was disappointment that the Bill did not include provisions relating to provision of independent advocacy.

198. Emphasis was placed by witnesses on the important role of advocacy in improving people’s experience of the mental health care system. Shaben Begum of Independent Advocacy Alliance told the Committee—
Advocacy has been shown time and again to be a useful vehicle for enabling people to have a better knowledge and understanding of their rights. People are more likely to nominate a named person and have an advance statement if they know about those things in the first place and if they have an advocate who supports them.\(^{162}\)

199. Shaben Begum’s main concern was that access to advocacy was not being implemented in a coherent and consistent way across the country. She told the Committee that, whilst funding for advocacy had fallen, the demand for services was continuing to increase.\(^{163}\)

200. The Mental Welfare Commission for Scotland commented that it was disappointed that the intentions of the 2003 Act in relation to advocacy had not been fully borne out and that advocacy services, where they existed, were often targeted explicitly at supporting people subject to compulsory proceedings.\(^{164}\)

201. The specific issue of carers’ rights to advocacy was raised by Karen Martin of Carers Trust. She believed that if advocacy were to be provided, it would enable carers to feel more confident in having a greater role in supporting a service user.\(^{165}\)

202. Some calls were made by witnesses to strengthen the provisions relating to advocacy in the 2003 Act. The Mental Health Network Greater Glasgow, for example, recommended inclusion in the Bill of duties on health boards and local authorities to provide, monitor and quality check advocacy provision.\(^{166}\)

203. Colin McKay felt that improvements needed to be made to build accountability into the system of advocacy provision—

> “The Government might commit to proper auditing of the availability of advocacy and the performance of local authorities and health services. It might be possible for the legislation to give a steer in that regard.”\(^{167}\)

204. Beth Hall of COSLA supported the call for a better understanding of what the issues were regarding advocacy provision and what was leading to the problems.\(^{168}\)

205. Shaben Begum suggested that the Mental Welfare Commission should have responsibility for monitoring the availability of access to independent advocacy.\(^{169}\)

206. The Minister responded to the comments made by the Committee regarding accountability and advocacy provision. He told the Committee that preliminary discussions had taken place between officials and the Care Inspectorate regarding the possibility of the inspectorate’s programme of audit including a review of how well local authorities were meeting their duty to provide advocacy.\(^{170}\)
207. The Minister also told the Committee that the Scottish Government was working to produce guidance on advocacy for carers, with the aim of launching it next year. The Minister believed that the guidance would be a useful tool in making people more aware of their right to advocacy and the existence of advocacy organisations.  

208. The Committee recognises the importance of advocacy in improving the experience for service users. The Committee received evidence which suggested that the provision of advocacy services across Scotland may be patchy and that services are often required to be targeted at supporting people who are subject to compulsory proceedings. The Committee believes that the benefits of the provision of advocacy services should be felt throughout the system.

209. The Committee believes that whilst the current provision for advocacy is quite strong in the 2003 Act, concern lies with regard to whether the provisions in the 2003 Act are being fully met. The Committee believes that there needs to be more assessment of advocacy services to establish whether there is a need to increase provision and access to independent advocacy.

210. The Committee believes that strengthening the line of accountability may help ensure that local authorities are delivering their duty to provide advocacy services. The Committee notes that assessment of advocacy provision by local authorities could become part of the Care Inspectorate’s review programme and therefore welcomes the comments from the Minister that discussions have taken place regarding this possibility.

211. The Committee also asks the Scottish Government to provide further information on how it will ensure that, in addition to monitoring the provision of advocacy services by local authorities, it will seek to assess advocacy provision in secure settings and hospitals, which lie outside the responsibilities of the Care Inspectorate.

212. The Committee welcomes the Minister’s comments that it is planning to launch guidance on advocacy for carers. The Committee seeks further information from the Scottish Government regarding whether this guidance will seek to strengthen the rights of carers to access independent advocacy.

Learning disabilities, autistic spectrum disorders and wider review of legislation

213. The issue of the inclusion of learning disabilities and autistic spectrum disorders (ASD) in mental health legislation was raised by a number of witnesses and in written submissions to the Committee.
214. Autism Rights and Psychiatric Rights Scotland called for the removal of people with learning disabilities and ASD from mental health law. Inclusion Scotland commented that people with learning disabilities were concerned that they could be subject to compulsory treatment as a result of their learning disability alone.

215. The Committee received powerful testimony from Steve Robertson of People First, which questioned the appropriateness of the way in which people with learning disabilities were considered under current mental health legislation—

>> We honestly believe that the time has come for a new piece of legislation that is just about people with learning disabilities. We think that it is only right and fair that learning disability is properly defined as an intellectual impairment rather than a mental disorder. With that definition, we would want recognition that additional time to learn and support to understand things, together with easy-read documents and support to make some decisions, are what we need. We need those things to help us take part in our communities, rather than restrictions, detentions and efforts to keep us apart from the world that we want to live in”.

216. There was a call made by some witnesses for a wholesale review of mental health and incapacity legislation. Cathy Asante told the Committee that there was a need for consideration to be given to a more extensive review of the Adults with Incapacity (Scotland) Act 2000 and mental health legislation because of new information on and knowledge of neurodevelopmental disorders.

217. The Mental Welfare Commission told the Committee that, whilst the 2003 act and the Adults with Incapacity (Scotland) Act 2000 for a time “genuinely led the world”, there was a need to start thinking about the “next wave” and particularly about supported decision making in future plans.

218. The Minister responded to these issues in evidence to the Committee. He told the Committee that the Scottish Government did not have any current plans to remove people with learning disabilities or autistic spectrum disorders from the scope of the 2003 Act.

219. He explained that if people with learning disabilities and autistic spectrum disorders were removed from the 2003 Act, protective legislation would still be required and their care could potentially be impacted on by four pieces of legislation. He stated that it, “could be argued to create another layer of complexity to what could be felt to be an already complex legislative landscape”.

220. The Minister emphasised that he wished to have an open and on-going dialogue with both the mental health sector and representative organisations on these issues.
221. He also told the Committee the Scottish Government was currently considering the findings of the Scottish Law Commission’s long term review of incapacity legislation and the broader issues of restriction of liberty and capacity.180

222. The Committee notes the comments made in evidence calling for the removal of people with learning disabilities and autism spectrum disorders from mental health law and for further consideration to be given to a review of mental health and incapacity legislation. The Committee recognises that this Bill does not seek to deliver a wholesale review of mental health legislation in Scotland and is not calling for such a review at this time. Nevertheless, the Committee invites the Scottish Government to set out its views on whether a wider review of mental health legislation is required.

223. The Committee believes that an open and on-going dialogue between the Scottish Government the mental health sector and people with learning disabilities and autistic spectrum disorders is vitally important to ensure that individuals’ needs are met.

224. The Committee supports the comments made by the Scottish Government regarding the future development of adults with incapacity legislation and the need to take these issues into account.

225. The Committee notes that no Equality Impact Assessment (EQIA) has been produced to accompany this Bill. The Committee seeks clarification from the Scottish Government regarding why this has not been produced.

The use of force, covert medication and restraint

226. Another issue raised during the Committee’s scrutiny which is not included in the Bill was the call for greater reference to the use of force, restraint or covert medication in legislation and in the 2003 Act’s Code of Practice.

227. Jan Todd of the Law Society told the Committee that there was “not sufficient guidance out there.”181 The Law Society’s written submission explained—

“Any non-consensual treatment must be considered and administered with the 2003 Act’s underlying principles and human rights standards firmly in mind. However, given the potential for Articles 2, 3, 5 and 8 ECHR182 to be engaged in such situations, and taking into account the aforementioned comments on Article 12 CRPD, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.”183

228. Cathy Asante expressed a similar view, suggesting that there was “quite a lot of confusion about use of covert mediation and restraint in practice”. She argued that it would be beneficial for both patients and staff to have a clearer
understanding of the boundaries and legal requirements to protect patient’s rights.184

229. The Committee asks the Scottish Government to respond to the comments made by witnesses for a greater reference to the use of force, restraint or covert medication in legislation and in the 2003 Act’s Code of Practice.

Consideration by other committees

Delegated Powers and Law Reform Committee

230. The Delegated Powers and Law Reform Committee (DPLRC) report on the Bill draws the power in section 45(2) of the Bill to the attention of the Parliament. Section 45(2) inserts new sections into the Criminal Justice (Scotland) Act 2003.

231. The new section 17B affords a person who is to be given information by virtue of the new victim notification scheme a right to make representations before certain decisions are taken in respect of the offender. Those representations must be about how the decision in question might affect the victim or the victim’s family. The new section 17C(2) of the Criminal Justice (Scotland) Act 2003 obliges the Scottish Ministers to issue guidance as to how written representations made under the new section 17B are to be framed and how oral representations are to be made.

232. The DPLRC considers that, as a matter of general principle, where guidance is to be issued, it should be published, and a requirement to publish the guidance should be included on the face of the legislation conferring the power.

233. The DPLRC recommends in its report that section 45(2) be amended at Stage 2 so as to include a requirement that guidance issued under the new section 17C(2) of the Criminal Justice (Scotland) Act 2003 be published.

234. The DPLRC report can be viewed on the Health and Sport Committee website (see Annexe C).

235. The Committee draws the specific recommendation made by the DPLRC for amendment to the Bill to the attention of the Scottish Government.

Finance Committee

236. Scrutiny of the Financial Memorandum for the Bill was undertaken by the Finance Committee. The Finance Committee’s findings are set out in a letter to
237. The letter from the Finance Committee drew attention to the potential impact of the Bill on Mental Health Officers and the related financial implications for local authorities. These issues have been discussed earlier in the report.

Concluding remarks

238. This Bill is not a wholesale review of mental health legislation. It aims to make a number of changes to current practice and procedure to ensure that people with a mental disorder can access effective treatment in good time. Viewed within this context, the Committee found that there was broad support for the Bill’s provisions.

239. The report has, however, identified several issues that have arisen in evidence which require further clarification from the Scottish Government or where the Bill could potentially be strengthened by amendment. Several of these have related to ensuring the Bill delivers on protecting the rights of patients whilst improving administrative efficiency.

240. Overall, the Committee supports the general principles of the Bill and recommends to the Parliament that they be agreed to.
The Mental Health Tribunal for Scotland. Written submission.
The Mental Welfare Commission for Scotland. Written submission.
The Mental Welfare Commission for Scotland. Written submission.
Royal College of Psychiatrists. Written submission.
The Mental Welfare Commission for Scotland. Written submission.
COSLA. Written submission.
Mental Welfare Commission for Scotland. Written submission.
Mental Health Tribunal for Scotland. Written submission.
Law Society of Scotland. Written submission.
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).


The Mental Welfare Commission for Scotland. Written submission.


Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).


Inclusion Scotland, SIAA and SHRC. Written submission.


Legal Services Agency Mental Health Representation Project. Written submission.


Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).

Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).

Mental Health Tribunal for Scotland. Written submission.


Mental Health Network Greater Glasgow. Written submission.


The Carers Trust Scotland. Written submission.


The Scottish Human Rights Commission. Written submission.


SAMH. Written submission.


SAMH. Written submission.

Scottish Human Rights Commission, SIAA and Inclusion Scotland. Written submissions.

Centre for Mental Health and Incapacity Law, Rights and Policy and Edinburgh Napier University. Written submission.


SAMH. Written submission.

The Alliance. Written submission.

East Lothian Health and Social Care Partnership. Written submission.
The Mental Health Foundation. Written submission.
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014))
The Mental Welfare Commission for Scotland. Written submission.
The Mental Welfare Commission for Scotland. Written submission.
Scottish Independent Advocacy Alliance. Written submission.
SAMH. Written submission.
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014))
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014))
The State Hospitals Board for Scotland. Written submission.
Royal College of Psychiatrists in Scotland. Written submission.
Centre for Mental Health and Incapacity Law, Rights and Policy Edinburgh Napier University. Written submission.
Mental Welfare Commission for Scotland. Written submission.
SAMH and Scottish Independent Advocacy Alliance. Written submissions.
Definition of these terms is provided in the Scottish Parliament Information Centre. (2014) Mental Health (Scotland) Bill. SPICE Briefing 14/65 page 7.
Mental Health (Scotland) Bill. Policy Memorandum (SP Bill 53-PM, Session 4 (2014)).
Mental Health Tribunal for Scotland. Written submission.
including the Centre for Mental Health and Incapacity Law, Rights and Policy at Napier University,
The State Hospital Board for Scotland. Written submission.
The Alliance. Written submission.
Mental Welfare Commission for Scotland. Written submission.
Mental Welfare Commission for Scotland. Written submission
Mental Welfare Commission for Scotland. Written submission.
The Mental Health Network Greater Glasgow. Written submission.
Inclusion Scotland. Written submission.
European Convention of Human Rights Article 2 (right to life), Article 3 (prohibition of degrading treatment), Article 5 (the right to liberty and security of person) and Article 8 (respect for private and family life).

Law Society. Written submission.

Annexe A

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence

21st Meeting, 2014 (Session 4), Tuesday 24 June 2014
1. Decision on taking business in private: The Committee agreed to take item 10 in private.
10. Mental Health (Scotland) Bill: The Committee agreed its approach to the scrutiny of the Bill at Stage 1.

Written Evidence
- Mental Welfare Commission for Scotland
- Mental Health Tribunal for Scotland

24th Meeting, 2014 (Session 4), Tuesday 30 September 2014
Mental Health (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Dr Joe Morrow, President, Mental Health Tribunal for Scotland;

Written Evidence
- Glasgow City Council Social Work Services
- British Psychological Society
- Royal College of Psychiatrists in Scotland
- The Royal College of General Practitioners Scotland
- Social Work Scotland

26th Meeting, 2014 (Session 4), Tuesday 7 October 2014
Mental Health (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Colin Fraser, Mental Health Officer, Glasgow City Council Social Work Services;
Beth Hall, Policy Manager, Health and Social Care Team, COSLA;
Dr John Gillies, Chair, RCGP Scotland
Dr Ruth Stocks, Chair, British Psychological Society Division of Clinical Psychology Scotland, British Psychological Society;
Dr John Crichton, Chair, Faculty of Forensic Psychiatry, Royal College of Psychiatrists in Scotland;  
Derek Barron, Chair, Mental Health Nursing Forum Scotland (Royal College of Nursing Scotland)  
Karin Campbell, Chair (Principal Mental Health Officer, Highland Council), Social Work Scotland Mental Health.

Supplementary Written Evidence

COSLA

Written Evidence

Mental Health Network Greater Glasgow  
The ALLIANCE  
Carers Trust Scotland  
SAMH  
The Scottish Independent Advocacy Alliance  
Inclusion Scotland

Late Submission

People First (Scotland)

29th Meeting, 2014 (Session 4), Tuesday 11 November 2014
Mental Health (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—  
Gordon McInnes, Development Worker, Mental Health Network Greater Glasgow;  
Andrew Strong, Policy and Information Manager, Health and Social Care Alliance Scotland (the ALLIANCE);  
Karen Martin, Mental Health Development Coordinator, Carers Trust Scotland;  
Carolyn Roberts, Head of Policy and Campaigns, SAMH;  
Shaben Begum, Director, Scottish Independent Advocacy Alliance;  
Sue Kelly, Outreach and Development Officer, Inclusion Scotland;  
Steven Robertson, Chair, People First.

Written Evidence

Victim Support Scotland  
Legal Services Agency Mental Health Representation Project  
Scottish Human Rights Commission  
The Faculty of Advocates  
The Law Society of Scotland  
Centre for Mental Health and Incapacity Law, Rights and Policy Edinburgh Napier University)
Supplementary Written Evidence

Victim Support Scotland

30th Meeting, 2014 (Session 4), Tuesday 18 November 2014
Mental Health (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Sarah Crombie, Acting Director of Corporate Services, Victim Support Scotland;
Karen Kirk, Solicitor Advocate, Partner, Legal Services Agency;
Kenneth Campbell QC, Faculty of Advocates;
Cathy Asante, Legal Officer – Human Rights Based Approach, Scottish Human Rights Commission;
Dr Jill Stavert, Reader in Law and Director, Centre for Mental Health and Incapacity Law, Rights and Policy, Edinburgh Napier University;
Jan Todd, Solicitor, Law Society of Scotland.

Supplementary Written Evidence

Scottish Government

32nd Meeting, 2014 (Session 4), Tuesday 2 December 2014
Mental Health (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Jamie Hepburn, Minister for Sport and Health Improvement, Penny Curtis, Acting Head of Mental Health and Protection of Rights Division, Carol Sibbald, Mental Health (Scotland) Bill Team Leader, and Stephanie Virlogeux, Solicitor, Legal Directorate, Scottish Government.

1st Meeting, 2015 (Session 4), Tuesday 13 January 2015
1. Decision on taking business in private: The Committee agreed to take items 5, considering the main themes arising from the oral evidence heard and a draft report on the Assisted Suicide (Scotland) Bill, in private and in private at future meetings. The Committee also agreed to take item 6, a draft Stage 1 report on the Mental Health (Scotland) Bill, in private and in private at future meetings.

6. Mental Health (Scotland) Bill (in private): The Committee agreed to defer consideration of a draft report to its next meeting.

2nd Meeting, 2015 (Session 4), Tuesday 20 January 2015
Mental Health (Scotland) Bill (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its meeting on 27 January.

3rd Meeting, 2015 (Session 4), Tuesday 27 January 2015
Mental Health (Scotland) Bill (in private): The Committee considered a revised draft Stage 1 report. Various changes were agreed to, and the report was agreed for publication.
List of other written evidence

- ADSW Mental Health Sub Group
- Autism Rights
- Barnardo’s Scotland and NSPCC Scotland
- The College of Occupational Therapists
- Dr Andrew Watson (Individual)
- East Lothian Health and Social Care Partnership
- East Renfrewshire Community Health and Care Partnership
- Fife Council Social Work Service
- The Forensic Mental Health Services Managed Care Network
- Maurice Frank (Individual)
- General Medical Council
- Glasgow Caledonian University School of Health and Life Sciences
- Greater Glasgow and Clyde Area Psychology Committee
- Professor David Healy
- Mental Health Foundation
- Midlothian Council
- NHS Forth Valley
- NHS Greater Glasgow and Clyde
- North Ayrshire Health and Social Care Partnership
- North Lanarkshire Mental Health and Learning Disability Partnership Board
- Police Scotland
- Psychiatric Rights Scotland
- The Royal College of General Practitioners Scotland
- Scottish Ambulance Service
- Scottish Disability Equality Forum
- Scottish Tribunals & Administrative Justice Advisory Committee (STAJAC)
- South Lanarkshire Council
- The State Hospitals Board for Scotland
- Tom Todd (Individual)
- Together (Scottish Alliance for Children’s Rights)
- Patricia Whalley (Individual)
- W. Hunter Watson

Late Submissions
- Walter Buchanan
- A Burns
- Mrs Judith Gilliland
- Anne Greig
- Thomas Leonard - The Edinburgh Equality Collective Advocacy Forum
- Claire Muir (3 October 2014)
Claire Muir (20 October 2014)
Lesley D McDade - Individual
Chrys Muirhead (17 October 2014)
Chrys Muirhead (28 October 2014)
Edwin Zarthurusz
W Hunter Watson (3 October 2014)
W Hunter Watson (15 October 2014)
W. Hunter Watson (22 October 2014)
W.Hunter Watson (26 October 2014)
W.Hunter Watson (7 November 2014)
W.Hunter Watson (18 November 2014)
W.Hunter Watson (25 November 2014)
Annexe B

Letter from the Finance Committee, Report from the Delegated Powers and Law Reform Committee

Letter from the Finance Committee

The Finance Committee letter on the Mental Health (Scotland) Bill: Financial Memorandum can be found on the Scottish Parliament’s website at the following webpage:

http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/Letter_to_lead_cttee_on_Mental_Health_FM.pdf

Report from the Delegated Powers and Law Reform Committee

The Delegated Powers and Law Reform Committee report on the Mental Health (Scotland) Bill can be found on the Scottish Parliament's website at the following webpage:

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/82974.aspx
Mental Health (Scotland) Bill: Stage 1

10:37

The Convener: Item 2 is stage 1 scrutiny of the Mental Health (Scotland) Bill. We have one panel of witnesses. I welcome Dr Joe Morrow, president, Mental Health Tribunal for Scotland, and Mr Colin McKay, chief executive, Mental Welfare Commission for Scotland.

I offer you both the opportunity to make some introductory remarks, after which we will move directly to questions. Do you need to toss a coin to see who goes first?

Colin McKay (Mental Welfare Commission for Scotland): I will kick off, although I have not prepared anything.

Thank you very much for inviting us to give evidence. I make it clear that the tribunal, which is a statutory body, authorises and makes decisions on measures of compulsion. The commission does not make decisions on detention, so Dr Morrow will be much better placed to tell you about the detail of how some of the compulsory treatment processes operate in practice. The commission monitors the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and have information to give you on how the act is working.

The commission also visits people who are subject to compulsion under the act. Where we have concerns about people’s welfare, we investigate those. We also publish guidance and advice on the operation of the act, particularly around ensuring that it properly balances the ethical, medical and legal issues that need to be taken into account when decisions are made about care and treatment. We have a particular responsibility for ensuring that the Millan principles are promoted and upheld in the operation of the act.

Briefly, the commission’s general take on the bill is that, as the Government has made clear, it is relatively modest. It is helpful as far as it goes, and it has a number of provisions that will improve the efficiency and operation of mental health legislation.

We have one or two general points. First, the Millan report was a visionary report but it was also carefully balanced between the protection of people who are subject to compulsory treatment and the important principle of ensuring that people do not have to be detained or sectioned in order to get the care and treatment that they require. Millan was greatly exercised by that; we cannot have a situation in which, in order for people to get a gold
standard of care or even an acceptable standard of care, doctors have to force them to be detained. There are important aspects of the Milan report and the 2003 act in relation to voluntary care, particularly the duties on local authorities in sections 25 to 27 and the duties to promote advocacy. We have concerns about whether those duties, which are quite strong and powerful and are very much part of the scheme in the act, are being fully fulfilled in practice. Some of the other evidence that the committee has received tends to support that point. There is a general anxiety that some of the aspirations of the 2003 act are not being fully met.

However, we also recognise that local authorities are under great pressure; mental health officers in particular are under pressure both from the increasing use of the 2003 act and from the use of the adults with incapacity regime.

Although we do not have any huge concerns in principle about the way in which the bill increases the duties on MHOs, we have real concerns that, unless the Government invests in some kind of strategic review of the provision of MHOs, it will not be possible for the protections in legislation to work effectively. It is important to remember in that context that 44 per cent of compulsory treatment orders are now carried out in the community so the role of local authorities is increasingly important.

Although, in general, we think that the bill is good and helpful, we have concerns about a number of areas where timescales are being extended. We are sometimes not entirely sure of the justification for extending timescales for statutory bodies to do certain things, whereas some of the timescales in relation to patients and their rights are being contracted. We hope that the committee will examine those provisions very closely.

There has been quite a long delay in sorting out issues around excessive security. The bill seems to be taking a step back and saying, “Let’s start again and try to get it right this time.” That may be technically the correct approach, but we will be looking for some clarity and some clear timescales around improving appeal rights in relation to excessive security.

It is important that you look at the bill’s delivery of the McManus recommendations. In the context of the wider implementation of McManus, the bill has a modest and perfectly sensible provision to create a register of advance statements in the hope that that will help to promote the use of advance statements. We strongly believe that there should be a much greater use of advance statements, but that will not happen just as a result of that measure. There needs to be a concerted look at the barriers and at why people do not use advance statements. Service users need to be helped to use them, and there needs to be an advance in relation to the extent to which they have increasing control and the ability to negotiate and participate in decisions that affect them, even if they have an impaired level of capacity or understanding.

Dr Joe Morrow (Mental Health Tribunal for Scotland): Convener, I can give an opening statement if you want me to, but I am very keen that we get on to questions from committee members on areas of interest to them.

I will be very brief. The tribunal exists to administer justice in this arena. Throughout my presidency of the tribunal, the focus has been on the patient and on their participation. Those are often referred to as the Millan principles.

I think that the bill is generally a good thing. According to its policy objectives, it seeks to improve the efficiency and effectiveness of Scotland’s mental health system, and I think that some of the amendments that it makes will make the legislative framework much more efficient and effective and hence much more focused on assisting the patient in the process. It also makes a number of technical amendments that, as far as those of us who have to deal with certain technical legislative issues are concerned, are long overdue and are therefore welcome.

10:45

I also greatly welcome the creation of the victim notification scheme. As president, I sit on a large number of compulsion and restriction order cases that involve victims, and I have been quite moved by the effectiveness of the process with regard to the involvement of victims at tribunals. It has certainly been significant in providing a humane system of mental health law and, as such, I greatly welcome the creation of the scheme.

I am sure that the committee understands this, but I want to explain why we support the extension of the period of detention beyond the expiry of a short-term detention certificate from five to 10 days. I know that there are a number of views about this issue, which initially arose out of the number of duplicate hearings that it took to reach a decision. That was a serious issue for the tribunal that I have worked away at, and it has now been eradicated. However, the tribunal supports the extension to 10 days to give the patient and named person more time to prepare. A patient will often receive an application for a compulsory treatment order at the end of a short-term detention, after which they have five days to instruct a solicitor, put an advocate in place and arrive prepared at the hearing. In many cases, it is
day 3 by the time that the named person, who is a very significant protection in the system, is engaged, and hearings are often put off to allow the patient and named person to prepare.

I will continue to work to improve the situation in relation to multiple hearings. At one stage, and for a variety of reasons, we were down to only 20 per cent of cases going to a second hearing. However, we have evidence to suggest that a wee bit more time will allow more mature thinking to be carried out with the patient, solicitors and advocates to be instructed and the named person to get involved.

It has been suggested to me that there is no need for such a measure, because the tribunal has done such a good job in getting the number of multiple hearings down. That is not where I am coming from; I believe that that is a separate issue. I am committed to the efficiency and effectiveness of the administration of justice in the tribunal, and I will continue to progress that as part of our improvement mode, which focuses on the patient. Our support for the extension from five to 10 days is really to help us focus on the patient’s involvement.

We also need to bear in mind that, until they get through the tribunal, the patient is mentally disordered—after all, having to appear before the tribunal is stressful for them as well as for their carer or named person—and having a wee bit more time for consideration will allow us to support the process. I am in the committee’s hands, but I have said regularly that this is not about making the tribunal more efficient; it is about giving the patient time. That is generally where we are with regard to the bill.

I never know what to say about these things, but it is about time that the 2003 act was tidied up. Given the amount of practice and development that has happened under that legislation, we need to focus on tidying things up, and in that respect I welcome the bill.

The Convener: Thank you both. We now go to questions.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Can I ask a specific question and then a general one, or would you rather that I stuck to the general one at this point?

The Convener: Just proceed, Richard.

Dr Simpson: I want to clarify an issue that Dr Morrow has just raised. Do you feel that the proposed powers in the bill actually give the named person, carer or independent advocate the power to seek an extension to 10 days? Who will be able to seek that extension? Is it a tribunal? Is it the responsible medical officer? I am much more comfortable with the principles that you have laid out, but I want the bill to be clear that it is for the named person, carer or independent advocate to request more time.

Dr Morrow: The 10-day period will be set out in law, so the bill will allow for a period in which to put into place everything that you are talking about. I would intend to intimate the hearing as soon as practicably possible. That would involve a wee bit of work with the patient, the patient’s advocate and the named person, so that we do not end up a day short, with everybody lined up, but then having to put off the hearing for a further period.

I welcome the idea in the bill that such a period could come off any other period of detention. I have no desire for a patient to be detained for any longer than necessary. There are suggestions that the time could come off the overall period of detention or any interim period.

There is a difficulty under the current legislation. If we have to put off a hearing, we are allowed to do so for up to 56 days over two periods. Those are called interim orders. That can radically extend the period of detention, simply because we are not at a stage of preparedness in relation to the named person or the patient.

Dr Simpson: It is your anticipation that, if we get the bill right, the use of interim orders to take things forward would reduce. There would be a more definitive result, either to detain or not to detain.

Dr Morrow: Yes. It goes back to the old mantra used by the Ministry of Justice: right first time. We are talking about a different setting but when we are dealing with the suspension of the liberty of a person with a mental disorder and with forcible medical treatment, which must be at the highest end of any state intervention, we must do that as quickly as possible, without dragging it out any longer than necessary.

The Convener: I invite committee members to ask supplantaries strictly on this issue, which concerns the tribunal, so that we can then move on. Are members satisfied that it has been explored and that we now have good evidence?

Dr Simpson: Perhaps Mr McKay could comment. The MWC’s submission included a bit about the matter.

Colin McKay: We took a slightly different but balanced view in our response. We recognise and very much agree with the wish to reduce the number of interim and repeat hearings, which we know to be extremely distressing for the patient and the family. The more hearings there are, the more likely the patient is to disengage from the whole process.

We are more persuaded of the argument that, if the extension allows the service user or patient to
prepare and to get legal advice and a medical opinion so that the matter can be dealt with at the first hearing, that is a good thing.

Against that, we have some nervousness about the proposed 10-day extension being automatic. I have great faith in Dr Morrow and his administration of the tribunal, but there is always a risk that, in practice, when timescales are stretched out, people will start to work to those new timescales. Effectively, the extension would be for everybody, so it could be quite a long time before a decision to detain someone and potentially to give them forcible and compulsory treatment was reviewed.

If Parliament decides to provide for the extension, we would like some commitment to ensuring the good outcome that we want, which is that far fewer interim hearings happen—and possibly a provision whereby, if that does not happen or if it turns out that there are other negative consequences, the measure could be scaled back again. There might be ways to allow the timescale to be reduced by order.

At the moment, we are not sure that the case is yet proved. I do not know whether the committee is taking evidence from some of the legal bodies that have responded, such as the Law Society or the Legal Services Agency's mental health representation project, but it might wish to do so. It is interesting that those organisations have said that they do not welcome the proposed powers, although if the powers are intended to give such organisations more time, I would think that they would welcome them. It would be interesting to test their views on that.

Dr Simpson: I should have declared my connections with psychiatry and the Scottish Association for Mental Health. SAMH has proposed a sunset clause that might satisfy Colin McKay and the Mental Welfare Commission. If we try out the suggestion but include a sunset clause, that might be a reasonable way to proceed, because there would be a review by Parliament.

Colin McKay: That would make sure that the things that we want to achieve happen and the things that we do not want to achieve do not happen, and that would be helpful.

Dr Morrow: There is absolutely no evidence that the tribunal’s practice has ever been to delay dealing with a case that could be moved forward.

On the issue of increasing the extension period to 10 days, I would almost give the committee a commitment that I will work extremely hard and focus on making sure that a decision is delivered for the patient as soon as possible. The tribunal’s results in reducing the number of multiple hearings, interim hearings or adjournments during the past six years have been radical. I am committed to that, not for some kind of structural or legal reason but because it is the best practice that I can provide in administering the justice system for a mentally disordered patient who appears before the tribunal.

All the fears and the anxieties that people talk about are not evidenced by the tribunal’s current practice. I want to assure the committee that it is not about making things more comfortable for the tribunal; it is about getting the procedure right for patients. That is why I support having a 10-day extension.

The Convener: Bob Doris has a final supplementary on this point before we move on.

Bob Doris (Glasgow) (SNP): I have lots of very brief little questions. I am sympathetic to the proposals, but there are one or two things that I want to check. For example, for someone on a short-term certificate, a five-day extension is permissible after 23 days. After that time, is it usually pretty clear whether you want to apply another form of order?

What is it about 28 days in the first place? If someone is going to go to a tribunal for a more meaningful extension or a decision on what a disposal should be, surely mental health professionals should have a pretty good idea after 23 days. If mental health professionals already have that information after 23 days or, in some cases, after 18 days, does it become quite clear to them that an extension will be required? I am just trying to get beneath the numbers. It would be helpful to know why it is 28 days in the first place.

Dr Morrow: I cannot answer that, but Colin McKay might be able to. The 28-day period is what is in the legislation. I can tell you about the practicalities, which are that we start getting the applications in for compulsory treatment orders between day 23 and day 28. That is just a matter of practice, but it does not apply to every case. Sometimes the applications come in much earlier and sometimes they come in right at the end of the 28-day period. When I have attempted to find some reasons for that, the medical people have told me that it is about the assessment process. They require the time to do a proper medical assessment and they have suggested to me—although it is not really a rule if that is what Bob Doris is looking for—that approximately three weeks is necessary to do an initial assessment and it is in that fourth week, which is day 21 to day 28, that the discussions with the multidisciplinary team are held about whether to continue towards a compulsory treatment order.

11:00

Colin McKay: I would generally reinforce that. I should also say that, like Joe Morrow, I have a
legal background rather than a medical one, so you might want to ask the medical people who give evidence to you. However, what he said is also my general understanding. It will vary. Obviously, some people may be in recurrently and, if the patient is known, it will become clear much earlier what is going on and that their situation has deteriorated and they are going to need a longer-term stay. Often, though, it will take about three weeks or so just to get a sense of whether the patient will require a CTO. Very many orders will not go beyond the 28 days of the short-term order.

The time was 28 days in the Mental Health (Scotland) Act 1960 and the Mental Health (Scotland) Act 1984, so it is a long-standing period that is deemed enough time in which to make an assessment. What is more challenging now is that the tribunal requires a more detailed proposition to be put to it than the old sheriff court did back before the 2003 act was passed. We recognise that there are quite a lot of pressures on both sides to get this stuff ready at the end of the 28-day period.

Bob Doris: That is helpful, because we have a bit of agreement between the witnesses that the 28 days has not been plucked out of thin air but is based on practice that has been built up over the years regarding what is needed. The other figure that Dr Morrow gave was that 80 per cent of hearings do not lead to a duplicate hearing or multiple hearings.

Dr Morrow: That was for one good month. In fact, between 20 and 30 per cent each month go to a second hearing, but the figure for the best month that we have had was 20 per cent.

Bob Doris: The best month had 20 per cent, but the figure is on average between 20 and 30 per cent, depending on whether it is a good or bad month.

Dr Morrow: Yes.

Bob Doris: Therefore, for the vast majority of cases—the 70 to 80 per cent of hearings that do not require a duplicate hearing—are you content that the families and named persons have a full opportunity in the absence of a second hearing to make their views known?

Dr Morrow: I would not say that I was completely content, because in fact I do not know the answer to that question. I do not personally hear every case, but I know that every process possible is put in place to engage with families and named persons. Some named persons who are automatically appointed because of their relationship with the patient do not really want to be the named person, so they may not engage, and sometimes the patient does not want to have a named person.

From my personal experience, though, I can tell you that, in the cases that I hear, I am content that the families and the named persons who come before me have often had an opportunity to engage with the process.

Bob Doris: The point is that they have had the opportunity. You cannot force them to engage in the process, but in the 70 to 80 per cent of cases in question the families and named persons have had a clear opportunity to engage.

Dr Morrow: Yes. I should explain to you, though, that not all our cases are on short timescales; it is only the compulsory treatment order cases at an initial stage that are on short timescales. About 50 per cent of our cases are what are commonly called two-year reviews, so they have a much longer lead-in and people are often in a settled position, which allows much more time to engage with families and named persons. It also means that professionals may have been working with carers and named persons for a much longer time.

It is only the cases that go from short-term detention to compulsory treatment orders that have a short timescale. It is the only real timescale that we have in the legislation, and it is that group that we are trying to tackle with the extension. I do not like talking generally, but that is the group of patients who are often most unwell, so there is a difficulty there.

Bob Doris: Thank you.

Richard Lyle (Central Scotland) (SNP): Mr McKay, in your opening remarks you touched on the point that I want to question you on. I would welcome Dr Morrow’s viewpoint on this also.

Section 2 will insert a new section into the 2003 act that sets out new duties for mental health officers, including submitting a written report to the tribunal when the tribunal is required to review a determination about compulsory treatment. The Mental Welfare Commission noted that it “would be concerned if large numbers of additional MHO reports were required”.

What is the commission’s estimate of the number of additional reports that would be required? What concerns do you have about the workforce and about the capacity of MHOs to do those reports? What is the Mental Health Tribunal’s viewpoint?

Colin McKay: In principle, we would love mental health officers’ reports all the time, but the reality is that those officers have other things to do. Mental health officers are social workers and have other important duties, so we sometimes have to balance the wish for MHO involvement with the practicalities of that.
Our difficulty with the figures is that we cannot quite reconcile what is in the policy memorandum with what is in the bill. The suggestion that there would be only a few reports seems to relate particularly to cases in which an MHO disagrees with the RMO. In those cases, we agree that the MHO should say why they disagree with the RMO, but that would be in a very small number of cases. However, the bill seems to suggest that two-year review cases would also require an MHO report. Again, in principle, we have no problem with that, but we think that there would be about 500 cases a year, which would place increasing pressures on MHOs.

I will say a little about those pressures, many of which arise not just from the 2003 act but from the Adults with Incapacity (Scotland) Act 2000. In the next few days, we will publish our statistics from monitoring that act, which show that there has been a pretty consistent year-on-year rise in the use of guardianship applications under it. With such applications, mental health officers have duties to prepare reports and supervise guardians. The numbers are startling, with local authorities reporting fairly long delays in the preparation of reports for private guardianship cases.

In the next few days, we will publish our statistics on the use of the 2003 act. Over time, there has been a substantial decrease in, for example, the number of social circumstances reports that are prepared where a short-term detention is sought. We do not think that a social circumstance report has to be produced in every case but in Glasgow, for example, the proportion of cases in which a social circumstances report is prepared is now down to 14 per cent. There has also been a 5 per cent fall in the number of cases of emergency detention where an MHO has consented, as ideally they should.

Our worry is that the system has already started to come apart at the seams a bit. We have said that, actually, the issue is not so much about the provision in the bill but about the Government looking at the workforce strategy for recruitment and retention of MHOs. The Government needs to get serious about finding a way to ensure that we have the necessary degree of MHO cover for the 2003 act to work effectively.

Richard Lyle: Dr Morrow, do you know offhand whether any tribunals have not been able to go ahead because reports have not been submitted timeously?

Dr Morrow: You might allow me to say that I think that the MHOs are the stars of the mental health tribunal system. I get teased for saying that by lots of professionals who think that I am sweeter than I actually am, but we could not work without them—they are the ones who co-ordinate and make a whole lot of things happen. After this meeting, I am going to speak to MHOs in Polmont college, and I will tell them that. Until the day I retire, I will get up and tell MHOs that they are the stars of the system, because they hold it all together. They also bring a dimension that is essential for us if we are to understand the context in which we detain people.

In general, if we have no report, we often have the MHO before us to give oral evidence. The MHOs are committed to turning up at tribunals. We have very little non-attendance, and the reason for it is often to do with holidays or other reasons why any of us would not attend something. MHOs also provide reports for the tribunals.

Although MHOs have distinct and independent functions in the tribunal, they participate in the multidisciplinary teams, so they have often already contributed to the annual report, the annual review or the statement that has come before the tribunal. In general terms, from the tribunal's point of view, we have an effective system and provision from the MHOs. Moving out of the tribunal setting, and bearing in mind that we are just set up for that judicial purpose, I recognise the pressures that Colin McKay has referred to with regard to the Adults with Incapacity (Scotland) Act 2000 and the work that is done in that respect by MHOs.

Colin McKay: Another set of helpful data that has just been published—it has just been produced by the Scottish Social Services Council—is the Scottish social services workforce data. Among the statistics that it reports are that the number of practising MHOs decreased by 3.4 per cent last year; a third of MHOs are 55 or older—the workforce is therefore ageing; and the number of MHOs on out-of-hours rota duty is at an all-time low. Perhaps that is something to do with issues around emergency detentions, which will often happen in the middle of the night. There appear to be difficulties sometimes in accessing MHOs in such cases.

Richard Lyle: I have said many times before that I previously worked with an out-of-hours doctor service. There were two occasions when we had to wait for a mental health officer to attend while they were on standby. They took a couple of hours to come along. Is the system or the service under pressure at the moment?

Colin McKay: Yes, and I think that we have said that it is under pressure. It is not collapsing, but it is under severe strain. Local authorities have to balance statutory duties that have very strict timescales with other things that they would like to do but which they often cannot do. We think that the whole system needs to be looked at.

It is not just about money; there are issues around what training people need to do to be an
MHO, how they are recruited, and how they are incentivised to want to be an MHO. There are quite a lot of meat-and-potatoes workforce issues that need to be looked at to make it attractive for social work professionals to want to become an MHO and to ensure that they are able to do an effective job when they are in post.

Richard Lyle: Finally, are we doing enough to attract people to the profession?

Colin McKay: To the social work profession?

Richard Lyle: Yes—or to become an MHO.

Colin McKay: I suspect not. Choosing to become an MHO is quite a commitment. The training requirements are quite extensive, and the option is not necessarily a huge boost to people’s careers or salary prospects. Some local authorities have the concern that, if they invest in MHO recruitment, the MHOs will then go and work for another local authority once they have been recruited. There are many practical issues around making the option attractive, and I think that it is probably not an attractive enough option at the moment.

Rhoda Grant (Highlands and Islands) (Lab): I will ask a short question on the back of that. You talked about MHOs and the increase in the time that a nurse can detain somebody for before an MHO is present. I cover the Highlands and Islands, which includes many small islands. Is there sufficient time in the legislation for a nurse to detain if there is a shortage of MHOs? How quickly can we physically get someone there?

Colin McKay: That is a tricky question, because again I suppose that two desirable things are being balanced. On the one hand, the period that the nurse holds a patient for before a decision about detention is made should be as short as possible; on the other hand, ideally we would want both the doctor and the mental health officer there.

As you will know, the power at the moment is to hold for two hours. If the doctor arrives within two hours, the person can be detained for a further hour while the doctor makes an assessment and a decision.

The bill proposes that three hours would be the new time limit. The Mental Welfare Commission has said that, on balance, we do not support that, because we think that it is potentially quite distressing for everybody if a nurse is physically holding a person until a doctor can come and examine them. While we recognise that it would be good if, across the piece, more MHOs came out, we are not sure that just extending the two-hour limit to three hours would make a difference. In some cases, the MHOs are never going to come out anyway, because they are not available.

On balance, we would not support extending the time limits. The evidence is that doctors can attend, even in remote areas; there does not seem to be a huge concern that doctors cannot make it within the two hours. We would want MHOs to be able to make it to an assessment, too, and there may be changes that can be made to systems, including on-call systems, to help that. However, we do not support extending the time period simply in the hope that that would increase the number of MHOs participating in such cases because we think that those numbers will probably be limited.

Rhoda Grant: In a lot of rural and remote areas, including Harris and many other islands, nurses are providing out-of-hours care, with no general practitioners on call at any point.

Colin McKay: The nurses’ holding power would typically be used when people are in-patients. The issue is about when a person says, “I’m not staying here—I’m going”, and the nurse responds, “You’ll have to wait here until a doctor comes to examine you, because we think you’re not well enough to go out on your own.” That is a slightly different situation from nurses providing care in the community. I am not sure how often they would use the nurses’ holding power, if that is the situation that you are describing.

Rhoda Grant: Okay. My main question is about the named person. There are concerns about the position under the 2003 act if someone has not stated their decision not to have a named person or if the appointment of a named person is causing a problem. Families and carers are concerned that they may not be involved because the person does not want them to have access to their medical records, which is a fair enough comment. How do we balance all those needs while ensuring that we get it right for the patient?

Colin McKay: Dr Morrow will be able to say much more about how that operates in the hearings system. However, our general position is that we are broadly supportive of what McManus said: people should choose to have a named person. That carries with it the need to pass a significant amount of information to that person.

We are about to produce a report on the operation of the named person system; we will share that with the committee when it is published in the next few days. Generally, we find that, for a lot of relatives, the experience is confusing and distressing; sometimes, the first that they hear about the named person role is when a bundle of papers comes through the letterbox with information that can be personal and, as I said, distressing.
We agree that the system is not working. We should probably move towards a situation whereby if a person wants a named person, they should have one and we should do much more to explain to the patient and, indeed, to the named person, what the role involves and how they can participate effectively in a hearing. That takes us back to the importance of the role of the mental health officer in liaising with the family, as well as their advocacy role.

Although we generally support that, we worry about carers and families, particularly where the person may be so unwell that they are not able to say what they want or whether they want to appeal. There are provisions under which carers and family members can participate in the tribunal, although they do not have, for example, the formal rights to appeal that a named person has.

Evidence from carers organisations has suggested that carers should have a right of appeal, particularly if a person is not able to do so themselves. There is perhaps something in that—if we are to take away the named person role, the legislation might need to do more to allow carers and family members to step into the patient’s shoes where the patient is too unwell to make such decisions.

**Dr Morrow:** It has been fairly well established that if the family and carers can be integrated and can participate, the overall outcome for a patient in a tribunal setting is better.

As many of you will remember, the Mental Health (Scotland) Act 1984 set out a special role for the primary carer, and the introduction of the named person in the 2003 act sort of developed that role. The difficulties that have emerged relate to the patient’s having no say in who the named person is; the automatic legal procedure is that you work through their relatives, one of whom becomes the named person. The patient has no say in that; indeed, the named person themselves might not have any say, other than to say no.

In such situations, there might be highly sensitive material kicking around a tribunal setting that it might or might not be of assistance to share with family members who are named persons; whatever the case, we are obliged to serve that material to the parties. The new provisions allow for much more proactive engagement by the patient in the choosing of the named person, and promote the idea that the individual who is so chosen has to buy into the process.

Let me just talk personally about this matter. My mother had a long-term mental disorder, and under the old system I was her primary carer. As a young man, I simply did not want to receive the material that I received. I did not want to know those things about my mum. I knew that she required care and that she required me to be engaged in the process, but I have to say that, as a young 20-something at the time, I was not experienced enough to understand what the detail meant. Indeed, the roles could be reversed; if the patient were a son or daughter and the named person their mother or father, the son or daughter might not want the mum and dad to know such detail. At the moment, there is almost a compulsion to send out such material, and I am not sure that it leads to the best relationship for getting families and carers engaged in the process. As a result, I feel that the proposals will wise up the system, respond to what the patient and named person say and result in much more buy-in.

**Dr Morrow:** That is the bit that I find hard. I am not sure that it leads to the best relationship for getting families and carers engaged in the process. As a result, I feel that the proposals will wise up the system, respond to what the patient and named person say and result in much more buy-in.

I do not want to suggest, however, that the named person does not play an absolutely critical role. They will often stand up for patients when they are at their most critical and vulnerable stage and provide a context that helps the whole tribunal understand where to go next. The named person’s role is important, but it is also important that we get the right person and the right relationship between them and the patient to ensure that ongoing activity is not compromised.

I make no apology for speaking personally because I think that such comments often put the point across. I still have information in my head about my mother that I wish I had never been given by the doctors. It would not have meant that I would have cared for her or responded as her principal carer any less, but I think that the information changed the relationship. As a result, we need to look very carefully at the interplay between patients and named persons.

**Rhoda Grant:** My understanding is that the bill provides for a more proactive approach; however, if that approach is not taken, we go back to the provisions in the 2003 act, which brings us back to the case in point. Do we need to find some other way instead of simply reverting back to the 2003 act in cases where the patient says that they do not want a named person—or, indeed, have named a certain person? Do we need to think about the role of family and carers to ensure that they have some input but do not have to receive the level of information that you have described? Would that allow us to protect someone’s privacy while giving their nearest and dearest the opportunity to express a view and, if not to represent them, then to make clear what would be in their best interests?

**Dr Morrow:** That is the bit that I find hard. I am here in a judicial capacity and not in a general policy capacity, but I think that the judicial outcomes are more positive for a patient when the family are engaged. We need to seek proper ways of achieving that. I recently dealt with a hearing not far from here in which, if the patient’s mother...
had not been there to give input, we would have missed significant points for the patient and the tribunal’s decision making. There is merit in getting that engagement right and looking at how families are involved.

Families’ engagement in a patient’s care and treatment is a solid principle for me. That does not always work—we all know the complexities of families—but it is a solid principle to work on and it has good outcomes judicially and in general for patients in the long term.

Colin McKay: I generally agree with what Ms Grant suggests. The named person role is not quite right to do what we need to do, but we need to find a way to bring people’s insight and their knowledge of a person before the tribunal, when that is appropriate. If the person involved has profound depression or a florid psychosis and cannot say that they want to exercise certain rights, it is sometimes appropriate for a carer to do that.

The legislation provides for a curator ad litem to be appointed when a person cannot instruct legal representation, but the person can have a curator only once the process has begun. It is difficult for somebody else to challenge an order on a patient’s behalf. We need to strike a balance that allows the nearest and dearest to have a say—particularly when people cannot make the decisions for themselves—but without all the baggage that goes with the named person.

The Convener: Colin Keir has a supplementary question on the named person. If anyone else has questions on that theme, I will take them before moving on.

Colin Keir (Edinburgh Western) (SNP): I have every sympathy with the witnesses’ view on the named person. I have been there, although I have not been involved in a tribunal, and I know that it can be tortuous. I thank Dr Morrow for talking about his experience, which rang a few bells for me because of what happened 15 or 16 years ago.

The witnesses have mentioned most of the difficulties. The family member who is the named person does not necessarily want to get into understanding the problems of whatever part of mental health is concerned, such as a hereditary condition, for argument’s sake—they might be blocking out their own possible future difficulties.

The named person has responsibilities. If somebody has to say that the approach is not right for the person who is being cared for, what happens if that is not accepted? How do we get through that in a sympathetic manner so that the system does not look as if it is overwhelming the named person and the person whom we are dealing with?

Dr Morrow: You describe a complicated set of relationships. Positive work is done among the professionals before a hearing, so such issues are often brought out before a hearing. The MHO and the responsible medical officer raise such issues sensitively and appropriately to nurse the situation forward.

We are a judicial body, but my thrust has been to make the process as sensitive as possible. Such matters are often aired at a hearing. People talk about the difficulties of being the named person and about when that is and is not appropriate.

11:30

The final point is that we have a rarely used mechanism for revoking the named person. It is used sometimes because the professionals take the view that something has become entrenched and the named person is not acting in the best interests of the patient. Such situations are always hard, because it is rare that a carer would do other than focus on what they thought was in the best interests of the patient.

A number of things go on, but in practice I am not aware of too many difficulties in this area and we have, as I said, 3,500 hearings a year. Not many difficulties arise, mainly because of the highly professional input at the early stages.

The advocacy services in Scotland do excellent work. They are underrated, but they certainly do a lot of relationship work; I am sorry—I mean that they are undervalued, not underrated. I rate them very highly, but they are undervalued. They do a lot of the work that you are talking about by running between two parties to assist the communication to take place. There are lots of bits of the system that help to prevent conflict.

Colin McKay: Much of this is to do with the quality of communication and interaction before the hearing. It is about the mental health officers and the other professionals having the time and space to have a proper engagement with the family rather than people just having papers served on them. I endorse what Dr Morrow said about advocacy.

Returning to the other themes around the 2003 act, advocacy is a crucial safeguard in terms of facilitating the conversation about whether someone wants their parent, spouse or whoever to be their named person. That is a difficult decision to make and a person needs somebody to help them make the decision and, once they have come to a view about it, to ensure that it is heard.

It is crucial to ensure that advocacy is available; that includes advocacy for carers, because they often require help. Sometimes the service user
knows the system better than the family does and it might be a completely new and bewildering world for them. Advocacy for carers is therefore a very important part of the mix.

Dr Simpson: In the event of a named person not being appointed, does the tribunal have the right to require the appointment of an advocate?

Dr Morrow: We do not have the right to do that, but in most cases the patient has the right to have an advocate. We would suggest that that is the route to go down.

Dr Simpson: And in practice?

Dr Morrow: In practice, the advocate is often appointed or someone else is appointed.

Dr Simpson: That is fair.

Dr Morrow: We should also be conscious that we do not have so many layers of representation for the patient that the patient gets smothered underneath it all. The MHO has an independent role for the patient and the RMO has an independent and caring role. The patient can also have a solicitor and an advocate, and they have a named person, who can also have an advocate or solicitor. The trick for the tribunal is to provide all the protections that are required for us to do our task but not to smother the patient's voice by having layer upon layer of representation. An advocate is one of the options that can assist a patient.

Dr Simpson: I am concerned that the decision has now been made that the person has a right to say, "I don't want a named person at all" and that that will not be overruled. Under the new proposal, would the tribunal in those circumstances have the right to go beyond suggesting the use of an advocate and to say in particular cases that it is critical that there is an advocate? Do you want that power?

Dr Morrow: As I understand the law at present, we do not have that power. Do I want it? I have not thought about it, but I think that having such a power would have a lot of implications, including resource and availability. I would need a variety of things. If the committee wants me to address that issue, I can respond in seven days with my thoughts on it. The response would not necessarily be about administrative justice, but I would take on board negotiating with Colin McKay about that. I have never thought about that issue, but I can respond on it if you want.

Dr Simpson: That would be helpful.

Dr Morrow: I will write to you and negotiate with Colin McKay on that. We will probably do a joint thing. I do not think that it would be too difficult.

The Convener: Thank you for that.
impact. One of the other things that we do is look at how often advance statements are overridden.

It would be interesting to join up all that and to decide what would help a person to draft an effective advance statement. When is a person wasting their time when they say something that will not be upheld because it is not a practical thing to say, and in what circumstances can they have an effective say? A lot more work needs to be done with service users to understand the barriers and to help them to make a worthwhile statement.

On the point about privacy, we are happy to consider what assurances we can offer.

Aileen McLeod: Thank you. That was helpful. To follow up, what are the barriers to people completing advance statements and what training is available to help people to draw up advance statements?

Colin McKay: We have to recognise that one of the barriers is that people feel generally disempowered within the system so they do not feel that an advance statement will be a worthwhile tool for them. They think, “If I am ill, the decision will be taken for me anyway, so what’s the point?” That is the kind of attitude that we need to change; we need to change the sense of disempowerment and use the advance statement as a tool for people to get some of what they want, as part of their dialogue with the professionals who are involved in their care.

The Convener: Dr Morrow, do you want to add to that?

Dr Morrow: No. I will not respond to that, if that is okay.

Dr Simpson: Can I ask a quick supplementary on that?

The Convener: Yes.

Dr Simpson: The bill will remove the requirement for notification of short-term orders to the MWC. Will not that result in a disconnect from the register? If you are not informed about an STO, how will you let those who make the order know that there is an advance statement on the register? Will the register be published? I assume that it will be confidential.

Colin McKay: I think that it is the requirement for notification of emergency detentions that is being removed.

Dr Simpson: Is the provision purely in relation to emergency detentions?

Colin McKay: I think that it is. We suggested that provision, because a notification was often just a phone call left on our answering machine in the middle of the night, so it felt as though we were not able to do anything about it. However, we hear about orders as they come in.

As I said, it is important that, if advance statements are made, the local services are made aware of that so that they can operate without having to check in with us.

Gil Paterson (Clydebank and Milngavie) (SNP): Colin McKay said in his introductory statement that, in some regards, patients’ rights will be “contracted” under the bill. The proposal in section 15 is to reduce the appeal period in relation to the transfer of patients from one hospital to another from 12 weeks to four weeks, which is a substantial difference. However, it seems that the bill is trying to allow for medical care for patients. What are your views on that?

Colin McKay: Again, there is a very difficult balancing act. We understand entirely the point that, if a person genuinely needs to be in the state hospital, there are significant risks involved in their care and treatment, and there are particular things that the state hospital can do that cannot be done safely by local services. It is not good for a person who needs that level of care and security to be denied it for long periods, even though they may not want it. We entirely get that but, against that, we have to recognise that somebody who is ill enough to need to be in the state hospital or to be transferred into it from another hospital is pretty ill, so it seems to be a bit heroic to expect them to negotiate, or to engage with a lawyer and prepare an appeal within 28 days. I know that there is a suggestion that people just need to lodge some sort of appeal that says that they do not want to be in the state hospital, which will meet the timescales, but I do not think that that is the appropriate approach.

We have suggested two things on that. First, given that the proposal is for a very large cut from 12 weeks to 28 days, perhaps there will be a meeting somewhere in the middle. Alternatively, if a patient is transferred before an appeal is determined—which ought to be possible if they need the care—there needs to be a guarantee that the place that they came from will be held until the appeal is determined. For us, the worst-case scenario is that a patient transfers to the state hospital, appeals successfully but is then told, “I’m sorry, but you’ve lost the bed that you came from.” We are in favour of provisions that allow early transfer where it is needed, but that also ensure that the patient has the right to go back to where they came from, should they win an appeal.

Gil Paterson: I gather that you are not against the principle of restricting the timespan for the good of the patient, but you say that we need to guard against problems with the mechanisms in between. In effect, you are asking that we fit into the legislation that the individual would, for a time,
lose their right. They would, I think, be placed against their wishes, because they would have already said that they are against the move, but that would only be temporary. The issue might not even relate to their mental situation—they might have some other ailment that needs to be treated and which might exacerbate their mental condition. You are saying that there could be some middle ground.

Colin McKay: Yes. Appeals to the state hospital would usually be made on the basis of a person's mental condition because either their risk level or concern about their mental health had increased. The balance that we must strike is to allow the person to move quickly to an appropriate care regime, when there is evidence that they really need to be in a different place, while maintaining the right of appeal for long enough to ensure a reasonable chance that the patient will be able to exercise it effectively. We are concerned that 28 days is not long enough to cover all circumstances.

11:45

Gil Paterson: What, in your opinion, would be a more suitable length of time?

Colin McKay: I do not think that such figures can be scientific. Our feeling is that going from 12 to four weeks is a bit drastic, and the issue might be as much about maintaining the ability to appeal after the patient has gone to the state hospital.

The other point is that the patient might not know what things will be like until they get there. Of course, they will eventually have the right to appeal a placement in the state hospital, but we feel that six weeks is better than four. However, I am not saying that that figure has a particularly scientific basis.

Gil Paterson: I suppose, then, that I should ask whether there is any evidence with regard to the normal time for this process—if there is such a thing as a normal time. Could that guide us?

Dr Morrow: The questions are very important, because they relate to the rights of the patient. I want to preface my response with a few comments; First, in such situations the patient's rights have almost already been compromised because they have already been compulsorily treated and detained in hospital. The state does that because it needs to provide care and treatment. We can look further at those rights, but the fact is that the state has, through legislation, decided that the patient in question should be detained for care and treatment.

Secondly, the cases with which I have dealt that have moved to the state hospital, and in which the patient has appealed against the transfer, are often highly complex with high risk factors. Although my instinct is, because that would set a boundary, to give a figure of three, four, five, six weeks or whatever, the fact is that the complex care that is required in such transfers is, in my experience, often individual to the patient, so it would be hard to give you the sort of framework that you are looking for. It would be helpful if we could do that, but I am not sure that we can.

Bearing in mind that a patient's rights have been suspended because they are already being treated against their will, we should remember that any such move happens for complex reasons. We deal with such appeals as a priority, and in many cases, I deal with them myself. The aim is to redress the balance, which the committee is trying to explore, of the judicial process offering protection for the patient while allowing the state to intervene. The matter becomes so complex because the problems are so individual and because it is about the patient and where they are.

Colin McKay: We must also consider the ability of local services to meet patients' needs. This is a complex issue in which a balance must be struck; after all, sometimes the issue is not the person in question but the quality and range of local services, as we find with people who have learning disabilities and who might have very complex needs. In an ideal world, they would not go to the state hospital, but it might be that the services that they need are just not available locally. In such cases, it is important that the judicial system tests very vigorously the acceptability of saying that a person must go to the state hospital because there has been a breakdown in their placement in a local service. Those cases take time to prepare and argue out; the fallback for us is that the person needs to be able to go back to where they came from, if that is what the judicial determination is, whenever it is made.

Gil Paterson: I do not want to put words in your mouth, but I think that you are saying that you are sympathetic to the proposed approach, as long as people's rights are safeguarded.

Colin McKay: Yes. I think that that is right.

Dr Morrow: Yes.

Nanette Milne (North East Scotland) (Con): Both witnesses have stressed the importance of the right of access to independent advocacy. I understand that advocacy is not available consistently throughout the country. SAMH has said to me that it is concerned that there is nothing about advocacy in the bill. The Government says that legislation is not necessary in that regard. What are the witnesses' views? Should the matter be in the bill or can it be sorted out by other means?
Colin McKay: I agree that the evidence from, for example, the surveys that the Scottish Independent Advocacy Alliance undertakes is that the availability of advocacy is patchy. However, by and large, if someone who is enmeshed in detention proceedings seeks an advocate, they will get one.

The 2003 act deliberately did not say, “You shall have an advocate if you are subject to a CTO application”, because the whole point is that advocacy can help someone to negotiate a care package that might make compulsion unnecessary, so it is vital that it is available to people before things have broken down to the extent that the professionals are saying, “We cannot get you to agree to treatment, so we will have to force treatment on you.” Such an approach was very much what Millan wanted and what the 2003 act set out to deliver.

It would be hard to strengthen the advocacy duty in the 2003 act, because it is already strong. It seems to me that the answer is to do with accountability in relation to that duty—perhaps we need more on that. The Government might commit to proper auditing of the availability of advocacy and the performance of local authorities and health services. It might be possible for the legislation to give a steer in that regard. Local authorities are assessed by the Care Inspectorate on how they fulfil their statutory duties. I am not sure whether the discharge of the duties on advocacy has ever been looked at.

The answer is something to do with building in a better accountability mechanism, whether that operates through the commission, the Care Inspectorate or some other means, to ensure that when people want advocacy they can get it, whatever stage they are at in the process—given the evidence that that is not universally the case at the moment. The issue is more about building in accountability than about strengthening a duty that is already pretty strong.

Dr Morrow: We have good experiences of fairly active advocates on many of our cases. I recognise that we are often at the hard end of the decision making; advocates are needed at that stage but they are also needed elsewhere. We have pretty good coverage for tribunals. The advocate’s principal role is to facilitate communication between the patient and the professionals, the named person and the tribunal. That is a very significant role.

Early on, with the Scottish Independent Advocacy Alliance, I initiated the writing of guidelines for advocates who were appearing in the Mental Health Tribunal. Everyone is agreed on what they should do, which gives an element of accountability for practice in the tribunal.

The committee should take into account what Colin McKay said about coverage, about negotiating care packages and about other things that happen outside the tribunal.

We have good experience of advocates. If members of the committee have time—as I am sure you do—to speak to service users and ask them about the function of advocates, you will find that they talk highly of the support that they are given.

I recommend a very good book called “Skydiving for Beginners: A Journey of Recovery and Hope” by Jo McFarlane. It has a chapter on her experience of advocacy and how it supported her through a particular period. Because you would all benefit from reading it, I would be happy to put up the money to buy you all a copy. If you get it from the Independent Advocacy Alliance, you can put it on my account. It is well worth reading if you are dealing with this bill, for a variety of reasons, but I particularly commend the section on advocacy.

The Convener: I also take Mr McKay’s point that there is a question of equity. It depends on where someone is, the advocate that they get and the audit and measurement of what is available, how freely it is available and what quality it is. All that is very important; I am sure you agree.

Dr Morrow: Yes.

Nanette Milne: Thank you. That was very helpful.

The Convener: We have concluded our general questions but I am aware that Richard Lyle and Bob Doris want to ask some additional questions.

Richard Lyle: We are getting near the end of the session, so I want to say that I am quite happy to read the book, but I do not want to go skydiving.

I wonder whether there are any other issues that the witnesses would like the bill to address.

Dr Morrow: I am content that it has covered what it can at this particular stage. I have expressed the view in writing to my members that it will not be long before we will have to take an overall look at mental health legislation, but at this stage the bill addresses where we are in the progress of mental health legislation.

Colin McKay: I generally agree with that. I reinforce my point that the bill is a useful tidying-up exercise but the interface with incapacity legislation and adult support protection legislation needs to be addressed. The Scottish Law Commission will report tomorrow on the problems of people being deprived of their liberty by being placed in care homes or other kinds of care settings when they are not able to agree or
disagree. That will be another strain on the system.

My general sense is that the 2003 act and the Adults with Incapacity (Scotland) Act 2000 were leading pieces of legislation—for a time, they genuinely led the world. However, there is a danger that we do not start to think about the next wave, particularly about supported decision making. We have a fantastic framework for times when we have to take decisions away from people and allow other people to make them, but we need to move towards supporting people and empowering them to maximise their choice and control in the system so that the use of mental health legislation becomes the exception rather than the rule. Advocacy and advance statements are part of that. Those points are not so much for this bill but I urge parliamentarians to consider them in their future plans.

Richard Lyle: Thank you.

Bob Doris: The points that I was going to raise have been raised by some of my colleagues.

The Convener: I thank both the witnesses for their time and valuable evidence. I am sure that we will reflect it in the committee’s final report.

Dr Morrow: Thank you, convener and members. I wish you all well with your work.

Colin McKay: Thank you.

The Convener: As we agreed earlier, we will now move into private session.

11:59

Meeting continued in private until 12:56.
Mental Health (Scotland) Bill: Stage 1

09:47

The Convener: We proceed now to our normal format for a round-table session.

I am Duncan McNeil, the convener of the Health and Sport Committee.

Colin Fraser (Glasgow City Council): I am a mental health officer from Glasgow City Council and am here as a member of the MHO forum for Glasgow social work.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and the deputy convener of the Health and Sport Committee.

Beth Hall (Convention of Scottish Local Authorities): I am part of the health and social care team with the Convention of Scottish Local Authorities.

Dennis Robertson (Aberdeenshire West) (SNP): Good morning. I am the MSP for Aberdeenshire West and SNP substitute for the Health and Sport Committee.

Dr John Gillies (Royal College of General Practitioners Scotland): Good morning. I am chair of the Royal College of General Practitioners Scotland.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the member for Clydebank and Milngavie.

Dr Ruth Stocks (British Psychological Society): I represent the British Psychological Society.

Colin Keir (Edinburgh Western) (SNP): Good morning. I represent the Edinburgh Western constituency.

Aileen McLeod (South Scotland) (SNP): I represent South Scotland.

Dr John Crichton (Royal College of Psychiatrists in Scotland): I am representing the Royal College of Psychiatrists.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife. While I am at it, I declare interests as a fellow of the Royal College of Psychiatrists and of the Royal College of General Practitioners, and as honorary chair of psychology at the University of Stirling.

Derek Barron (Royal College of Nursing Scotland and Mental Health Nursing Forum Scotland): I am associate nurse director for mental health services in NHS Ayrshire and Arran.
Six patients who were about to depart on the same was rushed through to ensure that another five or had a personality disorder. Emergency legislation who was let out of the state hospital although he Parliament in 1999 and concerned a gentleman rise to the first bill that was passed by the referring to the Noel Ruddle case, which is the first forensic psychiatry, but I think that Dr Crichton is required in the treatment of mental health.

detailed care plan would direct practitioners to pay towards a far more biosocial approach. A care away from the traditional medical model and to provide a shift in emphasis in mental health detailed care plan, and it is felt that that would help

The McManus report comments on the need for a scrutiny. Does anyone have any comments about anything that has been omitted from the bill as it now stands and that you regard as being important?

Dr Crichton: There is a general feeling, particularly in the faculty of forensic psychiatry, that there has been a wee bit of a missed opportunity, in that it would have been welcome to have had an opportunity to look more fundamentally at all the aspects of the Mental Health (Care and Treatment) (Scotland) Act 2003, including the forensic aspects that, because of various other pressures, have found their way into the bill without quite the same consultation and scrutiny.

Dr Stocks: The British Psychological Society is disappointed that the bill does not go far enough. The McManus report comments on the need for a detailed care plan, and it is felt that that would help to provide a shift in emphasis in mental health care away from the traditional medical model and towards a far more biopsychosocial approach. A detailed care plan would direct practitioners to pay far more attention to the broad range of psychological and social therapies that are required in the treatment of mental health.

Dr Simpson: I will not go into the issues around forensic psychiatry, but I think that Dr Crichton is referring to the Noel Ruddle case, which is the first one that I got involved with in Parliament. It gave rise to the first bill that was passed by the Parliament in 1999 and concerned a gentleman who was let out of the state hospital although he had a personality disorder. Emergency legislation was rushed through to ensure that another five or six patients who were about to depart on the same basis were contained, and the provisions were then put into the 2003 act. With your permission, convener, I will come back to that later.

The other issue that I raise for general discussion is the extension of the short-term order to allow additional time for tribunals to sit. As the convener will remember, we received evidence the other week that, where there had been stress in the system, the numbers involved had been substantially reduced by improved administration. I know that some of today’s witnesses have concerns—on both sides—about the extension of the time for which the tribunal can sit beyond 28 days. Would anyone like to comment on that?

Colin Fraser: When the matter was discussed, Glasgow City Council had concerns about the extension and the idea of deducting time at the other end, which it felt would be to treat the detention period almost as though it were a prison sentence, whereas the point of someone being detained is for them to get treatment. We felt that there had been improvements, but that there would be a risk that people would work to the wire, always going up to the last minute, without there being a real purpose to that.

Dr Stocks: It is important that detentions be as short as possible. However, longer periods are sometimes required in order to complete assessments thoroughly. Psychological assessment sometimes cannot be done in a short period, and it is occasionally necessary—if the assessment is to be done properly—for the period to be extended.

Dr Crichton: I will make an observation about how we are dealing with the evolving pattern of the tribunals. The tribunals have been working much more efficiently in the past few years, particularly under the current president, than was the case at the start, when they were finding their feet. Therefore, when members consider the proposed time limits it is worth reflecting on where we are now rather than on where we were some time ago, in that the view of what is a sensible time limit might have changed during the past couple of years.

The Convener: Does anyone want to respond to that? Dr Crichton has expressed a slightly different view.

Dr Simpson: May I come in briefly? At the moment, a short-term detention certificate lasts for 28 days, with a five-day extension; I think that the proposal is for a 10-day or 14-day extension. Colin Fraser’s comment about people going up to the wire is pertinent. Would it be practical to shift the duration of the certificate back to 24 days, and then to have a longer extension? That would mean that the total period of the order would not be longer, but people would come up against the
As it were—earlier, and an assessment could be made early in cases in which that is possible. I do not know whether such an approach would be clinically practical.

Dr Crichton: That is an interesting proposal. In many cases, a decision can be made in 24 days. Dr Stocks talked about complex psychological assessments, and many cases that require such assessments might not be resolved even if there were a two-week extension. None of the time limits that we are discussing would particularly answer that point. However, Dr Simpson’s proposal is worthy of further reflection.

The Convener: Do you want to respond, Dr Stocks?

Dr Stocks: If psychological assessment is requested early enough, there should generally be enough time to do it. Occasionally a longer period is required than is envisaged at the outset. I take Dr Crichton’s point about assessments sometimes being lengthy, regardless of when they start. However, the earlier they can be instructed, the better. That takes me back to my point about making psychological assessment a priority in people’s care, so that it is on everyone’s minds.

The Convener: I suppose that the proposed new rule could mean that people would end up waiting longer, rather than addressing the point about getting things done properly and quickly. That is the nub of the issue, is it not? Perhaps Mr Fraser will help me out there. No?

Colin Fraser: No—but I take Dr Stocks’s point about the need for psychological assessment.

I am a bit concerned about how the provision is drafted and the tone of the suggestion that the additional detention at the front of the process can be compensated for by taking a wee bit of time off at the end. The point is that there should be assessment and treatment, rather than some kind of balancing up in terms of the justice of the matter. I am not sure that that is the right way to think about the issue. The natural tendency is for people to work to the wire, and if short-term orders are extended it is almost inevitable that that will happen.

Bob Doris: The committee took evidence last week from the Mental Health Tribunal for Scotland and the Mental Welfare Commission for Scotland. I asked why a short-term detention certificate lasts for 28 days and whether the period could be reduced. Both witnesses broadly agreed that it takes between three and four weeks to get all the relevant reports ready so that an informed assessment can be made, so the number has not been plucked out of thin air. On balance, do the witnesses think that 28 days is about right?

We also heard last week that 70 to 80 per cent of tribunal hearings take place within the 28 days plus the five-day extension period, so the proposed additional five days would not be needed in those cases. It was suggested to us that the main reason for an extension from five to 10 days is to reduce the need for the repeat tribunals that happen in 20 to 30 per cent of cases and to give relevant family members more time to make statements and representations.

I suppose that that brings us to the crux of the matter. There is always a balance to be struck in relation to the rights of individuals who are detained. Last week we heard that 28 days is about right and that the intention behind the proposed extension is not to let people work right up to the wire but to reduce the number of repeat tribunals and give families more time to have a say. Do the professionals who are here today concur with that view? The committee has to make a judgment.

Dr Crichton: I broadly concur with that. I read the evidence from the commission and the president of the tribunals. We are talking broadly about similar timeframes, and it is difficult to say precisely what the correct timeframe is when we are talking about a week either side. We are trying to strike a reasonable balance, and ultimately we need to suck it and see. We will need to review how things are going.

It is clear that there have been some issues, which have led to the proposal in the bill. The only observation that I make is that perhaps some of the conclusions have been drawn as a result of experience when the tribunals were settling in and not working as efficiently as they are currently working. However, if the tribunal and the commission are saying that particular groups are disadvantaged by the current timeframe, I do not think that the professionals will have a strong view about a week either side.

Dr Stocks: Let me say again that we would be concerned if there was a deadline that the responsible medical officer felt could not be met if more specialist assessments, such as a psychological assessment, were instructed. We would also be concerned if such assessments were not instructed because of fear that the deadline would be missed. I appreciate that there is a difficulty in deciding exactly how long the period should be, but if there is pressure on the system at a time when psychological reports are not routinely instructed, we would be concerned if there were a timeframe that made such instruction less likely in the future.
**Derek Barron**: For the record, I should have said that I am here on behalf of the Royal College of Nursing Scotland.

I asked some of my colleagues across Scotland about the issue from the nursing perspective. They were not convinced that an extension from five days would make a significant difference, on the basis that a lot of extensions happen because solicitors ask for a second opinion. My colleagues acknowledged the point that Bob Doris made: that an extension might enable the named person or relatives to gather more information. On balance, they are not convinced by the proposal, but they recognise the argument about better access.

**The Convener**: I suppose that in the future the area will need to be thoroughly examined to ascertain whether the bill has made a difference. There seem to be questions about whether it will address the issue.

**Rhoda Grant**: Would there be a benefit in the bill allowing for a period—say five days—when the patient would be informed about the tribunal, so that they would be able to pull together second opinions and reports? The timeframe would not be shortened for the tribunal, but it would be extended for the patient, which would mean that a second tribunal might not be required. Is there merit in thinking about what proportion of time is available to whom?

Does that make sense? I sense that the panel does not understand what I am saying. I am looking at blank faces.

I suppose that what I am saying is that, rather than a patient going to a tribunal and asking for an extension because they need extra time to pull together the reports that they require to represent themselves properly, they should be allowed to do that sooner. The tribunal would need to present them with the paperwork within the five days as currently happens, but rather than go to a tribunal to ask for an extension, they can ask for an extension to gather their papers without having to go to two tribunals.

**The Convener**: That might have been a better question to ask last week to the representative of the people who run the tribunals. There is an attempt to reduce repeat appearances, and all the stress that they involve. The issue is that, as we instinctively feel from life experience, extending the time will not actually solve the problem at all. If we work within those limits, there will be no pressure, if you like, to increase the 70 per cent who go through successfully now to 80 or 90 per cent. Of course, the figure will go up because the timeframe will go up, so that stat will look pretty good, but what are the consequences of that for the individual who is caught up in the procedure?

**Dr Crichton**: There are issues of access to appropriate specialists to provide independent reports for patients who seek them, but often folk will know very early on with a 28-day admission that longer detention powers are under consideration and the ball can be started rolling. The conversation has perhaps been about the provision of timely reports, but the period is also about response to treatment and observing the person in a specialised environment in order to try to get clarity on diagnosis and the other questions that we have to address in relation to compulsory measures. That is worth thinking about, too. The time limits do not allow us as much time in every case to assess whether longer detention is the correct way forward. That is particularly the case with section 52 remands, which we might come to later.

**Dr Stocks**: We are talking about a difficult decision. As a number of people have mentioned, it would be interesting to know who is in the group of people who do not meet the 28 days and whether there is a pattern. I think that it was Mr Barron who suggested that that is often because a second opinion is requested. Those are generally the more complex cases, and it may be that it is a subset of people who require additional specialist assessments and a more thorough look at their situation who need additional time, while the vast majority of cases can be dealt with in the shorter time period.

**The Convener**: It might be worth examining whether there is any detail on the groups or individuals to which the issue particularly applies. We can maybe check that out and ask for some more information.

A related issue that we heard about in evidence last week is capacity among mental health officers and the importance of that role in the system. Does anybody want to comment on that?

**Colin Fraser**: I associate myself with the statements in the Mental Welfare Commission for Scotland’s written submission to the committee. There are serious implications for mental health officer resourcing. The proposals involve significant extra work for MHOs, which was of concern to the forum and when it was discussed in a group at council level in Glasgow.

In particular, there is concern about the proposals that a named person must sign up to be a named person. I am not clear whether there have been further developments in the thinking on who the prescribed person would be; our assumption is that that role would fall to MHOs in large part. We quite often have named persons who live in different cities, and our out-of-hours standby service can often give consent to detention at 2 o’clock in the morning—there is no
way that a named person could be accessed in those circumstances.

The proposals will certainly involve an extra visit by the MHO. I am concerned that we are having problems retaining MHOs at a national level—the numbers are going down and the national workforce is ageing. In 2011, we had 120 MHOs in Glasgow; in 2013, we had 94. That is during a period when their workload has dramatically increased, particularly in relation to people with incapacity requirements.

The number of adult incapacity applications relating to the older population has been increasing steadily over the past few years, but it has increased dramatically in relation to people with learning disabilities. Some of that is to do with the self-directed support agenda. Although an impact was anticipated, that impact has possibly been underestimated.

At the point when, if anything, our MHO workforce is in slight decline, our workload is increasing significantly. We need to be very careful with some of the bill’s proposals because I have no doubt that they will add significantly to the workload.

On the proposal that the MHO be required to produce a report at review stage, I wonder whether there is instead scope for amending the forms so, rather than simply including a signature, there is a statement of the MHO’s opinion. If that opinion was put in at that stage, that would go some way to addressing some of your concerns without requiring the significant extra work that would be involved in producing a separate report.

I have concerns that a number of the proposals would have significant workload implications for MHOs.

Beth Hall: I will echo some of Colin Fraser’s points, based on the work that we have done with our members on existing pressures on MHOs and the shrinking workforce. The numbers of adults with incapacity are projected to rise, which will impact on existing duties, such as guardianship. Information has been published showing that cases have been increasing by about 10 to 12 per cent per annum since those duties were introduced. The trajectory is upwards against a decline in the workforce.

Last week, the Scottish Law Commission published a report that is proposing a new scheme on the restriction of liberty, which would place additional pressures on MHOs. Against that backdrop, in looking at a bill that would introduce additional duties for MHOs, we concur with the Mental Welfare Commission’s call for a national strategy on MHO workload and capacity and recruitment and retention. We would want such a strategy to go further and also look at projected demand, what that means for capacity requirements and how that would be resourced.

On the bill’s specific proposals, we had other concerns where we were not able to reconcile what was said in the explanatory notes and the financial memorandum. It looked as though the latter’s estimates were based on a narrower interpretation of the duties that appear in the bill. The Mental Health Tribunal for Scotland also picked up on that. It shared the view that MHO reports would be triggered in far more circumstances than the financial memorandum anticipates.

I can give more detail on that later and say what we think the likely requirement would be. Overall, however, we should think carefully about any new duties within that context until a proper review is undertaken.

10:15

Derek Barron: This is not my area of expertise, so I asked some of my colleagues in North Ayrshire Council and the lead nurse there, and they concur with what Colin Fraser and Beth Hall said about the workload issue and the resourcing issue. To put additional responsibilities for MHOs into the bill would cause great difficulties in terms of workload.

The Convener: I suppose the question for the committee is whether it would cause great difficulty in implementing the bill as is intended. I do not intend to dismiss or play down the anxieties that we have heard, but in most cases people are worried when change is proposed. We would still be able to go ahead with implementing the bill and its objectives, would we not?

Beth Hall: The financial memorandum gives some estimates of the number of additional reports that would be required by measures in the bill, and specifically section 2, which relates to section 101 hearings. It estimates that an additional 20 reports per annum will be required. However, the financial memorandum bases that estimate on different, narrower circumstances than are contained in the bill. The Mental Welfare Commission and the Mental Health Tribunal for Scotland have also picked up on that discrepancy.

If we look at what the bill actually says about just the section 101 reports and we take Mental Health Tribunal for Scotland figures, the number of additional reports would be not 20 but 493. The same issue of discrepancy with the financial memorandum applies with section 41. The difference is significant enough to be a big problem.

Dr Crichton: We would, of course, welcome the input from mental health officers in a wider range
of circumstances, but we have some concerns that that might cause delays in appropriate treatment in various areas. An example is transfer for treatment directions. We have some national prisons, and MHOs from various parts of the country will be called upon to provide reports, sometimes in urgent circumstances.

As a general comment—I would not take away at all from the comments from our social work experts in the room—it has struck me as a curious thing that, for psychiatrists, the approved medical practitioner training is really quite modest, involving an online module and a day’s course, which compares rather starkly with the comprehensive training of mental health officers. I wonder whether we have the right balance in that, and also whether we have the right balance of expectation in all mental health social workers generally being expected to be mental health officers, as we would expect all psychiatrists to be approved medical practitioners.

**Karin Campbell:** I concur with what has been said about the extra duties on MHOs. The Social Work Scotland mental health sub-group has also raised concerns about the significant additional work to be placed on them. However, it is important to look at why those reports are being required. They are seen to be best practice, and it is important not to dismiss that. We need to remember what the bill is about.

Although we require to do more work, we need to look at how we will do that and what support we need to be able to do that rather than not do it, because the bill as it is being presented is specifically to support people who are mentally unwell and have mental disorders; those people need the legislation for their protection and their wellbeing.

Training for MHOs is another issue that was mentioned, and it is important to look at that very comprehensive training. The MHO workforce is ageing, so how do we make MHO training attractive to people? We have a lot of mental health officers in Scotland who are not going to be around in the next 10 years—they are going to retire—so we need to focus on how to encourage people to undertake the training and become MHOs.

**Bob Doris:** Karin Campbell has hit the nail on the head. First, the committee will of course explore the numbers that were outlined, whether it is a question of 20 additional reports or 493. We will look at the pressures, at workforce planning and at recruitment retention. Those points matter, and we will be asking the relevant people in Government and elsewhere the questions.

The bigger picture is: are those reports required? Are they essential? Are they highly desirable? Are they just a slight advance on how desirable they are now? I have not really heard from people about how desirable the reports would be. I want to make a judgment on whether that is the right thing to do, and then I want to make a judgment on how we resource it and enable it to happen.

I feel that, so far, the discussion has been on whether we can resource the reports and enable them to happen. We will look at those figures as a committee, and I am sure that we will make a well-rounded decision on that issue in due course. However, we have not heard enough—apart from Ms Campbell—about whether that step is desirable. I would like some information about how desirable or otherwise it is.

**Dr Crichton:** We feel that the reports are highly desirable but, from our real-world experience, we know that we can sometimes have difficulties and we would certainly need some measures whereby, in circumstances where we could not achieve the report, we could still achieve the urgent treatment required—for example, in transfer for treatment directions.

**Dr Stocks:** In the code of practice, it is recommended that MHOs seek advice from other practitioners who might be involved in a person’s care. To that extent, we feel that the reports are highly desirable. They are desirable anyway, but it is often the case that that wider input does not happen—possibly because of the resourcing issue—so we feel that it is extremely important to continue having the reports. However, there needs to be a contribution from other professionals into those reports.

**Dennis Robertson:** On that point, what about the role of the general practitioner? I would think that the pathway for a lot of patients in the initial stages is through GPs, and I am wondering about the pressure on the GPs themselves, from the initial judgment to refer patients for that specialist pathway of treatment.

**Dr Gillies:** Thank you for raising that point. Such events in general practice are not rare, but they are unusual and they are not part of the day-to-day work. When they happen, they are often complex and require a lot of time and attention. They can often be disruptive to the more routine parts of a GP’s day. GPs do not take lightly the decision to refer someone for a psychiatric opinion and for an MHO’s opinion.

My understanding and experience are that, when those events happen, they are dealt with by GPs in a reasonably timeous manner. As far as I understand from the bill, there is not a large implication of an increased workload for GPs. As far as I can see, the onus falls largely on mental health officers rather than general practitioners.
I will raise one or two points about general practice later on.

Does that address your concerns?

Dennis Robertson: What I am really trying to get at is that GPs will be under significant pressure to make the initial judgment calls. As you said, they are in general practice; they have generic rather than specialist knowledge. Are there enough specialists in practices in areas in which there is a high incidence of people who require referrals? Is that aspect covered adequately in general practice and medical centres? Basically, can you call on your colleagues?

Dr Gillies: The general practitioner’s point of view is that of an expert clinical generalist. That means having an understanding of the biomedical aspects of care, which means physical illness and mental health or psychiatric illness. We also have knowledge of what we would describe as the biographical aspects of care, which is an understanding of the person in the context of her family, community, culture and ethnicity. Those are the core skills of general practice, and we would draw on them to make a decision.

Obviously, specialists and generalists, which we are, work closely together. Specialists need generalists and generalists need specialists. The right starting point is still the general practitioner. She or he can make a decision about involvement. As far as I know, that system has worked reasonably well. I would be grateful for any discussion about that from specialist or psychological colleagues.

Dr Crichton: I support those comments.

We talked about why there was a period of 28 days. That has been a tried-and-tested timeframe. Another tried-and-tested observation is that the combination of specialist and general practitioner in decisions about compulsory treatment has worked very well historically. Colleagues who regularly make those decisions with their general practice colleagues give very positive feedback about that input, particularly the broader appreciation of families and communities that general practitioners bring to the decisions.

We have difficulties in areas in which people are not registered with the general practitioner, and we usually have to scratch around to find an advanced nurse practitioner from an independent area to come and assist us with second medical recommendations. I have often thought that, in those circumstances, it would be nicer to try to get an independent GP from some place, but GPs are, of course, under tremendous pressure. We are very grateful for all their contributions to the decisions.

Dr Stocks: We, too, support the role of general practitioners, and we see the more holistic view of individuals as very important in decisions about their management.

I reiterate my point that there are times when specialist input is also required. There are a number of ways to do that; psychologists are among the range of professionals who might contribute. Perhaps the views of those people could be taken into account more often.

Dr Gillies: I do not want to prolong the discussion too much, but we at RCGP are certainly on record as supporting an increased provision of psychological services for people with mental health disorders. There is some evidence that the biomedical model of dealing with mental health, which has been the predominant one for the past 30 years, has had great strengths and successes, but the paradigm is now changing. We are often frustrated in general practice by an inability to access psychological support timeously. There have certainly been improvements in that area in recent years, but there is still some way to go.

10:30

The Convener: Section 14 of the bill makes provision for certain nurses to detain people. Does anyone want to comment on that? The Mental Welfare Commission has expressed concerns about the provision.

Derek Barron: As I said the previous time I was at the committee, we are concerned about that power. We do not see it as a proper extension of the nurse’s role. To be able to exercise that power, the nurse has to be able to diagnose. However, that is not what nurses do. There are very few nurses who can prescribe. We do not support the provision at all.

The only power to detain for a nurse is in section 299 of the 2003 act, which I assume we will come to soon.

Dr Stocks: On Dr Gillies’s point, I was extremely pleased to hear that there is a recognition of the need for a shift in emphasis from the traditional medical model towards the more biopsychosocial approach. As psychologists, we are not presenting anything that is a challenge to what other people do. Our approach involves seeing mental health care as requiring a number of components with various interventions. We believe that, in addition to the more traditional forms of treatment, such as medicine and mental state monitoring, a range of psychological and social therapies is required.

It seems to me that the shift, which is recognised by the clinical professions, has to be
brought to the attention of the general public, carers and the users of services. We recommend that the language of mental health legislation is changed. Currently, there is reference to medical treatment. Although that includes a range of types of intervention, including psychological interventions, those are not given due recognition in practice.

Only by more fundamental changes in the legislation will there be a more progressive approach to mental health care. That is what was envisaged in the existing legislation, but it has not been recognised in practice—certainly not to the extent that users of services require.

Karin Campbell: The social work mental health sub-group viewed positively the proposal to extend the time in which a nurse can exercise their holding power to three hours, because it would enable the nurse to contact the MHO and the RMO. There are a number of local authority areas in Scotland in which the hospitals are not necessarily right where the MHO happens to be, so it would be useful to allow that extra time. That would mean that people would be more likely to be detained on a short-term detention certificate rather than an emergency detention certificate, which would be better practice.

Derek Barron: In 2013-14, there were 177 uses of the nurse’s power to detain. Only 74 per cent of those people went on to have a detention. Of that number, 40 per cent were emergency detentions and 34 per cent were short-term detentions; another 23 per cent stayed on in hospital without the use of a detention order.

The code of practice that was sent out by the Mental Welfare Commission earlier this year set out the process. The nurse tells the individual that they are going to use section 299, on the nurse’s holding power, and there is a form to fill out. The nurse also informs the doctor, and the doctor has to be there within two hours. Only once the doctor has agreed to the detention order does anyone call the MHO.

In order for the provisions to have any impact within a three-hour period, the MHO would have to be called at the beginning of the process. If that is done—bearing in mind the workload issue that we have heard about from MHOs—that would have involved calling an MHO for no purpose whatsoever in 70 cases, either because the person decided to stay in hospital or because the person was not then detained. That means using up MHO resources, because they could have to go from somewhere remote to a hospital for no purpose whatsoever. There is therefore no advantage to the proposal.

My other issue concerns reciprocity for the individual who is detained. We are saying that we will not allow them to leave for two hours. That places on those of us who are in service an obligation to make an equal response in acting as soon as possible. There is no evidence that the extension of the period for which someone may be detained from two hours to three hours would have any impact whatsoever.

In NHS Ayrshire and Arran, we used the nurse’s power to detain only nine times last year. Even in Greater Glasgow and Clyde, it was used only 27 times over the entire year. I am not sure why there has been a push for change.

I have the statistics—I think that they will be issued by the commission later this week—which indicate that there is no evidence that there will be any advantage to the proposals; nor is there any evidence that increasing the length of time for which someone can be detained will have any impact other than on the person. Our duty is to protect their human rights, not to make things easier for our workload.

Dr Crichton: One possible source of concern might be from rural and remote areas. I wonder whether other solutions could be considered. We are expanding our use of video technology and that sort of assessment. For example, telemedicine can be brought from a practitioner’s home computer into the clinical workspace, with the appropriate safeguards and security. I wonder whether there may be other ways to crack this particular nut.

Bob Doris: I seek clarification on a couple of points. I have no idea whether the proposed extension to the time for detaining people is the right thing to do; I have no preconceived views on the matter. I was not sure whether Mr Barron was saying that the period should not be extended. The Mental Welfare Commission said that we probably should not extend it, as it does not think that it will lead to any greater involvement from the RMOs—rather than saying that extending the period would necessarily be a bad thing in itself, or that it would not have the intended consequence. I might have picked you up wrongly, but are you suggesting that the current power to detain should not exist? I got the sense that you were saying that it is not a positive thing in the first place.

Secondly, my understanding is that only some nurses—mental health nurses and learning disability nurses—have the power to detain. Have such nurses across Scotland taken a view on the matter and raised concerns specifically about the current two-hour detention? If they have, the committee would wish to know about that.

Derek Barron: You asked whether the power to detain is a positive thing. Yes, it is. The power is not used as well as we would like it to be. The Mental Welfare Commission published its updated
guidance earlier this year, and we will be doing additional training. We would like far more nurses to use the power to detain, because that brings with it the protection of the 2003 act for the individual. However, we feel that some de facto detentions are happening without the provisions of the act, which is unfair on individuals.

On the second point, there is no concern from mental health nurse leaders across Scotland regarding the two-hour period. Our concern is about extending that time. We do not see any need to do that, and I do not think that it would be within the ethos of the 2003 act or of our approach to human rights. We do not think that such an extension would provide any advantage, yet it would impose a restriction that is perhaps not required.

**Bob Doris:** I will digest that point. I am not trying to be awkward, but I was not clear about the point that you were making.

A point was made earlier about detention being given in 74 per cent of cases once the RMO had arrived; often that was just a short-term detention, but it was given.

In the minority of cases, in which detention would be required for the safety of the individual, what would be the consequence if the nurse did not have the power to detain? I accept that the more power of detention that is given, the more the rights and freedoms of individuals in society are infringed. However, there has to be a balance because, at the same time, we are seeking to protect vulnerable individuals. Is there any benefit in an extension from two to three hours? I am trying to tease that out.

**Derek Barron:** My view and that of my colleagues in nursing—associate nurse directors in mental health and so on—is that there would be no advantage in an extension. The proposal may be workload related. We do not even know where the proposal came from; it certainly did not come from nursing. In fact, we would prefer to go back and do more work with our nursing workforce on the use of the power to detain.

**Bob Doris:** There is no reason for asking this other than that I am interested to know. When you talk about taking the views of senior nurses throughout Scotland, has the RCN done a deep survey of nurses in mental health, for example nurses on the wards in mental health units and those who work hands on, at the coalface, with learning disabilities? Are you describing a grassroots view or a senior clinician view? It may be both, which is fine, but I want to get a flavour of where the view is coming from.

**Derek Barron:** It is both, because we engage with our staff. In my area, we have a mental health nursing advisory committee, which has mental health and learning disability nurses on it. We get the feelings from them, whether it is a brand-new staff nurse on a ward or community team, or somebody who is more experienced. I speak on behalf of senior staff, who are accountable for detention and responsible for monitoring it. We do not see any advantage to an extension. Not one nurse has come to me and said, “If we’d had three hours, things would have been better.”

**Bob Doris:** That is really helpful. Thank you.

**The Convener:** Are there any additional comments?

**Dr Gillies:** In sections 21 and 22, on advance statements, the bill seeks to place a duty on health boards to ensure that a copy of an individual’s advance statement is placed in the medical records and a copy is sent to the Mental Welfare Commission. That seems like sensible practice.

Health boards, and presumably hospitals, have their own records. General practice has separate records. Good practice would obviously be that the advance statement is shared with the patient’s GP, as well as with the hospital. We know from practice that that does not always happen. I wondered whether there could be a duty on health boards to ensure that GPs, specialists and other clinicians who had an input into a patient’s care were made aware of the advance statement.

The advance statement often comes through the general practitioner, but that is not always the case. Everyone should be kept informed. Advance statements are significant and they must be looked at carefully in the context of, say, a recurrence of a serious mental illness.

**Dr Crichton:** One place where the advance statement should reside is the emergency care summary. As that rolls out and becomes more available to emergency mental health services, there will be greater awareness of its use in mental health services. It is essentially a matter for the code of practice and professional development, rather than statute.

**Dr Gillies:** I agree. I just wanted to raise it as an important issue. The emergency care summary has been hugely useful, but it includes very basic data about drugs, allergies and intolerances.

The key information summary, which is being rolled out electronically across Scotland, might be the best place for the advance statement to sit. If it sat there, the explicit consent of the patient would be involved. I would agree that that would be the way forward.

10:45

**Derek Barron:** I was going to suggest the key information summary. We should pursue that roll-
out. There will be technical difficulties with how we do it, but that should not preclude our trying to do it.

However, not everyone can access the emergency care summary or the key information summary. The emergency care summary is currently available only for out-of-hours practitioners, so it is not broadly available across mental health services and it is not available on our wards, where access to it is needed, and neither is the key information summary. I am not saying that we should not do as Dr Gillies suggests, because he is right and the key information summary is one central place to put the statement. We might have technical difficulties with how we do that so, when we roll it out, we need to be cognisant of that.

Dennis Robertson: The point that Dr Gillies makes is essential. For their follow-up care, patients will probably sit with the general practitioner. That will be the case not only for the patient but, perhaps, for their extended family or carers. I take his point that GPs do not always get sight of the advance statement. How often does that happen? I am aware of cases in which it did not happen, which, unfortunately, meant that the patient did not have the required follow-up care and the GP was basically in the dark about the treatment or recommendations from psychiatry or psychological services.

Dr Crichton is right that the advance statement needs to be in the code of practice, but it needs to be acted on. It cannot just sit there and be nice words. It is to the benefit of the patient and we need to ensure that it is followed up.

Dr Stocks: We mentioned in our written submission that there is a need to take account of the fact that service users often change their minds. Although we recognise that there might be a benefit in having a central register, there also needs to be some way of ensuring that the advance statement is kept up to date.

There is not always a good understanding among staff working with service users about how to create an advance statement. It would be useful to have some guidance in the code of practice but, as we have learned from previous experience, not enough attention is always paid to the code of practice. Training in how advance statements can be created and kept up to date may be required for staff working in mental health services across the board.

The Convener: Is there a role for advocacy in making people aware that they can and, possibly, should have advance statements to influence difficult circumstances? How common is it for a patient to have a statement or to have that information anywhere?

Colin Fraser: My experience is that advance statements are relatively rare. They are an aspect of the legislation that did not take off as much as people had hoped and anticipated. It is always a bit of a treat when we come across one. We are often asked at tribunals whether there is an advance statement and, more often than not, the answer is no. It is an area of work that, perhaps, merits revisiting in terms of guidance and training.

I agree with Dr Stocks’s comment that people with existing advance statements change their minds and, if there is a mechanism for recording an advance statement, there needs to be a mechanism for reviewing it and ensuring that the information is up to date.

Derek Barron: The answer to your question, convener, about whether there is a role for advocates is yes, there is. However, there is a much greater role for, for example, community nurses, who are engaged with people when they are less ill. The advance statement is about what somebody wants to happen when they become ill, so we have to be careful that the practitioner is not the one who generates it.

I agree with Colin Fraser that advance statements are rare. Some of them are not very good, in that they say things that are just not doable. The Social Work Scotland mental health sub-group mentioned a pro forma. We have asked the Mental Welfare Commission for Scotland to think about doing a pro forma so we can have one.

However, a lot of people choose not to have advance statements and we must be cognisant of that. I also have a huge concern about our having a central repository for those statements. The national health service in general does not have a fabulous track record of having massive, centralised systems that work in terms of who is allowed to access the data and when they can access it. Also, unless the system is available 24/7 it is pointless, as services need to be able to access a person’s advance statement when that person becomes unwell or is going to be admitted so that they know what the person wants to be done. Not all boards in Scotland have electronic systems that could make the advance statements available, and where would be the central point to get them from? In addition, as Dr Stocks said, if someone changes their mind, how do they ensure that their advance statement is updated from the moment that they change their mind?

The Convener: We do not need to worry about any of that, though, because it is a rare occurrence for a patient to present with an advance statement despite the fact that we all agree that having one could be helpful. Maybe we need to turn the argument upside down and say that, although those problems will present, we should recognise that it is a good thing that
someone wants to opt into the system. Maybe by making that happen, we will overcome some of the difficulties.

Derek Barron: We can do it in NHS Ayrshire and Arran because we have an electronic health record for mental health. All our advance statements are available 24/7—in fact, I could access one just now, although I obviously would not do that. We need the ability to do that. However, you are right to question whether we need to spend a lot of time doing that for a system that people are not opting into.

Dr Gillies: This has been a really interesting discussion. I agree with Colin Fraser that advance statements are pretty rare. I hoped that we would see many more of them when they became available because, when they have been available for a patient, they have often been hugely helpful in guiding professionals on how to deal with the patient.

On Derek Barron’s point, I assumed that the Mental Welfare Commission for Scotland was sent a copy so that it was aware of the data and statistics on advance statements rather than so that they could be used in the day-to-day care of patients. I still think that it would be useful to have some hard data on advance statements, and I agree that it would be really useful to encourage them. However, I would be concerned about advance statements going into the electronic care summary, as that will become more widely available over time. Patients would often be rather concerned if an advance statement were made available in that way. The place for them would be a key information summary, which should—to answer Dr Stocks’s point—be updated regularly in consultation with the patient.

Dr Stocks: In previous evidence to the committee, someone from one of the third sector organisations spoke about how their research shows that service users are not producing advance statements because they believe that they will not be paid attention to so there is no point in making one. That is very worrying for society. Given any opportunity to influence the bill, we need to ensure that it promotes collaborative care for people who suffer from mental health problems and that we do everything that we can to ensure that people feel empowered. It is important that they feel that their view, when they are well, about how they would like to be treated when they are unwell is going to be paid attention to.

Dr Crichton: There are some examples of good practice in this area. Patients in forensic mental health services are subject to the care programme approach, and we are rolling out innovations in that approach to make it more patient centred. However, within that process of regular review, the advance statement is revisited periodically. That information is shared with primary care and other forums, and it goes on to electronic databases in the health boards that have those systems up and running so that it is accessible to on-call and emergency services.

We can make the advance statements work a lot better. They work for those with severe and enduring mental illness, and those who are subject to the care programme approach or its equivalent, but their use becomes more problematic for those with less serious conditions.

Karin Campbell: The convener asked whether advocacy should play a role in the use of advance statements. We think that it should, as there are elements that such an approach could pick up on. I know, as I am based in the Highlands, that the Highland user group has been very proactive in that respect. Even while the 2003 act was being implemented in 2005, the group was doing a lot of work with its members on advance statements. I do not know whether the number has been reduced or there is less uptake now than there was back then, but I know that advance statements were viewed as very positive, especially for people with severe and enduring mental illness who required treatment on more than one occasion.

Perhaps user groups could become more involved with the issue, as they would be able to support their members in producing advance statements and understanding the benefits.

Derek Barron: I agree with that entirely. I was in the room when someone from the third sector said that people do not believe that their statements will be listened to. That is not necessarily evidence—it is the view of a few people, and I am not sure that it is entirely accurate.

The previous chair of the Highland user group stood up at a conference and actively promoted the use of advance statements. However, he said, “They are really good things, but I don’t have one.” He actively chose not to have one, and people must retain that right.

To come back to the point that Dr Gillies made about the Mental Welfare Commission, we send advance statements to the commission, which is the protector of human rights. If a board does not follow the terms of someone’s advance statement, we have a duty to inform the commission, and it will look into the matter specifically. The statement goes to the commission as a protective mechanism. There will be occasions on which we do not follow an advance statement and we have to answer for that. That is the purpose of the mechanism.
**Colin Fraser:** I reiterate the point that, rather than highlighting the low uptake for advance statements and organising around that, the priority should be to increase uptake. The statement is a really important part of the legislation, and it is unfortunate that the number of people who are making use of that availability has been so low. It would be interesting to do some research to try to find out why so few people make use of advance statements. I agree with Derek Barron—the statements are voluntary, and nobody is forcing people to use them—but it is striking how low the numbers are. That requires attention, as we at least need to know why.

**Dr Simpson:** Mr Fraser has partly made the point that I wanted to make. Is there any research on whether it is a myth that advance statements are not followed? The protective mechanism was written into the original 2003 act. The purpose was that, if someone had an advance statement, the MWC knew about it and could determine whether the treatment that the person received conformed with that statement. If it did not, the commission could ask why that was the case. It is disappointing to hear that there is a view that the statements are not worth the paper they are written on. It would be interesting to ask the MWC whether the situation has been properly analysed and how often there has been a problem.

Also, the convener raised the issue of advocacy. I will move that on a bit. There is a qualified right to independent advocacy—I think that the 2003 act refers only to that being a right if practicable. There is a view that it should be an absolute right. That might help us with the advance statement issue, too. Should we have a much firmer statement in law rather than only informing people that they have the right to advocacy if it is practicable?

**Beth Hall:** We are aware of issues with the availability of advocacy services across the piece. Across Scotland, a number of reports have indicated that provision can be patchy. However, in taking the decision to go down a legislative route to try and solve the problem, we must be very careful and clear that the proposed additional duties will solve it. First, we need to get a better understanding of what the issues are and what is leading to the problems. I am not sure that we have that understanding as yet. Therefore, I suppose I would want to pose back a question: do we have a good understanding of what is happening here?

**Dr Stocks:** Is the issue not more about making sure that local authorities and health boards fund the provision of advocacy services? It seems to be well recognised that provision is patchy, but in some areas it seems to work very well. We responded on that issue in our written submission. I must confess that that response is based on my knowledge of my job as a clinical psychologist working in Greater Glasgow and Clyde. We have an advocacy service that is fully funded by the health board—I am not sure whether the local authority contributes as well—and the advocates are embedded in the work of the health services. Every patient in forensic services, where I work, has access to an advocate.

The advocates also become a part of the culture and the environment, so they learn about how mental health services work and they get to know the professionals whom they sit beside at care programme approach meetings. It is much easier to advocate for someone in those circumstances. There are probably many other examples of good practice across the country from which we could learn. However, the point is to make sure that the financing is there to employ advocates.

**Beth Hall:** I agree with those points, but I want to add a little bit about local authorities’ work. They have a duty under the Social Care (Self-directed Support) (Scotland) Act 2013 to look at the marketplace of services in their area and to think about how they can develop that to ensure that it is sufficient to meet need. That includes looking at funding such services and looking at the balance between investing resource in direct service provision to the individual through, for example, self-directed support and personal budgets, and having resource available to fund universal services and specialist advocacy provision.

I agree that there is a funding issue, but that begs bigger questions that I am not sure will be solved by creating a stronger duty.

**Dr Crichton:** I endorse the general comment that advocacy has exceeded expectations. In areas where advocacy is well resourced, advocates become part of the mix that promotes patient welfare and rights. If we are a little bit disappointed in the take-up of advance statements, we are not disappointed in the use of advocacy where it is available.

On strengthening the right to advocacy, I would want to see the evidence of those areas that struggle to provide it.

**Derek Barron:** I agree with Beth Hall, because I am not sure about the advantage of putting an advocacy duty into the bill. I would prefer to find out where people are struggling just now and address those areas, rather than taking the blanket approach of putting a duty into the bill. We do not struggle on advocacy, and we provide it, including in dementia units. We approach advocacy as a right and a responsibility. I am not clear what advantage there would be in putting it...
into the bill. There must surely be an advantage in doing so—otherwise, why do it?

The Convener: I think that that issue has been well aired. Do committee members have any other questions on it?

Dr Gillies: Could I—

The Convener: I am just asking committee members.

Dr Gillies: I beg your pardon.

The Convener: You are fine. Did you want to come back on that issue, Dr Gillies?

Dr Gillies: No. I had a comment on another subject.

The Convener: That is okay. I was just about to move on to other subjects, because we are probably in the last 25 minutes of this session. Beth Hall and Derek Barron mentioned issues that they hoped to raise, so I will give you all the opportunity now to refer to areas that are of particular concern to you. If you want to put them on the record, that would be helpful to us all. If the issues stimulate more debate, the session will be all the better for that. Beth, you said that you would come back to some issues, so I will give you the floor. I will accept bids from other panel members to speak on issues that they feel have not been aired yet.

Beth Hall: I will try to be brief. I have two additional points that relate to the first point that I made around MHO reports being triggered in a broader range of circumstances. I draw the committee’s attention to sections 41 and 26 of the bill. Section 41 relates to compulsion and retention orders and section 26 relates to transfer for treatment directions, which we touched on. My point is a general one about the need to consider the resource implications for those provisions. I would be happy to provide further detail on that in writing later if that would be a better use of time.

The Convener: Yes, that would be useful.

Beth Hall: My final point is that I welcome the extension of the victim notification scheme. However, many of our members expressed concerns about what would happen as a result of that. For example, it could place offenders who have learning disabilities in quite a vulnerable situation. We would need to consider what additional measures we would want to wrap around that in those circumstances. My colleagues from the professions may want to say more about that.

Those are the key points that I wanted to make, and I am happy to provide more detail on them in writing.

The Convener: Those were three good points on important areas. If other panel members wish to say anything about that contribution, please do so.

Dr Crichton: I perhaps should have declared at the beginning that I am chairing a group, which is being sponsored by the Scottish Government, on the implementation of the victim notification scheme. We are at an early stage of deliberation, but one of the issues to ponder is that we have been involved with victim liaison for some time and that it is not new. However, the participation of victims in shrieval tribunals, for example, has been rather haphazard and patchy, and has depended on whether people happen to know that they have the right to go to the tribunal and ask to be treated as an interested person. There is an opportunity for making a much more sensible provision for victims.

At the minute, our discussions are concentrating first on restricted patients, which is the right initial focus. It is probably also the right and practical way forward to base the victim notification scheme in the Scottish Government, at least initially. That will allow us to get it right for that particular group of individuals, after which we can consider whether extension is appropriate to other compulsion order cases. In that, we should use as our guide the victim notification scheme for non-mental health cases, and peg ourselves to that.

Dr Simpson: On victims, I recently received a communication from the organisation Hundred Families, which deals with the families of the victims of homicides in which mental disorder has been involved. I am not sure whether its figures are correct, but it suggests that there have in Scotland in the past 10 years been 137 homicides in which mental health issues have been involved. That is 15 per cent of all homicides in Scotland, which is a greater proportion than the figure in England, which is 10 per cent. More concerning is that of those 137 homicides, only two have involved incident reviews, whereas in England there have been 321 reviews from 576 homicides.

I just put that on the record because, although the bill deals with victim notification, the victim may not be around—we may be talking about the families, as well. I just raise the issue and ask whether anyone has any initial comments on those figures which, if they are valid, show a rather stark difference of approach between Scotland and England.

Dr Crichton: I am pleased that the chair of Hundred Families is part of the expert group and is contributing to it. The figures that he has used are taken from the national confidential inquiry into suicide and homicide by people with mental illness, which is based in Manchester. If a practitioner is unfortunate enough to have a
patient who either kills somebody or commits suicide, they fill in a questionnaire that is sent to the national confidential inquiry. I am pleased to say that the apparent figure of 15 per cent is largely because of the greater problem with substances in Scotland, so the figure includes people who might be in contact with alcohol and drugs services. If we burrow down into the data and look at the absolute rate of, for example, schizophrenia-associated homicide, we find that Scotland is exactly the same as England and Wales. That is a really important message to get over.

Close family relatives of someone who is killed have always been considered to be victims—they are sometimes referred to as secondary victims. That is true of the current victim notification scheme in the criminal justice system and it will be true under the proposals. The particular beef of Hundred Families is about the inquiries that are made following a tragedy, on which we in Scotland take a very different approach from that which is taken in England. It is timely to have a discussion about whether we have the balance right. The new chief executive of the Mental Welfare Commission spoke about the topic at a Royal College of Psychiatrists meeting two weeks ago, at which we discussed whether the balance is right in the commission’s published inquiries. I think that Hundred Families has a point in saying that a discussion about the commission’s role in investigating such tragedies and about what it puts in reports would be timely.

Dr Simpson: That is helpful. Thank you.

Derek Barron: I am not sure of the Mental Welfare Commission’s role in relation to the issue, so I think that that point is an aside. The role that we are talking about is for Healthcare Improvement Scotland, and it is about scrutiny. Over the past couple of years, it has developed a robust process through which incidents of suicide or homicide by persons within mental health services must be robustly reviewed and reported on. We report to Healthcare Improvement Scotland on that, and to the MWC. We have to remember that the MWC exists to protect human rights, whereas Healthcare Improvement Scotland is there to scrutinise what the services have done. The two work together. Therefore, although Hundred Families may be saying that and it may have been true 10 years ago, it has certainly not been true in the past couple of years. We are well scrutinised by HIS. We have to do reports and publish them on our board websites, as well as produce action plans and the follow-up actions.

We have fatal accident inquiries, as well. The procurator fiscal looks at what we have done and what has happened and then makes a decision, along with the families, on whether to have an FAI as well as a board inquiry. I am not sure what else is being asked for on top of that. Having been through several of those inquiries, I know that they are quite robust.

Dr Simpson: That is very helpful indeed. It gives us a much better picture than the quite narrow one that I was getting. Perhaps we should ask HIS to give us some more information, as well.

Dr Gillies: On the victim notification issue, when we consulted our members, they welcomed the proposal. Certainly I can think from over the years of several instances in which victims and the families of victims have been severely distressed when offenders have been released, whether or not those offenders have mental health problems.

There are two other aspects. If one looks at crimes that are short of homicide or murder, there are people with mental disorders whom one would hope to rehabilitate partially or completely following those events. It is important to ensure that the victims and the families of victims are informed and that the victim notification proposal is taken forward in a practicable way.

We also have to bear in mind that there are humanitarian considerations for the person with the mental disorder. Where treatment is available, it should be made available to them, from the humanitarian point of view and from the point of view of avoiding consequential repetition of such events when the person is released. There is quite a delicate balance to be struck.

Colin Fraser: As chair of the MHO forum in Glasgow, I brought the bill proposals before the forum; the victim notification proposal was the most hotly disputed subject. People had strong views about the resource implications of additional responsibilities for MHOs and so on, but from an ethical point of view, that proposal was the subject that caused people the most difficulties and was the one on which I had to take a show of hands to establish the position of the people in the room.

The show of hands came down in favour of the broad view that if you are a victim, you are a victim and it does not matter what route you have come down to get to that position. However, the minority position—it was a slight minority—was concern that there should be a more nuanced and stratified approach to different types of mentally disordered offender. People could perhaps see the point of transfer for treatment directions, but there were real concerns about the vulnerability of people with mental health difficulties and the risk of their being exposed post-discharge, which had to be recognised. I merely flag up that that proposal was, ethically, the most contentious of all the bill’s proposals and it generated quite a lot of heat.
The Convener: Thank you for that. I thank Beth Hall for raising that issue, on which we have had a good discussion.

Dr Stocks: We have already spoken about the need to promote a biopsychosocial approach in mental health care, and about efforts to give greater attention to the broad range of therapies that service users would benefit from, of which psychological therapy is one.

I have already mentioned that the terminology could be looked at and I have spoken about the need for more detailed care plans, as was mentioned in the McManus report, as well as the need to make better use of specialist expertise. We have spoken about some of the ways of doing that, and I would like to add that the British Psychological Society would like the tribunals to seek reports from specialists more often, and we would also like future legislation to give consideration to extending the ANP role to other disciplines, including psychologists and, potentially, nurses and occupational therapists, if that was considered to be appropriate. I am thinking about cases in which the primary treatment may not be strictly medical. For psychologists that would be particularly in relation to people who suffer from learning disabilities or other cognitive problems, people who suffer from autistic spectrum disorders and people who suffer from personality disorders. Certainly, many psychologists have the expertise to be able to give the information that is required when people are to be considered for compulsory measures, and I do not doubt that there are other professions whose members might feel that they could play a role in that respect.

We have spoken about the resource problems in relation to mental health officers, but I think that there are also resource problems in relation to psychiatry. I know that the extension of the excessive security tribunals is going to lead to additional burdens on psychiatrists, so it might be that there is a need to look at who else can contribute to the function of the application of compulsory powers.

Dr Crichton: The issue was discussed a great deal in relation to Westminster's Mental Health Act 2007. In England, there are no longer responsible medical officers; instead there are responsible clinicians.

I think that in psychiatry, we had difficulty in articulating why we felt uncomfortable about that, because, of course, we wish to promote multidisciplinary working and an expansion of the role of our colleagues. I think that that is because we are sometimes a bit shy about saying what medical people bring to the table. The two things that they bring to the table in particular are a tradition of making clear diagnoses, although we are not the only profession to do that, and their experience of non-consensual treatment. We learn through dealing with unconscious patients or people who are clearly incapable of consenting to treatment—first of all in the medical receiving bay or in the casualty department—and we make sensible decisions accordingly. Those two professional backgrounds are brought by a medical perspective.

There is a question of equality of esteem with regard to psychosocial treatment and its contribution, but that perhaps might be addressed through tribunals asking for appropriate evidence from colleagues. I am not particularly convinced that changing the complement of who makes compulsory detention recommendations is what is required.

Derek Barron: As I have stated before, we in nursing are not in favour of the provision.

At 9 o'clock of an evening in Crosshouse hospital, the doctors toddle off home—I am talking about those in mental health; the doctors in the accident and emergency department are still there. After the doctors have gone, advanced nurse practitioners are on duty all night, from 9 o'clock until 9 o'clock the next morning. They are also on duty at the weekend.

I am not against extending the nurses' role. One thing that those nurses cannot do is diagnose or detain people under the act. The vast majority of nurses—either mental health nurses or learning disability nurses—are not qualified to make diagnoses. In order to apply the act, a person must be able to diagnose the problem. We diagnose what is wrong with the person and treat them accordingly. Advanced nurse practitioners can also prescribe, as non-medical prescribers. Again, I stress that it is not that we do not wish to advance the role; the issue is appropriateness. There is no support from within nursing—mental health or learning disability—for the extension of the ANP role to nurses.

Dr Stocks: I will make a couple of points. First, I do not see the issue as being to do with parity of esteem among professions; I just think that psychologists, certainly, can play a valuable role. It is about ensuring that patients get the best assessment and that the best decisions are made, based on a comprehensive understanding of the circumstances. In cases in which the mainstay of treatment is psychological, surely a psychologist is well placed to advise.

The point that Dr Gillies made earlier applies in that regard. Things are moving on. In the past, it might have been only psychiatrists or medical practitioners who were able to gain the experience that gave them certain competencies, but things are changing. Lots of psychologists have
experience of working with people who are detained, and are competent to diagnose a patient's mental disorder.

The Convener: Does anyone else want to raise an issue that they think might not have been covered?

Dennis Robertson: May I ask a quick question about people who are making the transition between child and adolescent mental health services and adult services? What difficulties does detention present, in the context of resourcing?

Dr Stocks: We have said that insufficient attention has been paid to the situation of young people under mental health legislation. I cannot comment on the resource issues, other than to say that educational psychologists will become less available now that the funding for their training has been stopped. The point was made in a previous meeting. We regard that as a serious problem in the context of young people's mental health. I think that most people agree that it is important not to stigmatise young people and that if difficulties can be dealt with by an educational psychologist when the young person is at school, the young person might be prevented from having to move into formal adult mental health services. The issue has not been given enough attention in the current revisions; it needs to be addressed.

Colin Fraser: Forgive me if I am a wee bit behind the curve on this. I want to raise an issue that is of concern to my colleagues, but it might already have been addressed in a previous meeting. In relation to the role of the second doctor in applying for a compulsory treatment order, the impression has been given that the responsibility for arranging that might somehow be transferred to the local authority. What currently happens is that the RMO contacts the GP. My colleagues are quite concerned about that, but I do not know what the current thinking is. It can be challenging for consultants to get hold of GPs in certain circumstances. It is difficult to anticipate what would happen if it were the responsibility of the MHO to deal with the GP. However, the thinking might have moved on. I would welcome comments on that.

The Convener: I do not recall the issue having been raised yet—I am looking around my colleagues. You have raised it now.

Dr Crichton: On the length of the assessment period when the court grants an assessment order under section 52 of the Criminal Procedure (Scotland) Act 1995, I think that sometimes people use the shorthand of treating that period as being the same as the assessment period during a short-term detention. We should be making up our minds about treatability criteria in a similar length of time.

However, section 52 cases can be very complex and can involve the most extreme circumstances. Section 52 allows for a period of in-patient assessment without a treatability requirement. There is a strong consensus among college members that sometimes we need a bit longer before we can nail our colours to the mast and say that someone fulfils the treatability criteria. I was involved in a case before the court of criminal appeal this year and I have another case coming up next year, both of which might have gone down a much less contentious route had the period of the section 52 assessment order been a little longer.

The Convener: If no one wants to respond to Mr Fraser and Dr Crichton's points, I thank everyone for attending and for their written and oral evidence. Thank you for your valuable time. I hope that we will be able to use your evidence effectively in the report that we produce.

As agreed, we move into private session.

11:30

Meeting continued in private until 12:19.
On resuming—

Mental Health (Scotland) Bill: Stage 1

The Convener: Agenda item 7—[Interruption.]

No—it is agenda item 8. I am doing well this morning.

Agenda item 8 is a round-table evidence-taking session on the Mental Health (Scotland) Bill. As is usual with such sessions, we will begin by introducing ourselves. I am convener of the committee and MSP for Greenock and Inverclyde.

Gordon McInnes (Mental Health Network (Greater Glasgow)): I am a development worker for the Mental Health Network (Greater Glasgow).

Bob Doris: I am a Glasgow MSP and deputy convener of the committee.

Andrew Strong (Health and Social Care Alliance Scotland): I am policy and information manager at the Health and Social Care Alliance Scotland.

Rhoda Grant: I am a Highlands and Islands MSP.

Karen Martin (Carers Trust Scotland): I am mental health co-ordinator at the Carers Trust Scotland.

Aileen McLeod: I am a South Scotland MSP.

Carolyn Roberts (Scottish Association for Mental Health): I am head of policy and campaigns at the Scottish Association for Mental Health.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

Nanette Milne: I am a North East Scotland MSP.

Shaben Begum (Scottish Independent Advocacy Alliance): I am with the Scottish Independent Advocacy Alliance.

Richard Lyle: I am a Central Scotland MSP.

Sue Kelly (Inclusion Scotland): I am outreach and development officer at Inclusion Scotland.

Dr Simpson: I am a Mid Scotland and Fife MSP.

Steve Robertson (People First (Scotland)): I am chairperson of People First (Scotland), which is the national self-advocacy organisation for people with learning disabilities. The organisation is run by the members, all of whom have learning disabilities.

Rhona Neill (People First (Scotland)): I work for Steve Robertson at People First (Scotland).

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

The Convener: I welcome everyone to the meeting; we are very pleased to have the guests we have invited along this morning, and I apologise for any inconvenience they might have been caused. We are not far off the time we expected to start, but the committee has had a very busy morning. Nevertheless, we will try very hard to give this issue our normal serious consideration by, in the main, listening to our guests. Just to get things going, however, we need to ask some questions. The deputy convener, Bob Doris, has agreed to do that, and we will see where we go.

Bob Doris: I was halfway through crafting my first question, which was about the proposal to extend from five to 10 working days the period after a short-term detention certificate ends before a compulsory treatment order must be applied for and whether the balance in that respect was right. However, in the spirit that the convener has referred to, I do not necessarily want to focus on and tie us down to that. Instead, I want to open up a discussion about whether our witnesses think that the balance of additional powers in the bill is appropriate.

The Convener: Karen Martin is showing an interest in answering that question.

Karen Martin: We feel that the bill has taken a very clinical direction. It has moved away from the person-centred recovery approach taken by “Towards a Mentally Flourishing Scotland”, the mental health strategy and, indeed, by the carers strategy, which is all about working with people at and building things up from the grass-roots level. As I have said, things have gone very clinical, and there is not an awful lot of evidence that the legislation will work towards the recovery of individuals with lived experience of mental ill health or that it will, in fact, involve carers in any meaningful way, even though respect for carers is one of the principles underpinning it.

Andrew Strong: As I said, I am from the Health and Social Care Alliance Scotland, whose 780 or so members include disabled people, people with long-term conditions and third sector organisations that work in health and social care. Earlier this year, we held a round-table session on this very legislation with a group of organisations and people who work with the Scottish Government on a wide range of the issues in question, and there was deep concern about the proposals not being particularly person centred, despite the wider push, not least in the 2020 vision, to encourage
such an approach in health and social care. There was also concern about the bill making a series of administrative duties in isolation from people and their rights, and about its focus on updating existing legislation instead of reflecting on the range of developments that have taken place over the past decade. For example, the alliance that I speak on behalf of is making a strong push on self-management but I do not see much of that coming through in the bill.

**Carolyn Roberts:** I want to talk about the bill in general and then I will quickly discuss the extension from five to 10 days that Bob Doris highlighted in his question.

We are concerned that the bill contains several proposals that seem to reduce people’s rights and their ability to participate fully. I refer in particular to the proposal to extend nurses’ power to detain; the quite limited nature of the proposals on appealing against excessive security; the proposal to decrease substantially the time within which a person can appeal against transfer to the state hospital; and the proposal to increase from seven to 14 days the length of time for which an assessment order can be extended. What the proposals have in common is that no detailed assessment that it has made of the measure’s impact and whether it is still required.

On the extension from five to 10 days, members will know that that was proposed by McManus, and we supported it at the time. We have not shifted our position, but we know that the number of interim orders—their number was the reason given for making the change—has fallen substantially, so we are looking for more information from the Government on the assessment that it has made of the measure’s impact and whether it is still required.

12:15

**Sue Kelly:** Our response to the bill was informed by work that we had been doing to consult disabled people across Scotland on whether the Scottish and United Kingdom Governments are meeting their obligations under the United Nations Convention on the Rights of Persons with Disabilities. Our concerns all relate to the extent to which the bill is being taken forward with proper account being taken of the way in which any changes have implications for people’s human rights.

It seems to us that the UNCRPD is crucial in the context of mental health provision, exactly because of the powers that are given to medical and legal professionals to deny what people would generally consider to be a person’s fundamental rights. Those rights are massive. They include a person’s right to freedom and autonomy and to make decisions on their own behalf. The bill gives professionals the right to do things to human beings that in any other context, including other medical contexts, would be deemed torture or abuse. Giving professionals those powers is not something that should ever be treated as routine.

We have been reviewing the bill, and the basis of our submission is our concern about the extent to which we think that it may be moving in the direction of being more about administrative necessity than about identifying people’s rights. That is why we asked for People First to be represented at today’s meeting, and I know that Steve Robertson wants to speak to those issues.

**The Convener:** Do you want to speak, Steve? If you are not ready yet, there will be opportunities later.

**Steve Robertson:** I have some views from People First. It is our input on the Mental Health (Scotland) Bill. Shall I go with that?

**The Convener:** Yes, of course—whatever you are comfortable with.

**Steve Robertson:** Okay—I was just checking.

Most disabled people, whatever their disability or impairments, get treated less well than the general population. In most areas of life, people with learning disabilities are even more disadvantaged than our friends and colleagues in the wider disability movement. In healthcare, for instance, we can expect to die 20 years sooner than other people. Educational opportunities are denied to us through a lack of adequate support and through inflexible systems. A greater number of crimes are committed against us, including sexual abuse. Our right to have relationships and to make decisions on their own behalf. The bill gives

The 2003 act defines us as “mentally disordered”. We described our experience of that in our open letter to all MSPs earlier this year.

The 2003 act defines us as “mentally disordered” because of our

“learning disability, however caused or manifested”,

and it allows us to be detained and treated for our mental disorder, even though we know that there is no treatment or cure for a learning disability. Ours is the only permanent impairment that is defined and dealt with in that way. Because of
that, we are routinely denied access to justice, and anyone with a learning disability who commits an offence can simply be diverted away from the criminal justice system and into the health system and forensic services. While that sounds like a good thing, what it means in practice is that we can be detained for many years and restricted in nearly everything that we do, sometimes for the rest of our lives. That is happening to many people with learning disabilities in Scotland at the moment.

The safeguards in the system are mostly controlled by psychiatrists. We accept that some psychiatrists are kind and well-meaning people, but we do not accept that psychiatrists have a monopoly on understanding and managing people with learning disabilities. If a psychiatrist says that someone needs to be detained and restricted and watched and escorted, and that advocacy is not in their best interests, that is pretty much the end of the story. It should not be.

We are asking to be taken out of the 2003 act. We say that most of its provisions do not apply to us and have little or no relevance to us. Our view is that we would benefit from help and support to learn and additional time to learn and remember, rather than treatment for a disability that we will have for all of our lives. In fact, for us, things that are called "treatment" are most often about restrictions on our lives anyway.

The other major assault on our human rights is the way that the Adults with Incapacity (Scotland) Act 2000 is being used and applied to us. When the Adults with Incapacity (Scotland) Bill was drafted and passed, we were pleased about it and supported it. The principles of the 2000 act are sound. It makes it clear that all other, less-restrictive options must be considered and applied before guardianship orders are granted, and that capacity is not an all-or-nothing idea.

However, over the past few years, sheriffs in Scotland have begun citing each other and claiming that, where a person has been found by a psychiatrist to "lack capacity" on the basis of their "mental disorder", a guardianship becomes the "least-restrictive option" in order to protect the person from claims of "deprivation of liberty".

We think that it is very scary that Scottish sheriffs claim to be protecting us from deprivation of liberty by removing all our rights to self-determination. We think that it is shocking that firms of solicitors are urging parents to apply for guardianship orders before we reach the age of 16, meaning that we might never experience adult citizen rights in our own country in the 21st century.

We honestly believe that the time has come for a new piece of legislation that is just about people with learning disabilities. We think that it is only right and fair that learning disability is properly defined as an intellectual impairment rather than a mental disorder. With that definition, we would want recognition that additional time to learn and support to understand things, together with easy-read documents and support to make some decisions, are what we need. We need those things to help us take part in our communities, rather than restrictions, detentions and efforts to keep us apart from the world that we want to live in.

Those have not been easy things to say, and some people may feel uncomfortable with what I have said, but those are the facts.

The Convener: Thanks, Steve.

Bob, you asked the original question and encouraged the responses.

Bob Doris: It would be inappropriate to leave Steve Robertson’s statement to the committee hanging. I apologise that all that I will do at the moment is mirror back to you a couple of the comments that you made. You set a challenge for the committee that is clearly outwith the scope of the bill but, if I were you, I would have taken the opportunity to put my views on the record, too. That is precisely what you did, and I respect that.

I wrote down your point about the definition of those living with learning disabilities and the appropriateness or otherwise of deeming people to be mentally disordered. You mentioned the term "intellectual impairment" and said that there should perhaps be different processes in place to support people living with learning disabilities. We have to consider that, although not in relation to the bill.

You made a point about how the Adults with Incapacity (Scotland) Act 2000 impinges on the rights of those living with learning disabilities. You specifically mentioned guardianship orders. You spoke about degrees of independence, liberty and freedom and about guardianship orders perhaps taking everything from certain people with learning disabilities.

I will just leave those remarks hanging there. I thought that it would be wrong not to respond to the powerful statement that Steve Robertson made.

I think that the most reasonable follow-up question is about advocacy. Within the legislation, there are additional powers taken by professionals. From my reading, they are well intentioned and there is some rationale behind additional powers being taken. Every step of the way, when people’s rights are impinged on—perhaps for acceptable reasons, because of clinical evidence—there is a strong need for
advocacy. I know that Shaben Begum has strong views on advocacy in the bill.

I do not know whether that is the best way to take forward the discussion but, as always, we are in the witnesses’ hands. I did not want to leave Steve Robertson’s powerful statement hanging there.

Steve Robertson: That is great. I really respect everything that you said. Thank you—it is much appreciated.

The Convener: Shaben Begum was named, so does she want to respond?

Shaben Begum: I support the points that Steve Robertson made about access to advocacy. Recently, we produced research called the map of advocacy for 2013-14, which is a snapshot of what happens in the world of advocacy in Scotland. We asked all advocacy organisations and all NHS and local authority commissioners and funders how much money they spend on advocacy. To go back to Steve Robertson’s point, one issue that came out was that funding for advocacy has been either frozen or cut. Overall, we found that funding for advocacy has gone down by 1p per head, but the demand for advocacy increases year on year. For this edition of the map, demand had gone up by 8 per cent.

One concern that we share with People First is that, even though people with a learning disability have a legal right to access independent advocacy under the 2003 act, they still do not have access to advocacy in the way that they should. Steve Robertson talked about the extreme ends of the spectrum, where people might be in forensic settings. Those people have some access to advocacy, but not in the way that we want to see it.

I want to concentrate on the people who are in the community but who might be leading isolated lives in many respects—we talked about that outside the committee room—through a lack of social networks or family and friend networks. Advocacy provides a vital life link for those people by promoting social inclusion and safeguarding their rights.

People with learning disabilities are one of those groups who still do not have the right level of access to advocacy. If they are in the community but have limited networks and are not in receipt of services from a community psychiatric nurse or mental health officer, they are less likely to find out about advocacy. We have found that fewer and fewer mental health professionals are telling people about advocacy.

We have in-depth research in which 12 people with a learning disability from throughout Scotland were interviewed. The majority said that they had never been told about advocacy. We are talking about adults in their 30s, 40s or 50s who had never found out about advocacy from a statutory source. A CPN or their social worker had not told them about it; they had found out about it through other people they knew, collective advocacy or self-advocacy groups.

12:30

We are finding out that people do not find out about advocacy in time. The majority of the people who took part in the qualitative research said that they wished that somebody had told them about advocacy, because it could have saved so much misery and distress in their lives. They said that it could have made a huge difference to them if they had known about advocacy, about their rights and about how they could challenge decisions that were being made about them, their financial freedom and their freedom to make decisions, have relationships and do all the things that you and I do, which include making the mistakes that we all make.

Making mistakes is one of the reasons that professionals use for safeguarding people with a learning disability. We give a lot of consideration to risk, but we all make terrible mistakes in our private lives every day. We have the freedom to do that, but people with a learning disability do not have those same freedoms. They do not enjoy the same level of freedom and opportunity to be active citizens in our society.

I am sorry; I have been waffling. If Bob Doris has a particular question on advocacy, I will answer it.

Gordon McInnes: I suppose that this is a supporting statement. My organisation has a contract with NHS Greater Glasgow and Clyde to do user-involvement work in mental health, but it is also a service-user-led organisation with 600 members. Our perception is that services are fire fighting. They are very much on the back foot and are not looking to do proactive work, which is the other part of advocacy. We can get a person when they are unwell and support them through the tribunal process—that is fine—but very little proactive work is being done with people.

We did peer promotion of advance statements. It was hugely successful to the extent that our limited capacity could deliver it—it was a sideline to my paid job. We took service users from being cynical about advance statements, because they can be overruled, to saying that everyone should have one and should have the narrative about advance statements to engage with. For instance, the issues that someone has with access to information for carers can be addressed in an advance statement, as can be their attitudes to
treatments. The statement represents the service user taking responsibility for telling services what they need to know about their care and treatment. The statement puts that on a plate.

NHS Greater Glasgow and Clyde has two computer systems: Genisys and PIMS—the patient information management system. If there is an advance statement, an alert flashes up. Genisys is a central database and the documents can be downloaded from it. An advance statement can be accessed in most mental health settings in Glasgow 24/7, 365 days a year. Few statements are made, because practitioners do not have the capacity to do proactive work, but they could be a huge part of a service user's greater involvement in their mental health treatment and improving outcomes.

We promote advance statements as documents that improve crisis response, minimise people’s time in hospital and improve their recovery post-hospital. That probably has a financial implication for the NHS and, were that approach to be adopted on a larger scale, there would be significant improvements not only in rights but in treatment.

Karen Martin: I echo what Shaben Begum and Gordon McInnes said but I make a plea for carers. The advocacy services that are available for carers are even less well known. The people we consulted throughout Scotland, including young carers and people in condition-specific charities that work with people with various mental illnesses, said that knowing that they could access advocacy or that it existed but they could not access it because it was full or did not operate in their areas might have made a difference to whether they became a named person. It might have given carers more of a say, more confidence and more of a voice to take part in treatment decisions and might have allayed a lot of family and relationship issues.

The Carers Trust would certainly like to see more in the bill about carer advocacy rights, to support carers. I agree with Gordon McInnes that building that into the advance statement is great, but we need to promote and publicise the role of the named person, as stated in McManus. It is a huge disappointment to carers that that is not reflected in the bill.

Andrew Strong: McManus mentioned that advocacy needs more promotion and that there is a direct issue about the appropriate provision of advocacy and the associated funding for it. That is further exacerbated by the perfect storm scenario, whereby lots of disabled people and people with long-term conditions are being affected by welfare reform and cuts to services.

I do not know whether the committee noted that this week the Scottish social attitudes survey revealed that there has been an increase in stigma and discrimination over the past few years in relation to people who come within the bill’s scope: people with mental health problems and people with learning disabilities. Advocacy can be a tool for challenging that, but a block is that a lot of people cannot access it because there is not enough provision. We would support monitoring of access to the independent advocacy that exists. There require to be consequences for local authorities and health boards when people cannot access advocacy services. Greater empowering of people to report failings on advocacy is probably required, too. I am not sure whether that is within the bill’s scope, but there is definitely a gap.

Gordon McInnes: When we are discussing somebody taking up the role of named person, another element is that somebody such as a mental health officer may take on the role. There are two issues. A family member who takes on the role often lacks advocacy skills or knowledge of the mental health treatment process or the legal frameworks. When a professional does it, they often do so at short notice and do not know the person. Both those factors have an impact.

I suggest that there should be some rules, because we often hear that a professional has been nominated as a named person at the last minute. The professional concerned might not know the person so, although they might have the skills and the knowledge of the system, how can they argue on that person’s behalf?

Shaben Begum: I will highlight research that the Mental Welfare Commission for Scotland published last year. A series of focus groups was held throughout Scotland to talk to people who have used mental health services. The majority of them knew nothing about the named person, advance statement, independent advocacy or their rights under the 2003 act. The people who knew about their rights to a named person and an advance statement had used advocacy or had been involved in a collective advocacy group.

Advocacy has been shown time and again to be a useful vehicle for enabling people to have a better knowledge and understanding of their rights. People are more likely to nominate a named person and have an advance statement if they know about those things in the first place and if they have an advocate who supports them.

Many of our members do a lot of work to raise awareness about what a named person is, what their responsibilities are and how that role can help the service user. They also help a lot of service users to draw up advance statements and to think about what will be a robust advance statement. Advocacy needs to be recognised for
the role that it plays in generally raising people's awareness about their rights and in specifically raising awareness about the two additional safeguards in the 2003 act.

Karen Martin: I agree with Shaben Begum. When we consulted carers through our network partners throughout Scotland and the Scottish young carers services alliance, we found that time and again we had to spend time explaining what a named person is, what we meant by an advance statement and where carers fit into being a named person. We also had to separate out the role of the named person from that of the primary carer when they are not one and the same person.

As McManus recommended, greater awareness is needed of the role of the named person and the consequences of taking it on. It is quite a powerful role and taking it on has a lot of consequences, especially for a sibling, wife, husband, mother or father of someone who has a mental health problem.

The role can interfere with family relationships. That is why the Carers Trust and the Scottish young carers services alliance want the McManus recommendation that 16-year-olds should be able to nominate named persons to be implemented, which would bring the legislation into line with that on issues such as the age of legal capacity. Many adolescents struggle with families. They do not have to have a mental disorder to have poor family relationships, but the situation is made worse if a 16 or 17-year-old has a mental disorder on top of that and their parents have to give consent. That seems to be an anomaly. The common view is that, if people can vote when they are 17, why can they not decide who will represent them or act in their best interests?

There are a lot of issues to do with the named person. The Carers Trust, the Scottish recovery network, the Glasgow Association for Mental Health and Support in Mind Scotland feel that the Government has missed out a lot of the robust powers and responsibilities that McManus recommended. Another issue is raising awareness about the role of the named person, which will impact on the service user, because the two can start to work together better.

Sue Kelly: I echo much of what has been said, particularly about advocacy. We have talked about McManus. The principles on which the 2003 act rests are completely disrespected if people do not have the support that they need to make their own decisions and do not have the advocacy available to allow them to challenge substitute decision making. Not having that undermines the spirit of the legislation, which was supposed to be groundbreaking.

People we have spoken to say that advocacy should not be provided just in times of crisis, that early independent advocacy should be provided and that things such as peer advocacy projects should be encouraged. Support should be planned early and the treatment that is required should be considered. I echo everything that has been said about advance statements, which help to prevent deterioration of mental health and avoid the necessity for compulsory treatment, which is such a difficult issue.

There are lots of debates about compulsory treatment and whether it is in and of itself a total denial of somebody's human rights. It would be a way of avoiding any such situations if people got early advocacy and made informed decisions when they were not feeling so unwell. We say in our submission, on the basis of what people have told us, that we would like a statutory duty to be placed on health boards to promote advance statements and ensure that people are fully informed about what making an advance statement means.

Gordon McInnes: There are two points when an advance statement is likely to be needed—one is in the tribunal process and the other is during treatment in a crisis. That is often when the proactive work bears fruit, which is part of the point to make about advance statements. Often, the treatment process is like a conveyor belt, so the people in the hospital do not see the benefit of the community work and those in the community do not see the benefit of the crisis work. Those things need to be tied together, which is why I stress the importance of the advance statement as a proactive document. When someone is in the community, a well-written advance statement might not make a big impact but, if they become unwell again, it will—particularly if the tribunal process adequately supports them. That is what I mean when I say that a well-written advance statement can improve almost every aspect of a person's mental health care and treatment.

12:45

The Convener: Gil, do you want to take us on to another subject?

Gil Paterson: Yes.

The Convener: Great. First, however, Rhoda has a supplementary question on the previous subject.

Rhoda Grant: Gordon McInnes mentioned the availability of the advance statement. Previous witnesses have given us evidence on confidentiality. Gordon, you seem to be saying that the advance statement is very accessible, so how do you deal with confidentiality issues?
Gordon McInnes: I have supported peers to do sessions with people who have had things such as disinhibited behaviours and other sensitive issues included in their advance statement. If there is a central database, there is a clear access requirement.

When we do the work, we get the person to draw up a list of people who have copies of the statement and include their names and addresses, and they put that distribution list, if you like, in the statement. That includes their GP and psychiatrist, as well as any named person, carer or anyone in any other such role.

The assumption is that they will discuss the matter and any access-related confidentiality issues with them. However, that requires someone to sit down and do the work to decide who should be on the list, what should be in the statement and who should get access to the information. If a person is not happy about receiving or giving information, they should not be put on the list.

A lot of our members are socially isolated, so they do not have a huge list of people to draw on.

Rhoda Grant: I am sorry, convener, but I should have referred members to my entry in the register of interests, because I have an intern from Inclusion Scotland.

The Convener: Carolyn, do you want to help us to conclude this bit of the discussion?

Carolyn Roberts: On the specific point about confidentiality, advance statements are a great tool—I absolutely echo what Gordon McInnes said—and people need to be encouraged to make more of them. When we have done research on the experience of being detained, people have said that they do not know about the statement or believe that the statement will have no weight, so we welcome the fact that the bill will introduce a register of advance statements. However, people have expressed concerns about the fact that the entire advance statement will be held in the register and have asked who will see what is a personal document.

In our submission, we propose that—ideally—the register should hold only the fact that a statement has been made, the date when it was made and whom to contact to get it. That would reassure people, while letting the register do everything that it should. Failing that, we urge that the provisions on who can access the statement be tightened up.

The bill says that a person’s mental health officer and the responsible medical officer can see their statement, which is absolutely right. However, it also says that anyone acting on the person’s behalf, as well as their health board, can access the statement. Those are incredibly broad provisions; we strongly urge that they are tightened up.

Dr Simpson: We should be aware of the fact that, the last time we looked, there had been 900 breaches in health boards, with people accessing confidential data that they should not have accessed. The witnesses raise a valuable point.

I have always been of the view that the person who holds the statement—provided that the individual is confident to do so—should be the general practitioner. A lot of confidential information should be held at that level and accessed only if the patient and the GP are in agreement that it should be accessed. That is in general, but we will need to return to the whole issue of privacy and confidentiality.

In the context of the bill, I support Carolyn Roberts’ view that the register should record the existence of the advance statement and not the full content of it. Enabling health boards to access advance statements is far too broad an approach; the bill must be much more tightly defined.

Bob Doris: I appreciate Gil Paterson’s patience, as I know that he wants to come in. I take on board the comment that health boards getting the advance statement is a fairly broad provision and that the bill might need to be tightened up in respect of what that means. I do not know the answer to this question but, if the advance statement is held by a GP or another trusted individual and we have a register that says only that a statement exists, might not there be times of crisis when one would need quick access to the statement—within minutes or hours—when one might not be able to access it from those sources? I am not arguing against Dr Simpson’s position; I am just wondering whether there are practical aspects to take account of, in case one needed to get the advance statement as quickly as possible.

Gordon McInnes: Roll up at Parkhead hospital at 3 am.

The Convener: Everybody seems to be in broad agreement that there are times when it would be needed quickly.

Gil Paterson: At the start of the session, Carolyn Roberts made a quick reference to appeals against hospital transfers and the rights of managers in effect to transfer patients from one establishment to another. Under the bill’s proposals, the length of time for making an appeal would be cut from 12 weeks to four weeks. I do not want to put words in the mouth of the Mental Welfare Commission for Scotland, but when we questioned it on the matter, its main concern was not so much about rights being taken away or reduced—it seemed to think that, in some cases, that was the right thing to do because the patient required treatment that could not be provided in a
particular establishment—but about the loss of the patient’s bed in the establishment in which they had been housed. In other words, after they had been moved elsewhere—perhaps against their wishes—they might have no right to go back. Of course, the panel might have entirely different concerns or might wish not to dwell on what I am saying if it thinks that it is irrelevant.

Carolyn Roberts: You have raised a really good point. The provisions relate specifically to transfers to the state hospital, which is our highest-security hospital. Our concern about the very substantial reduction in the timescales for appealing against decisions on people being transferred is that the reason why the proposal is felt to be required has not been very well outlined. The argument is that the time for appeal delays treatment that might be required urgently, but we neither understand that nor think that it has any substance. After all, the existing mental health legislation allows the tribunal to order a person to be transferred immediately, pending their appeal.

That brings us to the Mental Welfare Commission for Scotland’s concern about loss of the bed at the original hospital. I do not have the details, but I am told that on at least one occasion a person who was transferred to the state hospital won their appeal only to find that their bed in the sending hospital was no longer available. It is clearly an issue; I have read the commission’s evidence and I think that it has proposed that the person’s bed be guaranteed until the appeal has played out. That seems entirely sensible to me, but it does not necessitate a reduction in the appeal timescales from 12 weeks to 28 days, especially as the tribunal can already direct a transfer to take place, pending the outcome of an appeal.

The Convener: Does anyone else wish to comment on that?

Dr Simpson: I have a related question, convener, but it goes back to sections 10, 11 and 12, which relate to the right of appeal against certain levels of security. At the moment, that right applies only to those at the state hospital, but in light of the RM v the Scottish Ministers case, the bill now proposes to extend the right to those in medium-secure units, which we supposedly have an adequate supply of—that particular building programme has now been completed and we now have a unit at the Murray royal hospital development, a unit in Glasgow and a unit in Edinburgh. However, the point that some of the witnesses have raised in evidence is: why stop at that? What about lower-secure units? After all, one of the Millan principles was about providing the least restrictive care, and surely people who are being restricted in any way should have the right of appeal. Do the witnesses think that the bill should be amended to ensure that the right of appeal against excessive security is extended not just to medium-secure units but to low-secure units? What are the arguments for and against such a move?

Carolyn Roberts: We agree that the provision to appeal against excessive security should apply to people in low security, and we absolutely agree that the intention of Millan was for the principle of least restrictive security to apply. There has been a court case on the matter, which you referred to, and the person who brought that case was in a low-secure setting. As we know, it is possible to move from a low-secure hospital setting to a community-based order, and we believe that the Scottish Government’s argument for confining the right to appeal to medium-secure units is that an appeal against low-secure accommodation would essentially be an appeal against detention itself, given that the next step would be a move into the community. We do not agree with that. Someone can move from one level of security to another and still be in low-secure accommodation. We think that the right should apply as widely as possible.

We note that the purpose of this part of the bill is to bring in regulations that will give effect to a provision in the original Mental Health (Care and Treatment) (Scotland) Act 2003. It appears to us that the intention of the 2003 act is to allow a right to appeal against excessive levels of security to apply as widely as possible. We do not see why it would not.

We have concerns about whether there is sufficient low-secure accommodation provision. Given that people will be able to appeal against medium-level security, we would like to see work done on what low-level secure accommodation is available, whether it is enough and what more we need to do to develop that estate.

Dr Simpson: In his evidence, John Crichton said that now we have medium-secure accommodation sorted, we really need to look again at low secure.

When the 2003 bill was going through Parliament, we debated whether the provision should apply to lower levels of security, but at that point we did not have community treatment orders. We have now had 10 or 11 years’ experience of CTOs and we should regard them as another form of detention. A CTO is a restriction on liberty, even though it is a restriction within the community. Steve Robertson made that point eloquently. We need to look at that.

We also need to look at learning disability, although that might not be possible within this rather limited act.

Can I say one more thing, convener?
The Convener: Yes, you can, Dr Simpson, but you are not giving evidence.

Dr Simpson: I know. I just wanted to comment on Steve Robertson’s position. As a fellow of the Royal College of Psychiatrists, I hope that I am one of the kind psychiatrists to whom he was referring. Maybe he will tell me later.

I was concerned to hear that somebody could say that advocacy was not appropriate to an individual. I cannot think of circumstances in which advocacy is not appropriate. Are there any circumstances in which it is appropriate not to suggest that an individual might wish to take up the option of having advocacy?

The Convener: I will allow people to answer Gil Paterson’s original question on security, and the questions that flowed from that, before we go into answering another question, Richard.

Bob Doris, do you want to come in before we get a response from our panellists?

Bob Doris: I would rather hear witnesses’ opinions on security than ask about it. I was going to ask a question on that.

The Convener: Ask your question, then we will hear the responses.

Bob Doris: Okay.

Apologies; I am maybe showing my ignorance by asking this question but I am trying to get my head round the point that was made. If someone is being transferred from a low-secure setting—not in the community—to another low-secure setting, or if they are being transferred from a more secure setting to a less secure setting, how could they appeal on the ground that the security was excessive? The constraints on the person would be lessened or not changed. That is a common sense view of what I am hearing.

I appreciate that somebody moving from a low-secure setting to a community treatment order might be a different issue. However, when someone is transferred from one establishment to another with the same level of security, why would there be a need to appeal against excessive security? Are other mechanisms not available through which a detention can be contested, irrespective of whether someone is being transferred from one hospital to another?

I hope that that makes sense. I am just trying to understand the bill’s provisions and why they are unreasonable.

The Convener: Maybe the panellists will give us a wider sense of their views on security and the appropriateness of where someone is at any given time. Can we have some responses on that? I do not know whether I saw Gordon McInnes nodding—

Gordon McInnes: I was just agreeing.

The Convener: —or whether he was just nodding off. Carolyn Roberts?

13:00

Carolyn Roberts: I am not sure that I have fully understood the question. Perhaps I was not being clear when we were talking about appeals against excessive security. The provisions in the bill would give effect to the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 on the right to appeal against being held in excessive levels of security. That right came in for the state hospital, which has the highest level of security; you can now appeal against your being held there, and if your appeal is successful you get moved to a medium-secure facility.

We are arguing for a similar right at every level. Not only should people in medium security be able to appeal against their being held there and move to low-level security, as is set out in the bill, but people in low-level security should also be able to appeal and perhaps move to a community setting. That right would not come into play if you were being transferred from one medium-secure facility to another, because the level of security would not change, as you have said. Have I understood the question right?

Bob Doris: That was ideal. Are you saying that, for those who are currently staying in the lowest form of secure setting, there should be a standing right to appeal, full stop? If so, do you not agree that there are already mechanisms in place for reviewing compulsory treatment orders? I am just trying to establish what the difference is. Do you want people in the lowest level of secure setting to have the standing right to appeal on an on-going basis, or only at the point of transfer?

Carolyn Roberts: You can appeal against a hospital transfer, but we are talking about specific rights with regard to being held in excessive security. An appeal against a hospital transfer could be made on a number of issues such as appropriateness or clinical care, but the rights that we are talking about are specifically about being able to argue, “I am being held in a level of security that is not necessary.”

Bob Doris: I must have misunderstood that when I was talking about transfers. Do you want people, wherever they are and irrespective of other grounds for appeal, to have the right to appeal against the level of security in which they are being held?

Carolyn Roberts: Yes.

Bob Doris: But is there not already a statutory review process for those under compulsory treatment orders that say where they should be?
Carolyn Roberts: They would be reviewed every two years.

Bob Doris: Are there conditions attached to that right to have an order reviewed? I am not trying to be churlish—I just do not understand. Should there be a right to appeal every three months, every six months or every nine months? When should the person who is residing under that level of security and detention get the right to have their order reviewed or repealed? Is it a standing right or one that would be given every so often? I apologise for asking so many questions; I will not ask any more, but I see that I need to increase my knowledge and understanding of the process.

The Convener: Karen Martin will help us along.

Karen Martin: I hope so, convener.

My understanding is that the responsible medical officer—the consultant psychiatrist—has a duty to constantly review the care and treatment of anybody who is on a compulsory treatment order. If my understanding is correct, if someone was beginning to recover and could function in an open ward—they might not be quite ready to move out into the community, but they would not need to be in a low-secure unit and could have ground access and be allowed to get out and about—it would be a matter for the responsible medical officer, along with the treatment team, the carer and the service user him or herself. If somebody has been under a compulsory treatment order for two years, there is a statutory duty for the tribunal to review it. People are given an order for up to six months in the initial circumstances, pending on-going review, and I think that the situation is the same for those in low-secure units.

I do not know whether I have helped things or have muddied the waters further and confused everyone.

Bob Doris: It is my responsibility to get more knowledge of the situation. Thank you for assisting me.

The Convener: What if people found themselves in various types of accommodation not because they were appropriate but because of a lack of appropriate accommodation somewhere else? Can you give me some clarity about where their rights would lie in that situation? We have heard that you could find yourself in the state hospital and make an appeal but then lose an appropriate place elsewhere, the consequence of which would be a continuing stay in the state hospital because there was nowhere else for you to go. What happens in that situation? Indeed, the same question arises as the level of security flows down to the medium or low level or perhaps if you are in the community. I have heard about such problems, but I do not know about the timescales involved or how the regular assessments come into play. How can assessments ensure that people are in the appropriate setting based on their needs and clinical assessment?

Karen Martin: That is where we would certainly advocate greater involvement of family members and carers—not just named persons, who can be different from the carer—in the review process and assessments. What could happen is that someone might be deemed ready for discharge from a unit—perhaps not the state hospital or a medium-secure unit but a low-secure unit or open ward—but the family might not be ready. The person could still be discharged into a family that is not prepared, has not been involved and does not know the side effects of medication or who to call in a crisis.

Greater involvement of the family can help to prevent some of the issues that you have mentioned from arising. In particular, we need greater involvement from the forensic carers of people in the state hospital, which covers the whole of Scotland and Northern Ireland. A lot of forensic carers feel that they are underrepresented and are not brought into any discussions about movements or other changes, and involving them more could help to reduce the problem of people being moved about and then suddenly finding that they have nowhere to go.

The Convener: Does anyone else want to respond?

Shaben Begum: Can I comment on the point Richard Simpson made?

The Convener: Yes, because that is the one that we are going to come to next. You can kick off.

Shaben Begum: Before the Mental Health (Care and Treatment) (Scotland) Act 2003 was implemented, there were lots of situations in which people were told that advocacy was not suitable for them. Quite often that decision was made by a clinical team, and I know that Steve Robertson will have lots of examples of that. Unfortunately, we still hear of people being told, “Advocacy isn’t appropriate for you.” As a former advocate, I have experienced lots of situations in which I was told that advocacy was not helpful because it was putting ideas in people’s heads or that certain people would never have thought of challenging people in authority if I had not suggested the idea to them.

For me, advocacy is all about broadening people’s horizons and telling them about their options, their rights and all the things that they do not know about. After all, they might not know that they can exercise those rights. However, we still hear about cases of people with dementia or learning disabilities, or children and young people, who are not able to access advocacy.
11:02

On resuming—

Mental Health (Scotland) Bill: Stage 1

The Convener: Agenda item 2 is continuation of our scrutiny of the Mental Health (Scotland) Bill at stage 1. This week, we have another round-table evidence-taking session. We normally all introduce ourselves at the beginning of such a session. My name is Duncan McNeil. I am the MSP for Greenock and Inverclyde, and the convener of the Health and Sport Committee.

Sarah Crombie (Victim Support Scotland): I am the acting director of corporate services at Victim Support Scotland.

Bob Doris: I am an MSP for Glasgow, and the deputy convener of the Health and Sport Committee.

Karen Kirk (Legal Services Agency): I am a solicitor advocate and partner at the Legal Services Agency, a mental health project that acts for people with mental ill health.

Nanette Milne: I am an MSP for North East Scotland.

Kenneth Campbell QC (Faculty of Advocates): I am from the Faculty of Advocates.

Richard Lyle: I am an MSP for Central Scotland.

Cathy Asante (Scottish Human Rights Commission): I am a legal officer at the Scottish Human Rights Commission.

Colin Keir: I am the MSP for Edinburgh West.

Dr Jill Stavert (Edinburgh Napier University): I am director of the centre for mental health and incapacity law, rights and policy at Edinburgh Napier University. I am also a member of the Law Society of Scotland’s sub-committee on mental health and disability, but I am not representing it today.

Gil Paterson: I am the MSP for Clydebank and Milngavie.

Jan Todd (Law Society of Scotland): I am a solicitor, and I am here representing the Law Society of Scotland’s sub-committee on mental health and disability.

Rhoda Grant: I am an MSP for the Highlands and Islands.

The Convener: I invite Rhoda Grant to open up the discussion.
Rhoda Grant: Do the witnesses think that the victim notification scheme gets the balance right between the needs of the victim and the needs of someone who was mentally ill at the time that they committed the crime?

Sarah Crombie: Striking a fair balance between victims, witnesses and patients is a complex and complicated matter. Victim Support Scotland welcomes the provision of information to victims of mentally disordered offenders. We believe that every victim should be heard and should have a voice throughout the assessment process, and that information should be proactively provided to victims in an appropriate and timely manner, whether that is by letter, telephone call or email, and in plain English.

From victims whom we have supported through the process, we have found that there can be duplications and gaps. It would be good for the system to be streamlined under one scheme, so that victims of mentally disordered offenders receive the proactive information that is crucial if they are to understand the system.

The Convener: Would anyone else like to speak? Jill Stavert? You do not need to press the request-to-speak button. The sound will come on automatically.

Dr Stavert: Although I think that the supplying of information is a good thing, and the amendments that have been made to the bill as a result of Scottish Government consultation are welcome, we must be careful that mentally disordered offenders are not discriminated against, relative to the rest of the offender population.

Obviously, the sharing of information is a matter that impacts on people’s private lives, and personal information about them should be shared only in a proportionate and legitimate way.

Rhoda Grant: What do you mean by “personal information”? Victim notification schemes tend to be about when someone will be released, so that a victim knows where they are likely to be for that event. What other sort of information do you envisage being shared? Is the balance right in the bill? Does the bill suggest that information should be shared that you do not think should be shared?

Dr Stavert: It is a matter of discernment in each individual case. I think that, sometimes, informing a person where the offender lives in a situation that involves a minor crime would not be a proportionate response.

Sarah Crombie: I acknowledge the concerns that have been expressed, but victims and witnesses require information that will allow them to put in place safety plans, if they choose to, and ensure that they do not bump into the offender when the offender is on temporary release in the community or whatever. That is the type of information that should be proactively supplied to victims and witnesses, who have a choice about what they do with that information.

Kenneth Campbell: On the point about discrimination that was raised by Jill Stavert, my view is that the scheme should operate in the same useful way, irrespective of the character of the offender. In other words, we should not stigmatise people who are offenders and who were mentally disordered at the time of offending. Subject to that, I think that the balance that is proposed in the bill is appropriate.

Jan Todd: I agree with what my colleague has said. The Law Society was concerned that the victim notification arrangements should be the same in relation to offenders with mental health as they are in relation to other types of offender.

We note that the bill is going to consider guidance on exceptional circumstances in which the notification would not be made. It is important to discuss what would be included in those exceptional circumstances. Further guidance on that is probably needed.

The Convener: What would be appropriate—or inappropriate—in that regard? What would you be concerned about?

Jan Todd: I suppose that personal circumstances would have to be taken into account. If giving out information was going to endanger someone, that might outweigh the need to give victims information. Guidance will have to be designed on what would or would not be exceptional circumstances.

Karen Kirk: We agree that there needs to be a proportionate response, on the basis that the tribunal will be looking at a care plan for the patient’s care and treatment. If there were concerns about releasing information that might have a negative impact on the care plan and treatment, there should be an opportunity to try to stop the release of the information.

Cathy Asante: I want to pick up on the comment about the need for parity between mentally disordered offenders and non-mentally disordered offenders. We agree, and we were pleased to see that a change has been made since the draft bill was published, so that the proposal applies to offenders who are on compulsion orders with restriction orders.

However, the bill will give the Scottish ministers the power to amend the provision so that it applies to people who are not on restriction orders but are on only compulsion orders. A person on a compulsion order might have committed only a
minor offence, so we are not certain why that power is needed.

The Convener: Does anyone else have concerns about that? Gil Paterson has a question.

Gil Paterson: My question is about the rights of the patient. Managers currently have the power to move a patient from one hospital to another, or from hospital to the state hospital. Currently a patient has 12 weeks in which to lodge an appeal, but the proposal in the bill is that that period be cut to 28 days. What are the pros and cons of the measure?

Cathy Asante: We are concerned about what is quite a dramatic reduction in the timescale. A transfer to the state hospital has a significant impact on an individual's autonomy and right to a private and family life, so a restriction of the appeal period needs to be justified.

In the policy memorandum, one of the justifications is the need to bring the timeline into line with the timeline for other appeals. However, there are reasons for the longer timescale for such appeals. The longer timescale reflects the serious consequences of a move to the state hospital and the complexity of cases in which the person is very unwell.

Another justification is the need not to delay treatment for someone who is unwell during the appeal process. However, the Mental Health (Care and Treatment) (Scotland) Act 2003 has provision for a person to be transferred pending a decision on an appeal, if that is necessary, so we do not regard the delay argument as adequate justification, either.

Karen Kirk: We agree with Cathy Asante. There are provisions throughout the 2003 act that relate only to state hospital patients. I can see the rationale for bringing the appeal period into line with other appeal periods, but the state hospital is unusual, to an extent, and is treated as such in the 2003 act. There are concerns about patients who are subject to detention in the state hospital that are not relevant to other patient detention.

A transfer for treatment direction can be appealed only after the first six-month period, so sometimes the patient's right to challenge has to be exercised when the transfer takes place. A solicitor might need to do a lot of work, given the complexities of state hospital transfer, so we regard 12 weeks as an appropriate appeal period.

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Nanette Milne: A number of witnesses have highlighted matters that are not in the bill, but which they think merit inclusion in primary legislation. One such matter, which also struck me, is the use of forced covert medication and restraint, about which there is little in the code of practice under the 2003 act. Representations have been made to Parliament by people who feel strongly about the use of covert medication. What are the witnesses' views on that?

Jan Todd: The Law Society has said that it would like use of covert medication and restraint to be included, if possible. We think that there is not sufficient guidance out there, so anything would be useful.

Cathy Asante: I echo that. The SHRC also raised the issue in our written evidence. There is quite a lot of confusion about use of covert medication and restraint in practice, and more guidance would be beneficial to patients, in that it would protect their rights. Guidance would also be beneficial to staff, who would know where they stand.

Dr Stavert: I echo what Jan Todd and Cathy Asante said. Edinburgh Napier University, too, raised the issue in our response to the call for written evidence.

Dr Simpson: I am interested in a comment that I read in one of the submissions, which relates to the United Nations Convention on the Rights of Persons with Disabilities. The SHRC said:

"The recent radical interpretation of Article 12(4) CRPD by several human rights experts advocates that legal capacity cannot be denied on the basis of disability ... that decision-making be supported not substituted (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder."

That is clearly a pretty radical view, but it is out there. I understand that the United Nations has published a general comment on article 12, to that effect.

I should have said that I am a psychiatrist and a fellow of the Royal College of Psychiatrists. I do not know whether the witnesses have read the powerful evidence on people with learning disabilities that we heard from Steve Robertson last week. I cannot see us abolishing compulsory detention in certain circumstances, which is provided for by law. However, given the radical views that are out there, will the amendment to the 2003 act, for which the bill provides, move us in the wrong direction?

Dr Stavert: I appreciate that the view is extremely radical and I think that most jurisdictions would struggle with completely abolishing non-consensual treatment for mental disorder.

However, the general comment provides an opportunity for us to revisit what we understand by capacity and the extent of capacity, in the context of the exercise of legal capacity. The UN's general comment very much promotes supported decision making, so it provides an opportunity to look at
existing and other forms of supported decision making, in order to enable patients to be full partners in a shared decision-making process.

As it stands, the 2003 act promotes shared decision making—that is an underlying principle. However, if patients are additionally supported, they will be more equal players, so the debate presents an opportunity in that regard.

Advance directives are an important form of supported decision making, so advance statements should be promoted more. The 2003 act should be amended to place a duty on medical staff to encourage patients to make advance statements.

In addition, independent advocacy is an important aspect of supported decision making, but it is not, we note, covered in the bill. The issue should be reinforced, particularly given the provisions in section 259 of the 2003 act.

Cathy Asante: There is a wider challenge out there in terms of responding to the UN’s general comment. The recent interpretation is radical and we will need to consider it carefully if we are to make broader changes to our system of compulsory detention.

In the meantime, the issues that Jill Stavert mentioned are important if we are to show that we are taking steps to advance supported decision making as much as possible. There are opportunities in the bill to make provision on advance statements and advocacy. We can also look carefully at the named person provisions in order to ensure that they do what they set out to do. Those are the three real opportunities in the bill to begin, at least, to respond to the UN’s general comment.

Kenneth Campbell: I broadly agree with Cathy Asante. The structure of the bill and the existing provisions in the 2003 act to do with support for advocacy, and the general trend towards patient involvement in decision making, are not wholly incompatible with the UN’s general comment, which certainly takes a radical approach.

The question is about the extent to which further primary legislation is the appropriate way forward, and whether there is a case for revisiting the code of practice, which was issued when the 2003 act was originally passed. The time might be right for revisiting some of these important issues in a systematic way, by those means.

Karen Kirk: The concern that I want to raise in regard to one of the principles of the UN declaration is about participation. The proposal to extend the short-term detention extension period from five days to 10 days is our main concern about the amendments. The concern that Dr Simpson raised is quite right. If we are looking for more participation, and more effective participation, by our patients, is it right that they would have to wait a longer time before they would be called before a mental health tribunal for a compulsory treatment order? We very much feel that that is not right and we think that it would affect their ability to participate in the process itself.

The proposal is to extend the detention extension period from five days to 10 days, which would mean, as things currently stand, 10 working days. If we add up the time of a short-term detention certificate, an emergency detention certificate and the extension of 10 working days, we could be looking at a person’s being detained for more than seven weeks before appearing before a mental health tribunal. That potentially does not comply with European convention on human rights article 5, and it definitely does not promote participation of patients.

Bob Doris: My next question was going to be on the extension anyway, so maybe we can flesh the matter out a bit before we go on.

The Convener: There will be other opportunities to come in.

Bob Doris: It is perhaps worth saying that I am delighted that this Parliament is bound by the European convention on human rights, and that I hope that it will be on an on-going basis. It is no bad thing if it challenges the legislation that we scrutinise—that is why it exists.

Earlier, we heard evidence suggesting that the need in some cases—some people would debate whether there is a need—to extend detention from five to 10 working days is related to the need to prepare a variety of reports, including family reports and, if there is a named person, to get their details. It was also suggested that in some cases it may be beneficial to individuals because it might keep them from going through repeated tribunal disposals to decide what is best for them, although it would not be used as standard.

I am delighted that I am not a lawyer. I do not mean that flippantly. I am not a lawyer, but the word “proportionate” comes up in relation to the European convention on human rights. I suppose that my question is this: is there a balance to be struck in exceptional circumstances where there is a proportionate need to prepare all reports so that a tribunal can make an informed decision? Would that be compliant with the human rights of the individual? Some of the evidence seems to be quite black and white on whether extension of the time period would contravene human rights, but is it actually a grey area? Is not this about the checks and balances in the system, the policing of the system and making sure that advocacy groups
and the Mental Welfare Commission for Scotland are taking a view and checking on it?

Do witnesses have concerns about human rights as a matter of course, or is there a way of extending the detention extension period from five to 10 days, in exceptional circumstances, that would be compliant with the human rights of vulnerable individuals, irrespective of what they have or have not done, and whose human rights need to be protected by the state?

Cathy Asante: Our issue with the proposal is that we are talking about a blanket, across-the-board extension from five to 10 days. We absolutely acknowledge that there can be exceptional circumstances and that there are lots of very good reasons for such a move, including the need to prepare for a hearing, but that is what the existing provision, under which a hearing can be postponed until such time as people are ready, is designed to achieve. That is entirely compliant with human rights and gives people the time to get ready to argue their case.

I am aware of the Mental Health Tribunal for Scotland’s evidence that the number of repeated hearings has dropped and now happens in 20 to 30 per cent of cases, and we would query whether there is sufficient and proportionate justification for applying to everyone a blanket extension of the period of the short-term detention certificate. In certain circumstances, more time might be needed and a hearing might need to be postponed, but extending everyone’s detention in this way is not the way to go.

Jan Todd: The Law Society agrees with Karen Kirk and Cathy Asante. Perhaps this was an issue five years ago, when the McManus report was drafted.

At this point, I should declare that I am convener of tribunals; I therefore have first-hand experience and have not found the matter to have been a big issue in recent times. Obviously the patient has a right of appeal during the 28-day period of the short-term detention period; if they wish, they can instruct a lawyer to make an appeal at that point. Indeed, many patients appeal during that period. They appeal again when they make their CTO application, but the tribunal does not always get told whether they have made a previous appeal.

I take on board the point that some patients can be so unwell at the start of the process that they might not be able to instruct a lawyer or seek an appeal, so it is important that they have an early opportunity to have their case brought to a tribunal. I have found that, if an application for a CTO is made by a mental health officer within the five-day period and the case is brought to a tribunal for a hearing, the patient and their solicitor are quite often ready to proceed. However, I do not know whether a blanket extension of five days will provide any significant benefit to a patient who has just instructed their lawyer, or who allows their lawyer to get an independent medical report. It usually takes longer than five working days to get a proper independent medical report before a full hearing can go ahead.

In the meantime, the patient’s rights are protected, because they will get a full hearing. Even though the patient might not be able to make full representations based on the medical evidence that they have sought separately, the tribunal will still make it clear that it will need to be satisfied that all the tests have been met at that stage for the patient to be detained. The patient’s human rights are being protected at that point, and any order that is issued will be an interim one to allow that representation to be fully explored and expanded on with the independent medical report.

The Law Society is of the opinion that there is, at the moment, no benefit in having a blanket extension to the five working days. First of all, we do not think that there is a particular need for it now. A secondary point that we have made in our written submission is that extending the period and then attempting to deduct that extension from any future detention period might give rise to more confusion and uncertainty in any potential review, if the length of the extension has to be worked out and then deducted from a certain period—say, the 56-day period for two interim CTOs or the six-month period for a full CTO.

Kenneth Campbell: It seems to me to be unlikely that a provision that made it clear that a greater period of time might be granted in exceptional circumstances would be disproportionate and not convention compliant. The committee should be reassured on that front. The whole aim of involving the tribunal in the procedure that is set out in the legislation is to ensure as far as possible that patients’ convention rights are properly addressed. I do not think that truly exceptional circumstances would cause a problem in terms of the ECHR.

Karen Kirk: I agree with my fellow panel members. We very much think that the existing provisions provide the opportunity for a patient to participate and give them the time to prepare, which was what Mr Doris was asking about.

The benefits of an early tribunal are quite vast and depend on the individual circumstances of each case. For example, at a first hearing, a tribunal can direct certain matters to take place for the next hearing and can deal with named person issues and other preliminary issues such as the application’s competence under the terms of the
2003 act. An early hearing can have a number of uses for a patient, not least the practical use of allowing people to focus on the issues in a patient’s case. That is invaluable for a patient who is opposing a hospital-based, not a community-based, order, and who is challenging at the very beginning the responsible medical officer’s thoughts on the matter and why they believe hospital-based detention to be the least restrictive option under the general principles of the 2003 act. That early hearing can be effective in ensuring that such views are put across, and it very often means that, at the second hearing, a different case can be heard; for example, the patient might be better, and the focus might be on a community-based order.

We definitely feel that if there are two hearings for a case the patient is not necessarily being disadvantaged or caused upset, because they direct the proceedings and instruct their solicitor in both cases. We therefore think that the approach has benefits.

The only other point that I would raise follows on from Jan Todd’s comment about whether it is practical to expect that in every case an independent medical report can be instructed and received within 10 days. For this meeting, we did some research in which we looked at quite a few cases and found that it took about 30 days from an independent doctor being instructed until the written report was received. Those doctors do the work over and above their normal patient work in their local authority areas, and we rely on them to ensure that we have an effective system for the patient. The fact is that it takes time for an effective and appropriate report to be put together, and we would not want that time to be reduced and for an expectation to be placed on doctors to produce a report in an unreasonable amount of time.

I also point out that in some areas it can be difficult to identify someone to carry out an independent specialist psychiatric report such as a report on an adolescent or an eating disorder, so I think that, from a practical point of view, it would be quite unreasonable to say that that will happen in 10 days.

Bob Doris: I am probably more confused than I was at the start, but Mr Campbell has given me some ideas. I will also look at Ms Todd’s comments in the Official Report, as there was clearly quite a lot to take in.

I thought that towards the end of her comments Ms Kirk was almost arguing that if clients or patients need to commission an independent report, that process would not start after the 28 days. Instead, it would start at the beginning of the process. Is that not the case?

Karen Kirk: No. We might not be instructed until an application for a CTO has been lodged. We must also bear in mind that these patients are unwell, and that quite often they might not become well enough to instruct a solicitor until 24 to 48 working days before a hearing.

I should also point out that as well as having to go and see people who are detained—and who therefore cannot come to one’s office—we are also dealing with people with fluctuating mental health.

Bob Doris: Those comments are helpful to us in the committee as we tease our way forward on this matter, but I thought that that might be the reason why you would need additional time and why you were almost arguing for the extension.

It might help if we tease out and seek clarification on Mr Campbell’s comments. Perhaps the issue is not whether there should be an increase in the blanket extension from five to 10 days but whether its use, if it is ever used, can be justified as proportionate and reasonable on a variety of grounds and might therefore be ECHR compliant. In other words, the increase in the blanket extension from five to 10 days becomes an issue only if it is applied inappropriately. I suppose that what I am asking is whether there is a breach of the ECHR if it is applied appropriately. If there is not, do we need guidance on when it should or should not be used, or do we leave that to the good judgment of those who are seeking to extend it? I hope that that is clear. I know what I am trying to say, Mr Campbell, but I am not sure that I am articulating it very well.

Kenneth Campbell: What I understand Mr Doris to be asking is whether a provision for an automatic extension for 10 days, as opposed to the existing five days, is problematic in itself or whether we look at the reason for which an extension might be given in an existing case. Perhaps I did not make myself sufficiently clear when I was answering the question earlier. If the existing text were to be changed in such a way as to say that the period of five days could be extended in exceptional circumstances, speaking for myself I do not see an ECHR difficulty with that. There is then a second question about whether an increase in the blanket extension from five days to 10 days would give rise to a convention problem. I suppose that, in that case, we are into the issue of proportionality.

In thinking about that, the committee, and, no doubt the Scottish Government, will be mindful of the evidence that the committee has already had from the Mental Health Tribunal for Scotland about the number of cases in which this is an issue and the reasons for that. I would have thought that, in working out whether a rule is disproportionate, one would have to have that in mind.
I am not sure that I can be drawn much further on the answer to whether it would be convention compliant to have a blanket extension. I suspect that it probably would not be unduly problematic from that point of view, but I certainly do not see a convention problem with the ability to extend in exceptional circumstances from the existing five days.

Dr Simpson: I have a question on this topic, which I think is very important. I am grateful for the evidence that we have had so far. As I understand it, the reason for increasing the extension period from five days to 10 days is to reduce the number of repeat hearings. That was the issue identified in the McManus report. As Jan Todd has said, the number of repeat hearings has reduced quite significantly already. The exceptionality rule seems to be very important here. If the extension is going to save a repeat hearing and the patient, their named person, the person advocating on their behalf or their legal representative seeks an extension of five or 10 days, that does not seem to me to be of critical importance, because the individual is seeking to avoid having more than one hearing. If that was laid down as exceptionality or if the whole 10-day period was considered exceptionality, would that be okay?

Karen Kirk’s evidence is that if a specialist report or an independent report is required, there is going to be a repeat hearing anyway, because the period is 30 days and there is no way that that work can be undertaken within the period that we have been talking about today. That would be a quite different set-up. Can I just check that I am clear about that and can I have comments on the first bit of what I said?

Jan Todd: My concern with any change from the blanket extension, which we were opposed to anyway, to an extension in exceptional circumstances is how circumstances would be described and who would decide when to have a hearing within 10 days as opposed to five. As Karen Kirk said, if the patient needs further time to prepare his case by getting specialist evidence, a further hearing is going to be needed anyway. Would the extra five days make a difference? Are there going to be extra, multiple hearings that will not be helpful to the patient? I am not sure that I see a great need for the change, but that is just my view.

The Law Society was consulted on the proposed five-day extension. The consensus round our table was pretty much that we did not feel that it was necessary and that, from the patient’s point of view, it would be less compliant with the ECHR to have a later hearing rather than an earlier one, and I am still of that view. I prefer the current situation, both for the patient’s protection and from the point of view of not having multiple hearings. I do not think that the proposed change would save a lot.

However, I would be interested to hear what others believe exceptional circumstances would be and who would decide on them. Would it be left to the tribunal service? Would the applicant for a CTO have to make a request, saying, “Here are the exceptional circumstances, and this is why we want a hearing set within 10 days instead of within five days”?

The Convener: Does anyone want to respond to that?

Kenneth Campbell: In general, I would expect that the person who said that there are exceptional circumstances would have to show why that was the case.

Jan Todd: Would that be the applicant? With a CTO, that is generally the mental health officer. What if the patient or their solicitor said that they needed longer? We need to consider the practicalities of how that would work before we find out at a first hearing that has been set up that the patient wanted it to be a few days later because his mum, who is the named person, could not attend. I can see some practical difficulties.

Kenneth Campbell: As you know, there is already plenty of experience of applications for adjournments for exactly those sorts of reasons.

I suppose that we are drilling down into the conflict between the desirability of an early resolution and the desirability of avoiding multiple hearings. It may be that it is impossible to get a complete resolution and what is being sought is the most effective way of reducing to a minimum the number of cases in which there are multiple hearings. I am not sure whether the committee has a sense from the tribunal’s evidence that it has reached that point or whether it believes that further work can be done. The Faculty of Advocates does not have a view about that.

Cathy Asante: Part of the discussion that is taking place is about how the determination of whether there are exceptional circumstances is going to be made. Essentially, the current system, which allows people to seek an adjournment and have a second hearing, allows them to argue at the first stage that there are exceptional circumstances that mean that they need to put it off until a second hearing. There is provision for a tribunal to decide that within the format of a hearing, where it hears evidence and discusses some of the things that Karen Kirk brought up.

The alternative is to have an exceptional circumstances clause of the type that we are discussing, in which case there would be, essentially, a paper hearing, where the tribunal
The Convener:

Agenda item 3 is the final evidence-taking session for our stage 1 consideration of the Mental Health (Scotland) Bill. In this session, we will question the Scottish Government. Welcome to the meeting, minister, and congratulations on your recent promotion. We are pleased that you could make it to the Health and Sport Committee, and we look forward to working with you in your new role.

I formally welcome Jamie Hepburn, the Minister for Sport and Health Improvement, and his Scottish Government officials: Carol Sibbald, Mental Health (Scotland) Bill team leader; Penny Curtis, acting head of the mental health and protection of rights division; and Stephanie Virlo—what is it? [Interjection] The clerk tells me that it is Virlogeux. That is a difficult one for me this morning, I can assure you.

I invite the minister to make an opening statement.

The Minister for Sport and Health Improvement (Jamie Hepburn):

Thank you for your welcome, convener. I should tell you that I, too, had to check with Stephanie how to pronounce her surname, so I understand where you are coming from.

First of all, I realise that this evidence session got caught up in the changeover of ministers, and I apologise if that has delayed the committee’s consideration of the bill. That said, I am delighted to be here in my first appearance as Minister for Sport and Health Improvement, and I look forward to working with the committee. The First Minister has stated that she is seeking a consensual approach, and I hope that that will be a hallmark of our work together.

Before I get to the bill, convener, your clerk had asked for a run-down of my responsibilities, and I am happy to provide that to the committee.

The Convener: That will be useful.

Jamie Hepburn: Along with mental health—which will be an absolute priority area for me, and I will be seeking to engage early with stakeholders in the sector—my portfolio covers dementia, restricted patients, autism and learning disability. All of that sits alongside along matters such as continuing the legacy of the Commonwealth games and action on obesity, physical activity and healthier working lives. Policy for carers, self-directed support and older people’s health also sits with me, while my colleague Maureen Watt,
the Minister for Public Health, will oversee a wide range of issues, including health protection, alcohol and tobacco, and child and maternal health. I am sure that she, too, is looking forward to discussing her role with the committee.

With regard to the bill, I acknowledge the work that the committee has done thus far in its evidence taking. The evidence has been helpful for me as someone who has come to the issue somewhat late on in stage 1, and I am sure that it will also be helpful for the committee’s new members.

The overarching purpose of this amending bill—it amends the Mental Health (Care and Treatment) (Scotland) Act 2003—is to make a number of changes to current practice and procedures to ensure that people with a mental disorder can access effective treatment in good time. In doing so, it seeks to build on the principles of the 2003 act.

However, the bill also proposes the implementation of a victim notification and representation scheme for victims of mentally disordered offenders who are subject to certain orders. The scheme will put such victims on the same footing as victims who are currently eligible to be part of the criminal justice victim notification scheme.

I welcome the high level of stakeholder engagement with the bill. There were more than 100 responses to the Scottish Government’s consultation on its proposals for a draft bill, and the committee received nearly 70 written submissions following the stage 1 call for evidence. The committee has also had four evidence sessions, which stimulated some interesting discussions. I acknowledge the continuing stakeholder input. A small working group has already been convened to look at the necessary revisions to forms that will flow from the bill, and a second small working group will be convened shortly to consider any necessary revisions to the code of practice.

I will do my best to answer members’ questions, and I look forward to reading your stage 1 report when it is available.

The Convener: Thank you, minister.

Richard Lyle (Central Scotland) (SNP): Good morning, minister. I welcome you to your post and wish you well.

My question concerns the two submissions to the convener: the written submission from the Convention of Scottish Local Authorities and a letter from the Finance Committee.

COSLA commented in evidence that “MHO reports would be triggered in far more circumstances than the financial memorandum anticipates.”—[Official Report, Health and Sport Committee, 7 October 2014; c 10.]

In its written submission, COSLA states that it is “concerned that the scope of new duties on MHOs is unclear at this stage … However, it is clear that the additional cost set out in the financial memorandum is an underestimation of the costs associated with the measures contained in the actual Bill.”

In a letter to the committee, the Finance Committee highlights the fact that COSLA “suggested that the total number of hearings requiring a report could be in the region of more than 500” “as opposed to 20 and 40 as stated in the FM. As the FM estimates a cost of £475 per report this suggests an overall annual cost to local authorities of over £281,000 instead of the £18,000 noted in the FM.”

What is your view on those two submissions?

Jamie Hepburn: Given that I was a member of the Finance Committee when that letter was written, you might think that I have created a rod for my own back. We have looked into the matter and—in a nutshell—COSLA’s analysis is correct. I should clarify that I have been advised that there is a discrepancy between the bill and the accompanying documentation, which has resulted in understandable confusion and concern about the number of reports that mental health officers will be required to complete. I accept that COSLA is correct in its assessment of the difference between the policy memorandum and the financial memorandum.

The policy intention is that a mental health officer will be required to produce a report when the tribunal is required to review a responsible medical officer’s determination to extend a compulsory treatment order or a compulsion order in two specific situations, not the three specific situations that are described in the explanatory notes accompanying the bill. The two specific situations are when there is a difference between the type of mental disorder that the patient has now and that which was recorded in the original compulsory treatment order or compulsion order; and when the mental health officer disagrees with the responsible medical officer’s determination to extend the compulsory treatment order or compulsion order. A third situation was included erroneously.

We accept that COSLA’s analysis is correct but, on a practical level going forward, we estimate, on the basis of the most recent hearing figures from the Mental Welfare Commission, that a mental health officer is likely to be required to produce a report as a result of the proposals in fewer than 15 cases a year—that is the total for Scotland as a
whole. If we go with the £475 cost per report to which you referred, we can see that the global cost—based on the most recent year—would be £7,125 spread across all local authorities.

I apologise to the committee and to COSLA for the understandable confusion that the error caused.

Richard Lyle: To be clear, can you remind the committee how many hearings there were last year?

Jamie Hepburn: This is a slight revision to what was set out in the financial memorandum, as the figure at that time was slightly higher. In the past year, there were 15 cases.

10:00

Dr Simpson: My first question is on the same point. The minister has helpfully clarified that there will be only a modest increase in work for MHOs. However, last year, in the Greater Glasgow and Clyde area, there was no MHO report for about 60 per cent or more of detention orders. The annual monitoring report from the Mental Welfare Commission for Scotland indicates concern that, in relation to detention in Scotland as a whole, an MHO report is provided in only about 55 or 56 per cent of cases; I think that that is the figure—it is somewhere in the mid-50s anyway. Clearly, MHOs are already under enormous pressure. Although the increase in work will be modest, I hope that the minister and his team will consider closely whether the funding is adequate to ensure that MHO reports are provided.

My question is about the generality of the bill. It is a fairly narrow bill that is focused on the McManus report, but we heard evidence, both from Steve Robertson from the learning disability group People First (Scotland) and at last week’s round-table session, that, because of new information and knowledge of neurodevelopmental disorders, we should consider a more extensive review of the Adults with Incapacity (Scotland) Act 2000 and the mental health legislation. Have the minister and his team seen that evidence? Does the minister have any comment on whether a broader review is necessary or whether we should tackle the issue by amending the bill to broaden its scope?

Jamie Hepburn: On a longer-term review of incapacity legislation, the committee will be aware that the Scottish Law Commission has recently reported on adults with incapacity. The Government is actively considering that report and we are thinking about how we can look more broadly at issues of restriction of liberty and capacity, and about the best way to deal with that against the background of what is a complex operational landscape. Work is on-going on that, so I cannot say much more on the issue now, but I accept that it is important. We will of course come back to the committee with details of the Government’s consideration in due course. I am acutely aware of the views of many people with learning disabilities and autistic spectrum disorders that their specific conditions are not dealt with in the bill.

If the bill removed those conditions from the scope of the 2003 act, protective legislation would of course still be required, as Dr Simpson has acknowledged. That could be argued to add another layer of complexity to what could be felt to be an already complex legislative landscape. Indeed, it could result in some people with such conditions finding their care impacted on by up to four pieces of legislation—mental health legislation, incapacity legislation, adult support and protection legislation and whatever new legislation would have to be put in place.

I said that I want to have an open dialogue with the mental health sector but, equally, I want to have on-going dialogue with the representative organisations for people with those conditions. Indeed, tomorrow, I will attend the autism conference in Glasgow. I say to those organisations and the committee that my door is always open and that we are happy to consider those matters. However, to be absolutely clear, we have no current plans to remove people with learning disabilities or autistic spectrum disorders from the scope of the 2003 act.

Dr Simpson: Thank you—that is helpful.

I move on to a more specific point, which is the proposed extension of the period for the confirmation of orders from five to 10 days. When McManus proposed that, the number of mental health tribunals that had to be postponed or repeated was much higher than it is today. I pay tribute to the current president of the tribunal, who has reorganised the administrative approach in such a way that the number has dropped substantially and will, we hope, continue to drop.

Is the extension from five to 10 days still an appropriate measure, or might it have the unintended effect that many more applications from RMOs or MHOs will be automatically delayed and, therefore, the period of detention would be extended? The bill says that any additional time would have to be put in place.

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really need the extension now? If we do, should the power not be exercised under the specific condition that the applicant from the mental health side or the individual to whom the order is intended to apply or who will appear in front of the tribunal for a new order seeks to have an extension for a specific purpose? In other words, will regulations define absolutely and clearly the terms of the power so that we do not get the unintended consequence that I described?

Jamie Hepburn: We do not want any unintended consequences with any aspect of the bill. We might want to touch on this later, but the regulations will come before the committee, so the committee will be able to consider them.

I am looking through my notes because I have a summary of the evidence that the committee has taken and I know that the matter was touched on. Like you, I welcome the fact that the number of repeat, delayed and rearranged tribunals has dropped but I am aware that tribunals can still be repeated, delayed or rearranged. We want to minimise that because it always has an impact on the person who appears before the tribunal. Therefore, we still think that section 1 is an effective provision.

I understand that, for good clinical reasons—which can vary from case to case because we are talking about clinical judgments in specific circumstances—applications for compulsory treatment orders might not reach the tribunal until late on. That can create quite a tight notification period for the tribunal and service users—there might not be sufficient time to arrange notification and named persons might have difficulty arranging time off work at short notice. That is what leads to hearings being adjourned, which we want to avoid, because additional hearings can exacerbate the circumstances and the stress for service users.

In the round, we think that section 1 is still an effective provision but, if the committee cares to offer comment on it, we will examine that closely.

To go back to first principles, of course we want to avoid any unintended consequence arising from regulations. The committee will have a crucial role in assessing and providing feedback on the regulations.

Dr Simpson: I accept that it is a fine balance. We do not want to put the person to whom the order applies in the position of having unnecessary repeat, rearranged or delayed tribunals. However, it would be helpful to the committee if we could get further information and up-to-date figures on the matter and an indication of the precise reasons for current delayed, rearranged and repeat tribunals. That would inform us as to whether the balance is still right, given that McManus reported five or six years ago. If that is possible, it would be extremely helpful to us in coming to a conclusion in our stage 1 report.

Jamie Hepburn: Absolutely, Dr Simpson. I see that the officials either side of me are assiduously scribbling, so they have already taken note of that. We will, of course, get that information to the committee.

Dr Simpson: Thank you.

Bob Doris (Glasgow) (SNP): A number of MSPs wish to make points in relation to the matter raised by Dr Simpson. I point out that the Mental Welfare Commission and the Mental Health Tribunal for Scotland both supported the increase in the extension from five to 10 working days. They said that, in a good week or a good month, about 20 per cent of hearings still went to repeat hearings or multiple hearings because reports were not prepared, for a variety of reasons. We have to drill down to find the reasons for that.

We should do anything we can to do to avoid multiple hearings. It could be a case of not getting the views of the named person, and I am conscious that there are reforms to the named person process under the bill, which could create a knock-on effect, so I would be keen for you to take cognisance of that if you continue with the increase in the extension from five to 10 working days.

My question is twofold. First, I am content that, as long as the increase in the extension from five to 10 days is not just seen as an administrative convenience but is viewed as meaningful to those under short-term detention, it is a balanced and proportionate step for the Government to take. I would like some reassurance that the Government will monitor the reasons for the five to 10 working days being deployed by relevant professionals, so that the extension is to the benefit of the person under short-term detention, rather than being for the administrative convenience of professionals. If I could be reassured on that first point, I would be content.

Secondly, concerns were raised at last week’s meeting about compliance with the European convention on human rights. I made the mistake of asking two lawyers for their opinions on the matter, and I got 17 different views—which was quite helpful. That is perhaps slightly unfair. I should point out that the lawyers were witnesses at the committee and were not giving it legal advice.

One of the lawyers said that the new arrangements will potentially be less compliant; the other was content that they will still be compliant. The situation was as clear as mud at the end of that discussion. There seemed, however, to be a general feeling about it. The concern that was voiced last week was that the
extension could be used inappropriately or used uniformly across the board. I am determined to ensure that we get this right not just with regard to the administration of the system but also with regard to the human rights of all our constituents who could be subject to detention orders.

Information on both those aspects would be welcome.

**Jamie Hepburn:** Thank you for those questions, Mr Doris. I note your point that both the Mental Welfare Commission and the Mental Health Tribunal support the measure, which I think is for the same reasons that the Government wishes to pursue it. It is not about administrative convenience; it is about ensuring the best provision of service for those who appear before them.

I return to my earlier point. Although there are fewer rearranged hearings, there are still some, and we wish to minimise them, as they are stressful for service users. That is the primary motivation when it comes to giving service users and their named persons the chance to prepare for any hearing properly; I repeat that the motivation is not about administrative convenience.

You also asked about monitoring. I can assure committee members that the bill team will discuss with the tribunals service the type of markers that can be put in place to monitor the throughput of cases as a result of the proposed change. We of course have to monitor any legislative provisions that we put in place to see whether they are effective.

On the second issue, ECHR compliance, I think that getting only 17 views from two lawyers is arguably a pretty good job. We are convinced that the provision is ECHR compliant, and I think that that is fundamentally important. I used to be the convener of the cross-party group on human rights and I care deeply about human rights issues. I note the comment from the Faculty of Advocates on compliance with the convention, which centres around whether the change is proportionate. The intention behind the provision is, as I have said, to benefit the service user, so on that basis we think that it is a proportionate change. We consider that all the provisions of the bill, including this one, achieve the end of being compliant with the ECHR across the board.

10:15

**The Convener:** The general point was that the provision could be challenged because, although the current arrangement is compliant, we are going into an area where there could be challenge. That is what I took from last week’s evidence, which raised some interesting issues for discussion. If the officials who are with us today have not had time to read last week’s evidence, it is worth considering how practitioners think the process works, what time people currently spend in the system, and whether it can be improved or diminished.

**Jamie Hepburn:** Let me make it absolutely clear that we will look carefully at every bit of evidence that the committee has gathered, particularly with reference to your stage 1 report. On your point about the feeling that the provision could be subject to challenge, I would say that any legislation that the Parliament passes could be subject to challenge. The question, of course, is whether such a challenge would be upheld in the courts, but that is the nature of the Parliament’s competence.

We consider that the provision is compliant with article 5 of the ECHR. I think that I am right in saying that article 5 does not definitively set out a time period for which a person can be detained, so we think that the extra five days, given the safeguards that we have put in, will not fall foul of ECHR requirements. Of course, we will look at every bit of available evidence, because we want to get it right.

**The Convener:** I have a couple of bids from members who wish to ask questions.

**Dennis Robertson:** From what you are saying, minister, I take it that we are looking at the extension as an exception, rather than the rule. If particular conditions were to arise, would the flexibility of the extension allow factors such as the geography of remote rural areas of Scotland or inclement weather to be taken into consideration?

**Jamie Hepburn:** Accessibility for rural areas is not really the motivation for the change.

**Dennis Robertson:** I am not saying that it is the motivation. I am asking whether the change would give you the ability to be flexible. We are not discriminating against people who live in remote and rural areas—far from it—but I am suggesting that factors such as inclement weather could make the extension necessary. In some cases, it could happen that a person cannot return home not because of mental health issues but because of other factors.

**Jamie Hepburn:** I suppose that we cannot rule out any possibility. Although I recognise that it takes longer to get to more remote and rural areas, the increase in the extension from five to 10 days is not intended to address such factors. I repeat that the change is driven by efforts to improve the experience for service users by giving them time to get ready for their appearance before any tribunal. That is the motivation. We might well explore other areas in which the issue of
accessibility for rural and remote areas is more pertinent than in this case.

Dennis Robertson: You are primarily saying that it is the exception rather than the rule.

Jamie Hepburn: I will bring in my officials in a minute. It is the rule in the sense that the period is automatically extended by 10 days. Of course, we always hope that these matters can be expedited as quickly as possible.

Carol Sibbald (Scottish Government): As Dr Morrow said in his evidence, the tribunal will always work at holding the hearings as quickly as possible. As the minister has said, the main point is to assist service users and named persons at what can be a stressful time by ensuring that their case can be determined at the one hearing.

On the points that have been made about setting conditions, the committee might want to consider that the timescale is relatively short and that we can sometimes overcomplicate things. I saw in some written evidence that people might like certain specific circumstances to be set out, but that means having to define those circumstances and decide whether that has to be set out in legislation. It is not that those conditions could not be considered but, in the timescale involved, what we are proposing is a reasonable alternative. As the minister has indicated, should section 1 pass through the parliamentary process, we will monitor its usage. We will also beef up the text of things such as the code of practice, which is under revision, in relation to responsible medical and mental health officers submitting applications at the earliest opportunity.

Jamie Hepburn: Carol Sibbald made an important point. We do not want to overcomplicate the system. Mr Robertson asked whether we are talking about the exception rather than the rule and I am aware that the committee took evidence about this. In fact, I think that it was Mr Doris who asked whether section 1 could be an exceptional provision. I understand the intention behind that point, but Carol Sibbald has set out why that could be seen to be overcomplicating matters.

I make no apologies for making this point again. I want to make sure that we give service users an improved experience and minimise the stress that the system can cause. Let us face it: the system is going to place people under some duress and we want to minimise that as far as we can. If we add another layer of exceptional circumstances, that might make the service user or the named person wonder whether it is something else for which they need to apply. We want to keep the provision as straightforward as possible, but if the committee makes any comments on that, we will look closely at the evidence.

Nanette Milne (North East Scotland) (Con): The bill is silent on the issue of advocacy, which was raised in all the evidence sessions and is clearly important to all the witnesses. Many of them highlighted how advocacy provision across Scotland is quite patchy. The Mental Welfare Commission felt that the 2003 act is quite strong on advocacy rights, but it questioned whether it is being properly implemented across the country. It suggested that

“The Government might commit to proper auditing of the availability of advocacy and the performance of local authorities and health services.”

Do you have any comments on that? I have another question to ask afterwards.

Jamie Hepburn: Let me say at the outset that I am a strong supporter of advocacy, which I think empowers people. I have worked locally with independent advocacy organisations, albeit probably in a different context from the one that we have discussed today—although it occurs to me that the organisation concerned may well interact with the framework that we have put in place to help people with a mental disorder. I am a strong supporter of advocacy.

Forgive me if I am wrong, but I think that the committee was considering the matter in relation to the position of carers in particular, if I remember correctly. Preliminary discussions have taken place between officials and the Care Inspectorate, which is the independent scrutiny and improvement body for care services in Scotland, regarding the possibility of the inspectorate’s programme of audit including a review of how well local authorities are meeting their duty to provide advocacy.

That is something that we take seriously, and the work is on-going. If the committee feels that that is too narrow, we can reconsider the matter, but let me assure you that I, too, think that this is a very important matter.

Nanette Milne: My second question was going to be on carers, in fact. There was quite a strong feeling on the part of organisations such as the Scottish Association for Mental Health that there is nothing in the bill to strengthen advocacy.

Jamie Hepburn: I return to an earlier point. The bill before us is an amending bill. It is not a matter of starting afresh: the bill amends the 2003 act. The point that those organisations are making is that the 2003 act is pretty strong in this area. The question is whether the provisions of the 2003 act are being fully met. We will consider that. I do not know whether there is necessarily a requirement for legislative provision at this stage.

There is a general point across all our discussions today. No matter what aspect of this
area the committee comments on in its stage 1 report, we will examine it very closely.

Nanette Milne: I appreciate that—thank you.

Mike MacKenzie: In doing my homework for this meeting, I was pleased to note that a lot of the witnesses had placed a high emphasis on the importance of advocacy. I will pick up on that theme. How far could the accountability mechanism for the provision of advocacy be directed towards an examination of the special challenges of geography that we experience in the Highlands and Islands?

The Arbuthnott formula for health funding contains a provision for rurality, as has the grant-aided expenditure formula for local authority funding. Therefore, it seems reasonable that rural authorities ought to make provision for rurality in deciding what resources they make available for advocacy organisations. I am interested to hear from the minister—in pursuing the accountability mechanism or in considering accountability—to what extent there is proper provision of advocacy and how far rurality can be taken into consideration.

Secondly, we all agree that it is absolutely important to increase provision of and access to independent advocacy if at all possible, but to what extent is it possible to say that advocacy is genuinely independent? Advocates and advocacy agencies are very conscious of the fact that funding may well come from the very agencies that they sometimes have to challenge.

Jamie Hepburn: Mr MacKenzie is not the only one who has been doing his homework at the weekend, after coming to the bill a little later than might have been felt to be ideal.

In the legislative framework, those are clearly matters for local authorities. I have already pointed out that there are on-going discussions about how we can look at how well local authorities are fulfilling their legislative duties. I suppose that we can try to factor in issues of rurality. As with most things in life, it is just that little bit more difficult in rural areas. It is certainly something that we can reflect on.

10:30

On the question of how independent the advocacy agencies are, that is in the eye of the beholder, as with anything. In my experience, despite it often being the case that such agencies require core funding from the very bodies to which they may be making representations on behalf of their client base, they are assiduously clear about the need to be independent of those organisations, and they take that responsibility seriously. Of course, we are talking about a huge range of different organisations and no one situation will be precisely the same as any other.

Mike MacKenzie: Do you agree that the constructive criticism and analysis that advocacy agencies can provide on common issues can be extremely useful for the authorities that they engage with? I am aware that some authorities appreciate the value of that feedback mechanism, while others do not. Is there anything that you as a minister can do to encourage that positive feedback loop?

Jamie Hepburn: Criticism can sometimes be difficult to take, but if it comes your way you have to reflect on what has been said, and if there are areas that you need to improve on, you need to look at them. It is difficult to make a general comment about that. I do not know whether there is a specific situation that Mr MacKenzie has in mind, and even if there is I am not sure that I will be able to comment on it, but I certainly think that the process of constructive feedback can allow organisations to continue to improve their work. That is an issue not just for local authorities but for the bodies that are relevant to the bill—the commission and tribunal—and for the Government, because we also need to hear what is said.

The Convener: The minister said earlier that we should not expect any increased capacity in advocacy as a result of any part of the bill. Members have mentioned, and it is reflected in the evidence, that the bill complements all the Government’s legislation in relation to delivering advocacy on the ground, particularly as good advice is available on avoiding delays. Has the Scottish Government audited or evaluated advocacy services? Whether it is true or whether it is a perception, people feel that provision in rural areas is likely to be patchy. In urban areas, there is more availability, but the problem may be access. There is a question about whether the Government’s objectives and policies are working effectively for the people for whom we want them to work, and advocacy is a key aspect of that. Is there any recent work that suggests that there is a problem, or has there been an audit of the services? Are health boards meeting their responsibilities?

Jamie Hepburn: I say first that the answer depends on what kind of advocacy organisations we are talking about. There are some organisations that relate specifically to the bill, and I have referred to some of the on-going work, but I am aware that they will interact with elements of the public sector on a wider basis than just the area of the health service that we are discussing. I reiterate that there is, of course, dialogue with the Care Inspectorate on assessing how well local
authorities meet their advocacy duties under the 2003 act.

The Government is working to produce guidance on advocacy for carers, with the aim of launching it early next year. The guidance will be a useful tool in making people more aware of their right to advocacy and the existence of advocacy organisations.

The Convener: I am looking also to your officials. Has there been an evaluation of advocacy services and where they are effective, sparse, properly funded and so on?

Jamie Hepburn: I have to tell you that I need to look to my officials on that, too.

Penny Curtis (Scottish Government): I am not aware that there has been such an evaluation. The minister talked about our work with the Care Inspectorate, which is at an early stage and very much reflects some of the views that have been expressed in evidence on the bill. We will look at the Care Inspectorate’s work programme to ascertain whether we can accommodate the matter within it. We absolutely want to reflect on what people are saying.

Jamie Hepburn: If the convener is proposing a review of advocacy organisations, we need to be clear about what we would be asking about. If the issue is the provisions in the 2003 act, work is going on in that regard, but if the issue is wider aspects of advocacy we might need to discuss that with colleagues elsewhere in the Government.

The Convener: I was asking mainly about advocacy support for mental health patients under the various acts—the bill tidies up the 2003 act. Practitioners have talked to us about the issue. I am not proposing a review; I was picking up Mike MacKenzie’s point about the perception that expert advocacy is not always available or funded. It has been claimed, at least, that the service is patchy across the country, and I think that the committee and the Government want to establish whether that is the position. That is what I was driving at. As we all recognise, we can legislate, but there might also be practical steps that we could take to address the evidence that we have heard and to make the legislation meet its objectives more effectively.

Bob Doris: The committee is scrutinising a bill in which advocacy does not come up. We often talk about advocacy in general terms, rather than thinking about what it means in the context of the provisions in the bill, so I was considering that while I was listening to the minister’s discussion with the convener. You raised the issue yourself, minister.

We have from time to time had fairly lengthy discussions about extension by five days of the 28-day short-term detention order, and about whether the extension should be for 10 days. I do not expect the minister to have the answer at his fingertips, but it would be good to know whether sometimes extensions are needed because service users or their families have not had appropriate advocacy that would have enabled them to engage with services and prepare reports. If that is so, greater access to advocacy might mean that an extension of 10 working days would not be needed and might avoid the need for multiple reports and hearings. That is a concrete example of an area in which advocacy could have an impact.

There are other such areas in the bill, such as the provisions on appeal against being held in conditions of excessive security, appeal against transfer from one hospital to another and the preparation of advance statements.

There are pinch points in the system, for which the bill makes provision and in relation to which the Government might consider how advocacy should be used and whether there should be additional advocacy responsibilities. For me, that would be more meaningful than a general review of advocacy across the board. Will the Government consider that?

The Convener: I was not calling for an overall review, but I was addressing the evidence that we have heard and the points that have been made suggesting that advocacy is not necessary in some specialist areas in which there is very much a legal process and there are services to provide that. I was also thinking about people being encouraged to nominate a named person and being more aware of how the service works at a lower level that complements the bill and the Government’s objective. I do not want to labour the point too much. After the minister’s response, enough has probably been said on the issue.

Jamie Hepburn: I do not think that you are labouring the point at all, convener. The committee is absolutely right to consider the area seriously. As I said, the provision of advocacy is important. We will look closely at any recommendations that are made and we will look again at your evidence. I am inclined to agree with the points that have been made by the deputy convener about advocacy playing a crucial role in improving the experience of service users at pinch points. That is a fair way of looking at it. I have said that the 2003 act already sets out the right to advocacy, and I presume—I will invite Carol Sibbald to comment in a moment—that that provision will still allow for the interaction of advocacy agencies at those pinch points, as Mr Doris described them.

I agree that we need to ensure that service users are aware of the function of the named person. I am conscious that some campaigning
bodies and stakeholders have talked about having awareness-raising campaigns; they can be good for a short time, but once a campaign is over and done with its impact could be short lived. We need to look at how we can raise awareness from grass-roots level and build upwards from there. A number of organisations, including the national health service, local authorities and the Government, have crucial roles to play in promoting use of named persons. Of course, advocacy bodies themselves will want to tell people that they have a right to a named person. If the committee has a view on how we can better make people aware of the named person provision, we would be happy to look at your suggestions.

Carol Sibbald will comment on the 2003 act’s provisions on advocacy.

Carol Sibbald: I would like to pick up on the comments about pinch points, which were absolutely correct. It is crucial that people have access to advice. Part of the role of mental health officer is to make individuals aware of their right to advocacy and to help to put them in touch with advocacy agencies. We often find that nursing staff are familiar with the good work that is done by advocacy agencies, so assistance can be given to individuals in the hospital setting in accessing advocacy services.

Rhoda Grant (Highlands and Islands) (Lab): The bill includes a provision to nominate a named person and a provision not to nominate a named person. However, if the person has done neither, the situation will revert to provisions under the 2003 act, and the next of kin would be put in the named person role. We have taken evidence from service users and carers, and they do not like the reversion back to the 2003 act’s provisions, because the next of kin may not be willing to take on the role, or the service user may not wish the next of kin to have access to their medical records. Have you given any thought to changing that by amendment at stage 2?

10:45

Jamie Hepburn: I recognise that this is a sensitive area, and I understand the strong view that has been expressed by stakeholders who have engaged with the committee that service users should have a named person only if they want one. The Government is generally very supportive of that. Provision has been made for service users to opt out of having a named person.

You are correct to identify that if an individual has neither nominated a named person nor chosen to opt out, the role reverts back to the person’s primary carer or nearest relative. You have made the point already: there could be many reasons why an individual—the carer, the next of kin or the service user—would not wish that to be the case. The Government wishes to retain the provision in the best interests of service users, as a form of protection for people who lack capacity. To be fair, however, and having reflected on what has been said to the committee, we have perhaps not struck the right balance, so we will be happy to reconsider the matter.

Rhoda Grant: Carers and next of kin have also expressed the wish to be able to refuse to be the named person if they are nominated but feel that they are not best equipped to carry out the role.

There has also been some discussion around what the role of the carer or next of kin would be. It was suggested that they should perhaps have a separate role to that of the named person, such that they might be consulted and would be able to speak, but without having the powers that are given to the named person. They could play a role in their own right that they felt comfortable with and able to fulfil without encroaching on the rights of the service user and without having to take on the full role of a named person. That would give different people different roles, but it might be in the best interests of the service user to have those different roles in place.

Jamie Hepburn: That is the flipside of the point that I have just made. As I reflect on the matter further, it could equally be the case that a carer or next of kin will not wish to take on the role, as you have said. We will reflect on that specific point, too. Unless there are exceptional circumstances in which a carer or next of kin should not be involved, it would be understandable if they wished to continue to play a role in relation to the service user.

The tribunal can hear from persons of interest, which would include a carer or next of kin. If it is felt that that does not cover the point that Rhoda Grant is making, we could consider the matter further, but the essential point is that such people can continue to play a role in the process without being the named person.

Dennis Robertson: I wonder whether there might sometimes be some conflict. For instance, if the relationship between the consultant psychiatrist and the members of the family is not good, and the named person is the next of kin, but the consultant feels that that arrangement is not in the best interests of the patient if they are going to proceed towards a better outcome, where do we stand? Do we go with the views of the consultant in saying that the main barrier to achieving a positive outcome is that named person? Do you have a view on that, minister?
Jamie Hepburn: I will bring in Carol Sibbald on that point in a minute. I do not want to say something that might be incorrect. Having read the notes, I think that there is provision for the removal of named persons, although I could be wrong about that.

In such circumstances, when there is a disagreement between the qualified medical professional and the carer or next of kin, that is very unfortunate. If the disagreement relates to the interaction with the tribunal, the tribunal will consider the matter and will come to a decision. Under the bill, there is an increased role for mental health officers by way of the provision of reports to tribunals when that is applicable. That would be another point of view. It is for the tribunal to rule, taking into account all the evidence that is placed before it.

I invite Carol Sibbald to comment.

Carol Sibbald: The minister has covered the main points. Any disagreements between both parties will be fully explored at the tribunal hearing. The tribunal will then reach a determination on the basis of the evidence that has been presented to it.

In relation to the removal of a named person, the minister is probably thinking of the provision that we have for children under the age of 16. If they currently have a named person but it is felt that that named person is not acting in their best interests or is not carrying out the role, there is provision for the tribunal, on the basis of the evidence that is presented to it, to remove that named person and appoint a more appropriate person. That will involve discussions with the mental health officer and others.

Under the new provisions, someone will have a named person only if they wish to have one, and the person who is nominated to be the named person must sign to say that they are content to take that role. In our view, there will be less opportunity, and therefore less need, for the tribunal to step in and remove a named person.

Jamie Hepburn: That is, indeed, the provision that I was thinking of.

Perhaps I should have made this point earlier. We hope that, in such circumstances, any disagreement or problems between the medical practitioner and the carer, next of kin or wider family will be resolved amicably before things reach that stage. Nevertheless, there must be provision for such circumstances.

Colin Keir (Edinburgh Western) (SNP): Good morning, minister, and congratulations on your promotion.

My question is on the aspect of the bill that deals with people under the age of 16. Was any consideration given to the inclusion of McManus recommendation 4.16? It states:

“A young person under the age of 16 who has adequate understanding of the consequences of appointing a named person should be able to do so.”

Jamie Hepburn: I think that Mr Keir is congratulating me on my promotion because we used to share an office and he has finally got rid of me after three years.

That matter has, indeed, been raised. Although it is important to allow a young person to express a view on matters that will directly impact on them, it is equally important to protect those who are most vulnerable, and it could be felt that young people are particularly vulnerable in that regard. An overwhelming majority of respondents to the Scottish Government’s consultation on the bill did not say anything in relation to the matter. If Mr Keir or other members wish to make recommendations or comments on the issue in the committee’s stage 1 report, we will consider them in detail.

Colin Keir: It is just that that particular issue about those aged 16 and under was brought up in another context, so I thought that I would ask about it.

I have one more question. I do not know whether you addressed this point earlier—perhaps you did and I missed it because I am bit cloth-eared this morning. I gather that the chair of the mental health nursing forum Scotland said, in effect, that the proposal to extend the nurse’s holding power would not work. Can you comment on that?

Jamie Hepburn: Sure. Mr Keir can rest easy—we have not explored the issue thus far.

I will need to look again at that particular comment, but I do not think that the person in question went as far as to say that the provision would not work; the question was whether it was felt to be necessary. I recognise that there could be concerns that the changes to the nurse’s holding power could result in the restriction of a service user’s liberty, but the Government has made it very clear that the provision refers to a time period of up to three hours. The code of practice that we will put in place will strongly emphasise that the nurse must take all reasonable steps to contact a doctor and a mental health officer right at the start of the period and, equally, that hospital managers should impress upon their medical staff the need to make themselves available to examine the patient as soon as possible.

We would expect the detention to last only for as long as was required for the examination; in other words, the full three hours should be used only if that length of time is required. I also point out that, under existing powers, the current two-
hour period can be extended by an hour, which means that, if the extension is put into effect right at the end of the two hours, the period can be more or less three hours already. Several stakeholders have recognised in their responses to the Government’s consultation that the change should allow sufficient time for a medical examination to take place. They hope that it might reduce the number of occasions on which doctors have to apply for what could be an unnecessary 72-hour emergency detention certificate in order to complete a medical examination, given that such a move would have significantly more impact than the three-hour period.

The provision is driven by a desire to improve the experience for service users and should provide clarity for service users on the maximum period of time for which they can be detained under the nurse’s holding power. At the moment, the period is two hours but it can be extended to three hours. It should also, I hope, make it clear to service users that they are being detained to enable a medical examination to be carried out.

Colin Keir: I apologise for having misquoted in my previous remarks. My memory is obviously not as good as the minister’s. He is perfectly right—the chair of the mental health nursing forum Scotland said that there would be no advantage to such an extension.

The Convener: Indeed. He said that there would be no advantage to such a move, that it was not based on evidence, that it would impact on nurses’ workload and that the idea had not come from nurses. The Mental Welfare Commission, too, opposes the move. It is certainly an issue that the committee should look at.

Colin Keir: It is my fault for not phrasing the point properly.

The Convener: No—you are right, Colin.

Is your question on this specific theme, Dr Simpson?

11:00

Dr Simpson: Yes, convener. The Mental Welfare Commission has reported that a nurse’s order has been used on 177 occasions and that on no occasion did a doctor attend within the prescribed time. However, the two most interesting points in its submission are, first, that there is massive variation in the use of the orders—a quarter of them were made at the Royal Edinburgh hospital, which suggests that there is something not right about the way in which they are being applied—and, secondly, that there might be underreporting with regard to the NUR 1 form. We need further detail and some proper research done on what is actually happening. We also need to see what will happen as a result of the Mental Welfare Commission’s response to its own report, which was to issue new guidance on the use of the nurse detention system.

Given the evidence that has been highlighted by Colin Keir and quoted by the convener, I am minded to suggest that we recommend in our stage 1 report that the change should not be made unless the Government can produce convincing evidence of the number of occasions on which, as the minister has just suggested, an emergency detention order has been employed because of delays. Given that the number of such orders has dropped from more than 3,000 to 1,000, I would need to see evidence of the number of occasions on which that has occurred before I would be prepared to support the change. After all, we are talking about a further small but nevertheless possible period of detention.

Jamie Hepburn: I take on board Dr Simpson’s points, but I can tell him that, in its recent guidance, the Mental Welfare Commission says that the numbers involved will be reviewed. Moreover, the fact that the number of emergency detention certificates has dropped and there might not have been any recently does not mean that there is no possibility of utilising such certificates any more.

The proposal is to change the period in question from two to three hours; we are not proposing anything as drastic as an extension from two to 24 hours. I make the point again that, right now, nurses have the power to detain someone for two hours and that period can be extended by another hour. If that happens towards the end of the initial two-hour period, we might already be talking about a three-hour period.

The most important point—I am sure that Dr Simpson will accept this—is that the period in question should be up to three hours, as we want to ensure that such matters are dealt with as quickly as possible. We have already discussed issues of accessibility in rural areas and so on. When I said, in response to Mr Robertson’s question on the extension from five to 10 days in another section of the bill, that there might be other areas of the bill in which such a move might be more about accessibility, I was thinking of this as an area in which such a change might make things easier in rural areas.

Nevertheless, we will consider the points that Dr Simpson has made. We do not want to do anything that is felt to be disproportionate or absolutely unnecessary, but we feel that there could be some advantage in formalising the three-hour period instead of retaining the possibility of the two-hour period being extended to three hours. As I have said, such a possibility might not be entirely clear to a service user, who might turn up
in the expectation that the period will last only two hours and suddenly find that—bang!—it has been extended to three hours. If we make the change, the person will be clear from the outset that the period could last up to three hours.

The Convener: Richard Lyle has a question on the same subject.

Richard Lyle: It is on another subject, convener.

The Convener: That is good—we are moving on.

Richard Lyle: I want to ask about something that we have not yet covered: the wider review of mental health and incapacity legislation. Minister, you said that you are going to attend a conference on autism tomorrow. At a recent party conference, I had a discussion with Autism Rights. Autism Rights and Psychiatric Rights Scotland have called for the removal of people with learning disabilities and autistic spectrum disorders from mental health law. Inclusion Scotland has also commented that people with learning difficulties are concerned that they will be subject to compulsory treatment as a result of their learning disability alone. What consideration have you given to removing people with learning disabilities and autistic spectrum disorders from the scope of mental health legislation?

Jamie Hepburn: I touched on this earlier when I made it clear that I recognise that people out there hold such a view. We do not have plans to remove people with learning disabilities or autistic spectrum disorders from the scope of the 2003 act at this stage. I made the point earlier that, even if they were no longer covered by that legislation on the basis of their having a learning disability or an autistic spectrum disorder, the bill, incapacity legislation, adult support and protection legislation and new legislation would still encompass them. It could be felt that that would complicate matters, although that in itself is not necessarily an argument against such a move. As I said earlier, I will be happy to maintain an open and on-going dialogue with the representative bodies.

I suspect that you are talking about a party conference that I attended, and I confess that I did not have a conversation on the issue then. However, the First Minister has made the point that she wants this to be an accessible Government, so I will certainly be looking to play my part in relation to my portfolio, and I will be happy to speak with the representative bodies on that issue.

Richard Lyle: I am sure that the organisations that spoke to me will be happy with those comments.

Jamie Hepburn: I am sure that they will, and I look forward to meeting them in due course.

Dr Simpson: I have a question on the degree of security. The extension of the right of appeal to a medium-secure unit is welcome, but some of the evidence that we have heard suggests that it should be extended to low-secure units as well. Does the minister have any comment on that and on the extension of the right of appeal to civil orders?

Jamie Hepburn: It is an area in which we have to legislate because of the provisions of the 2003 act. It was the clear intent of Parliament that there would be a right of appeal. As it was framed at the time, the 2003 act addressed the need for someone to be transferred to another hospital, but, as I am sure Dr Simpson will appreciate, that does not reflect reality. In some settings, a person can be transferred from one part of a hospital to another part, which I hope the committee agrees is a lot better for the service user. However, the subordinate legislation that we would have liked to put in place was not possible under the scope of the primary legislation as it was worded in 2003.

There has, of course, been a ruling by the Supreme Court that emphasises the need for us to act swiftly. As I want to be as transparent as possible with the committee, I should also say that there is now a petition before the Court of Session on these matters. However, that is as much as I can say in relation to the issue for two reasons: first, that is about as much detail as I have at this stage; and, secondly, I do not want to fall foul of the Presiding Officer in terms of what is sub judice.

We have to get it right this time, and we are determined to do that. I am also aware that, as these are affirmative instruments, the committee will want to be able to assess their efficacy, so another good reason for getting them in place early is to allow the committee time to properly scrutinise the provisions.

The Scottish Government does not consider that there is necessarily a problem with patients being held in low-secure settings. The provisions relate to patients being held in “conditions of excessive security”, and we are not convinced that low-secure settings fall under the definition of “excessive security”, particularly since the next step in progressing patients in low-secure settings is getting them back into the community and it is open to the tribunal to order that as part of its ongoing review of procedures, which is covered elsewhere in the 2003 act.

We are not convinced that there is a need to extend the right of appeal—beyond what we are doing in relation to people in medium-secure settings—to include people in low-secure settings. However, I make no apology for saying again that
I am keen to hear what the committee has to say, and if the committee makes recommendations on the matter we will look closely at them.

The Convener: The test of that will be your response to our recommendations.

Jamie Hepburn: I am aware of that. I could be making a rod for my own back.

The Convener: That will be a test for you as a new minister.

If members have no more questions, I will ask about registration of advance statements, which is provided for in section 21. The Mental Welfare Commission welcomed what it described as a “modest and perfectly sensible provision”.—[Official Report, Health and Sport Committee, 30 September 2014; c 3.]

However, the commission also highlighted a matter that we heard about in evidence. We all recognise that if someone makes an advance statement when they are well it should improve their experience when they are unwell, but there has been a slow take-up of advance statements and the commission has said that the provision in section 21 will not in itself change that. We have heard that people have a notion that advance statements are not considered or acted on. Is the Government doing any work to promote advance statements? Have you talked to user groups about how we might do better in that area?

Jamie Hepburn: I am new to this, so I do not know what discussions have taken place. As I said, we will always be happy to have dialogue, but we have no plans to undertake research specifically on whether advance statements are underutilised and whether there are barriers to making them.

Advance statements are an important part of the process, and a register of statements, which will be held by the Mental Welfare Commission, will provide data on the number of advance statements that are made in Scotland and their geographic spread by NHS board. That will help us to build up a much better picture of how widely advance statements are being used. If need be, we will be able to respond to circumstances.

The Convener: I am sure that you have ideas for the future. Can the officials say what the historical position has been on how advance statements work and their slow take-up?

Carol Sibbald: It is a difficult issue. The register will help, because we will have everything in one place provided that health boards submit copies. We will then get a better picture. The anecdotal evidence is that take-up is quite good in some areas and perhaps not good in others.

There is the facility to override what is in the advance statement, and some people think, “What’s the point of making a statement if it is going to be overridden?” However, data from the Mental Welfare Commission show that that happens in a very small number of cases. We probably need to get that message out a bit better.

We recognise the good work that an advance statement can do, but an individual who is leaving hospital after a mental health episode probably does not want to start thinking about what they should put in place in case they are ill again—they want to think that they will not be ill again.

As the minister said in the discussion about named persons, it is about trying to raise awareness, from the grassroots up, of the effectiveness of an advance statement as a tool.

Jamie Hepburn: I suppose that one of the aims of the provision is to enable us to monitor the picture much better in the future.

The Convener: I accept that. I note that Carol Sibbald said that that will happen provided that health boards submit copies.

Carol Sibbald: There will be a duty on health boards—

The Convener: A clear duty?

Carol Sibbald: There will be a clear duty on health boards. The provisions in the bill require the health board to place a copy of the advance statement in the patient’s records and, at the same time, to send a copy to the Mental Welfare Commission.

Jamie Hepburn: As I remember from the evidence that the committee heard, the approach can improve the patient experience—I think that the deputy convener made that point. Currently, advance statements are held by the general practitioner and are not held centrally, so there is an issue if someone needs to access a statement quickly but the GP is not available. Again, the approach is driven by the desire to improve the service user’s experience.

The Convener: If you take note of what the deputy convener of the committee says, you will not go far wrong, minister—at least with him.

Bob Doris: That is not what you have said in the past.

The Convener: It was a pleasure to have you here for the first time, minister. We look forward to working constructively with you and your team in the future. I thank you all for your time and your evidence.

11:15
Meeting suspended.
WRITTEN EVIDENCE TO THE HEALTH AND SPORT COMMITTEE

MHB001 - Psychiatric Rights Scotland
MHB002 - North Lanarkshire Mental Health and Learning Disability Partnership
MHB003 - The College of Occupational Therapists
MHB004 - The Royal College of General Practitioners Scotland
MHB005 - Dr Andrew Watson (Individual)
MHB006 - Police Scotland
MHB007 - Tom Todd (Individual)
MHB008 - South Lanarkshire Council
MHB009 - Glasgow Caledonian University School of Health and Life Sciences
MHB010 - The Faculty of Advocates
MHB011 - Scottish Ambulance Service
MHB012 - Royal College of Psychiatrists in Scotland
MHB013 - Victim Support Scotland
MHB014 - Patricia Whalley (Individual)
MHB015 - Greater Glasgow and Clyde Area Psychology Committee
MHB016 - The ALLIANCE
MHB017 - Professor David Healy
MHB018 - East Lothian Health and Social Care Partnership
MHB019 - The State Hospitals Board for Scotland
MHB020 - NHS Greater Glasgow and Clyde
MHB021 - The Law Society of Scotland
MHB022 - Mental Health Network Greater Glasgow
MHB023 - Scottish Tribunals & Administrative Justice Advisory Committee (STAJAC)
MHB024 - The Forensic Mental Health Services Managed Care Network
MHB025 - Maurice Frank (Individual)
MHB026 - SAMH
MHB027 - Scottish Human Rights Commission
MHB028 - Fife Council Social Work Service
MHB029 - Barnardo's Scotland and NSPCC Scotland
MHB030 - The Scottish Independent Advocacy Alliance
MHB031 - Together (Scottish Alliance for Children’s Rights)
MHB032 - British Psychological Society
MHB033 - Midlothian Council
MHB034 - ADSW Mental Health Sub Group
MHB035 - East Renfrewshire Community Health and Care Partnership
MHB036 - North Ayrshire Health and Social Care Partnership
MHB037 - Legal Services Agency Mental Health Representation Project
MHB038 - Autism Rights
MHB039 - Glasgow City Council Social Work Services
MHB040 - Inclusion Scotland
MHB041 - Mental Health Foundation
MHB042 - Carers Trust Scotland
MHB043 - Scottish Disability Equality Forum
MHB044 - Social Work Scotland
MHB045 - W. Hunter Watson
MHB046 - General Medical Council
Psychiatric Rights Scotland

Mental Health (Scotland) Bill

Psychiatric Rights Scotland is an organisation which aims to protect the human rights of people in psychiatric settings in Scotland. It is made up of service users and carers, most of who have experienced or witnessed very bad experiences in psychiatric care.

It is a member of the Cross Party Working Group for Mental Health at the Scottish Parliament. It has a website on Facebook organised by a service user. This submission has been drafted by carers with input from service users.

We have serious concerns about the Mental Health (Care and Treatment) Scotland Act 2003 (the 2003 Mental Health Act) and the following is a précis of these concerns:

1. Psychiatric drugs have serious side-effects and do more harm than good
2. The United Nations is recommending an end to compulsory treatment for human rights reasons
3. The admission process to hospital is not robust, with treatment before a court hearing
4. Mental Health Tribunals are very unfair and lead to wrong conclusions
5. The Millan principles (principles of good practice) are ignored including carers’ views
6. The World Health Organization (WHO) recommends that Electro Convulsive Treatment (ECT) should only be given with informed consent
7. People with autism and no mental illness should be excluded from the 2003 Mental Health Act
8. Complaints are very rarely properly investigated

1. **Psychiatric drugs have serious side-effects and do more harm than good**

1. In one important 2013 study, patients stopping antipsychotics had more than double the chance of achieving "functional recovery" than those continuing to take the medication.
2. Serious long term antipsychotic effects are routinely ignored by psychiatrists.
3. Antipsychotics cause specific harm to people’s brains, for example: Brain Tissue Changes and Antipsychotic Medication [Puri BK (2011)].
4. Evidence of long term antipsychotics doubling the mortality rate of elderly patients and causing Parkinsonism.
5. Thomas Leonard has created a website researching side-effects.
6. There is overwhelming evidence that psychiatrists are increasingly working to a single treatment paradigm i.e. drugs and these are over prescribed e.g. there has been a 50% increase in the number of patients prescribed antipsychotic drugs in the last 10 years (ISD data).

7. There is good evidence of beneficial effect for some patients with severe and enduring mental illness such as schizophrenia and bipolar disorder, but drugs should not be the only treatment.

8. It is unfortunate that DSM has expanded from 160 diagnoses at outset 60 years ago to 550 different conditions now. This means that 20% of the population qualify as having a mental disorder.

9. Drugs get used for conditions they should not be, such as autism, dementia, learning disability and many cases of depression.

2. The United Nations (UN) is recommending an end to compulsory treatment for human rights reasons

1. UN Convention on the Rights of Persons with Disabilities (CRPD): Since the UK has ratified this Convention the Scottish Parliament is required to take account of it when it legislates.

2. On 4 March 2013 Juan Mendez, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment addressed the Human Rights Council of the UN and in his address made the following statement: “The CRPD offers the most comprehensive set of standards on the rights of persons with disabilities and it is important that states review the anti-torture framework in relation to persons with disabilities in line with the CRPD. States should impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind altering drugs for both long- and short-term application.”

3. It is doubtful whether there should be an absolute ban on all involuntary treatment. However, Parliament should study closely Article 12 of the Convention on the Rights of Persons with Disabilities. Article 12 is concerned with legal capacity, something to which insufficient attention has been given in the 2003 Mental Health Act and by those implementing it. An individual with capacity has the right to refuse treatment.

3. The admission process to hospital is not robust, with treatment before a court hearing

1. A patient has less rights than a criminal in comparison.

2. Andres Breivik of Norway killed 77 people yet was able to stand up in court and lucidly defend his actions publicly. He was able to examine the evidence
and get excellent legal assistance to show that he should not be put in a psychiatric institution.

3. A person who has committed no crime can be detained and treated for 28 days under a Short Term Detention Certificate (STDC) based on a single interview behind closed doors with a psychiatrist without legal representation or assistance from friends and family.

4. When compulsory measures are used the psychiatrist becomes the "police" taking and interpreting the witness statement, the "prosecution", the "judge" and the jury. While others i.e. the Mental Health Officer (MHO) and a General Practitioner may be involved this not in an adversarial way as occurs in the criminal justice system and what results is a lack of cross-examination or quality control.

5. Psychiatrists are as faulty as the rest of us and will make mistakes as do the police and Members of Parliament but the difference is that psychiatrists are able to operate and remove liberty without effective governance.

6. For a STDC there is no way of making sure an interview with the MHO and contact with the family takes place.

7. The only way to improve the system is to introduce a professional who can defend the rights of the patient and hold the psychiatrist and the MHO to account.

8. The treatment before a court hearing can actually make a patient worse, since the side-effects of medication can appear to be symptoms of a mental illness.

9. The Council of Europe have recommended that before someone is placed or treated in a psychiatric institution a fair and public hearing must take place.

10. The ECHR has ruled that no individual shall be deprived of his liberty on the basis of unsoundness of mind unless, at a minimum, he or she has reliably been shown to be of unsound mind.

4. Mental Health Tribunals are very unfair and lead to wrong conclusions

1. There is no “equality of arms” between the patient and the treating psychiatrist and therefore too many people are subject to compulsory treatment.

2. There is a presumption that the patient has a mental illness.

3. A patient is likely to be heavily sedated and cannot properly represent themselves.

4. The National Health Service (NHS) controls all the documentation. Thus they have more time to prepare and can also withhold information unfavourable to them.

5. The constitution of the tribunal (a lawyer, psychiatrist and usually an NHS employee) is such that the diagnosis of the treating psychiatrist is less likely to be challenged than if they were drawn from the public.
6. They are held in secret and can therefore not be scrutinised.

7. Witnesses are not on oath and are thus more likely to make misleading statements.


9. Tribunal members are paid about £400 per day. It is possible that it might be in their financial interest for people to be on compulsory treatment.

10. The tribunal too often functions as a tick box exercise where judicial process is seen to be done but is not really fair or proper. Usually it seems to boil down to the opinion of the Responsible Medical Officer which the tribunal team will rarely go against unless the patient can afford to get another psychiatrist as an alternate expert. The cross-examination process is quite feeble and clinical judgements such as how an opinion on lack of capacity was made are not tested.

5. The Millan principles are ignored including carers’ views (these are a set of principals enshrined in the 2003 Mental Health Act)

1. There are vast publications claiming stakeholder involvement but when it occurs it is usually tokenism.

2. Many of the submissions to PE1494 (a petition to parliament from us about amending the 2003 Mental Health Act) are from carers whose views have been ignored.

3. These principals are unenforceable. Claire Muir, a service user, took out legal action against the NHS. One of her claims was that the Millan principles were not followed. The sheriff dismissed the case without allowing her husband to speak.

4. The principle of participation (Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support) is not followed in any way in some cases.

5. The principle of benefit (Any intervention under the Act should be likely to produce a benefit for the service user) is not followed in many cases since in the 2009 Julie Ridley survey, 50% of all users said compulsion was not right for them.

6. WHO recommends that ECT should only be given with informed consent

1. The 2003 Mental Health Act permits ECT to be given to a patient who resists or objects to the treatment. However, since the passage of the Act, the WHO has recommended that “If ECT is used, it should only be administered after obtaining informed consent”.
2. The UN Special Rapporteur on torture, etc. has recommended that states should impose an absolute ban on non-consensual electroshock, i.e. on non-consensual ECT.

3. The safeguard relating to ECT requires a designated medical practitioner to consent before it can be given against a patient’s will. That this safeguard is worthless is evident by considering the experience of Claire Muir. She was seen by a designated medical practitioner but she claims that he had made no attempt to assess her. Fortunately she was put into the care of a different responsible medical officer who revoked her compulsory treatment order since he could detect no identifiable psychiatric disorder. There is no guarantee that a designated medical practitioner will carry out a proper assessment of the patient when required to do so under the Act.

4. According to the National Institute of Clinical Excellence (NICE) some who have been given ECT “report feelings of terror, shame and distress...”. The information from NICE in its consultation document would appear to make clear that involuntary ECT falls within the definition of inhuman and degrading treatment provided by the European Court of Human Rights in the 2002 case of Pretty v UK (para 52) in that it can cause intense mental suffering. Such treatment is prohibited in all circumstances by virtue of Article 3 of the European Court of Human Rights.

5. It is no excuse that those who authorise or practise ECT claim that in most cases it will be in the patient’s best interests to be given ECT even though it is against his or her will. It is certainly not always in the patient’s best interests.

6. Proponents of ECT claim that modern methods ensure that patients no longer suffer permanent memory loss. That assertion, I suspect, would be impossible to substantiate. Also, even proponents of ECT do not claim that it is 100% effective in curing severe depression. Further, in 2010 Richard Bentall and John Read co-authored a literature review on the effectiveness of ECT. Their conclusion was that “the cost-benefit analysis of ECT is so poor that its use cannot be scientifically justified”.

7. The Scottish Government states that there has been no ruling from the European Court of Human Rights that says ECT breaches any article (of the European Convention on Human Rights). This does not mean that an action raised there would fail. Note should be taken of the fact that in North America Dr Peter Breggin has acted as an expert witness in successful ECT malpractice suits. In one of those there was a settlement of more than $1 million.

7. People with autism and no mental illness should be excluded from the Act

1. Several carers of people with autism do not wish them to be treated with medication.

2. Fiona Sinclair has set up a group called Autism Rights to achieve this.
3. Christine MacVicar appeared on the front page of the Sunday Post and fled to Spain to save her son’s life.

4. Medical conditions need to be ruled out, before psychiatrists are involved. The DSMs all say this and also the British Medical Journal's best code of practice.

5. GPs just reach for the prescription pad and have little or no training in how to investigate conditions that present as mental illness.

6. There are a number of publications on this, not least "Emergencies in Psychiatry," by Basant K Puri.

7. The lack of training in nutrition, with a total emphasis on drugs, means that deficiency states are routinely missed. Our poor soil, because of artificial fertilisers, translates to deficient food and grazing, which affects humans and animals alike. From B vitamins to beriberi, they all affect our thinking. Someone who is chromium deficient can give an instant response.

8. There is a landslide of research on environmental toxins affecting neurology.

9. Autism is a neurodevelopment disorder and it makes no sense to include it in the mental health act as a mental disorder or as billed on some of the detention forms a mental illness. It would be like calling all cases of cerebral palsy a mental disorder. It seems very odd to me that conditions such as autism and Down syndrome are managed perfectly well by paediatricians - but once adulthood is reached the adult is left in the hands of a psychiatrist.

8. Complaints are very rarely properly investigated

1. A victim only has 12 months from the date of the alleged violation to bring a legal Human Rights challenge. This is a tall order for a sectioned patient who has to recover from their ordeal, especially as it can take months or years for necessary disclosures and documentations (suppressed favourable medical reports, etc.) to be obtained from the authorities.

2. The complaints process is characterised by defensiveness, a lack of willingness to find fault or even bring about positive change.

3. The Mental Welfare Commission have only published reports on anonymous people and not on any person who can challenge their findings. They very rarely criticise a professional.

4. Ill-treating a patient and making a false statement on a document are offences under the Mental Health Act but no-one has ever been charged. The police use corroboration rules as an excuse to delay investigations indefinitely.

5. The Scottish Public Services Ombudsman will not investigate complaints since they have a one-year timebar and have been through the Mental Health Tribunal Scotland (MHTS) system.

6. It is very hard to find a human rights lawyer to effect a civil legal challenge.
7. No-one has ever investigated tribunal transcripts.

8. The Scottish Legal Complaints Commission has a one-year timebar.

9. The General Medical Council will classify complaints as level 2 which means it is up to the NHS to investigate. 10. The NHS will not own up to errors for fear of litigation.

11. The Scottish Social Services Council will not investigate complaints against MHOs.

12. The MHTS will not investigate previous decisions.

**Recommendations**

1. The Mental Health (Care and Treatment) Scotland Act 2003 should be repealed or drastically amended to meet the needs of carers and service users.

2. An investigation should be carried out of those people who have had bad experiences under this Act and a formal apology should be given by the Scottish Government to those people affected.

**Psychiatric Rights Scotland**  
**August 2014**
North Lanarkshire Mental Health and Learning Disability Partnership Board (NLMHLDPB)

Mental Health (Scotland) Bill

Introduction
This Partnership Board welcomes the opportunity to comment on the proposals set out in this consultation. Generally, we accept the need to bring forward changes to improve the operation of the 2003 Act and hope that those intended will lead ultimately to be better service for people subject to the legislation. It is recognised that many proposals have been subject of earlier consultations and considerations.

Whilst, in our view, proposals within the Bill will address a number of operational difficulties within the legislation it should, perhaps, not be viewed in isolation from a quickly moving, complex legal and policy framework that surrounds the reshaping of Scotland’s health and social welfare agenda.

From a local authority perspective, the Bill proposes additional duties and responsibilities for mental health officer services. It is widely recognised that this service is already under considerable pressure across all local authorities and urgent consideration needs to be given to ensure that local authorities are appropriately resourced to meet their statutory functions across the legislative framework in which they operate.

Consultation questions:

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions?
There is currently some confusion precisely where an Advance Statement should be lodged. This proposal, which places a duty on Health Boards to ensure Advance Statements received are placed in the person’s medical record, clarifies the existing position. We would ask that clear guidance be provided to ensure a person’s Advance Statement is always kept in a prominent position within the record so this does not become ‘lost’ amongst other documents and notes contained in a medical record.

It is noted; that people making a Statement, any individuals involved in assisting the person draw up the Statement, or a person acting as witness for the Statement, must be made aware of the notification requirement and ensure an appropriate member of the Health Board’s staff is given the finalised document. It needs to be made clear which central point within health boards the Statement should be sent.

Health Boards are also required to send copies of Advance Statements to the Mental Welfare Commission (MWC) which, in turn, is required to maintain a central register of statements that will be accessible to certain people authorised by, or acting in connection with the person who made the statement. This Board believes this centralised depository will be a useful
reference point for those people who may transit different health boards, and should further afford statistics of interest between health boards in Scotland.

**Question 2: Do you have any comments on the proposed amendments to the Named Person provisions?**
This Board welcomes the proposals put forward which will amend the provisions for named persons. The recognition that an individual has a right not to have a named person, if that be the wish, is correct. The proposal puts the individual more in control of their situation and, as such, from this point alone is to be welcomed. The intention that the named person will, in future, need to actively consent to holding that position (and therefore have an understanding of what the role entails) is also to be welcomed. That declarations, in both cases, will need to be formally witnessed places some safeguard to each process.

We note with interest the concerns that have been expressed about the automatic entitlement of a named person to be involved in Tribunal and Court hearings. This Board shares these concerns and agree with the proposals being put forward to address them. In this respect, we note that a separate consultation on draft amending regulations will be issued later this year.

This Partnership Board agrees that mental health officers are best placed to provide the Tribunal with information that can assist it in coming to a decision under section 257 regarding the appointment of a named person by the Tribunal.

As with the issue of Advance Statements, the existence and contact details of named persons must be easily accessible to those requiring the information. Systems which allow easy access and amendment when changes take place will need to be developed.

**Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions?**
This Partnership Board notes with interest the proposals which seek to overcome medical reporting problems when application is being made by an MHO for a Compulsory Treatment Order. With some reservation we are generally supportive of the proposal where just one AMP report will be required with comments to be made on this by the person’s GP. We are concerned that every effort should be made to keep the individual’s GP involved and believe guidance should be made available to GPs about just what is expected in their reporting. Our belief is that GPs, in conjunction with MHOs, are in a good position to comment on whether less restrictive options could satisfactorily meet the person’s needs.

The Board is also of the opinion that whilst practical difficulties can arise for patients who need to seek their own independent medical report, it is extremely important that this right is retained.
Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions?
We agree with the criticisms that have been levelled at the provisions currently in force for suspension of detention as being arbitrary, complicated and difficult to operate. The amendments proposed to simplify the requirements of suspension will, in our view, be of assistance to those who have to work with the provisions.

This Board also agrees with the proposals set out in paragraphs 18, 19 and 20 which seek to simplify suspension requirements for certain forensic cases.

Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal?
This Partnership Board agrees with the Scottish Government’s assertion that there be a requirement placed on MHOs to submit a report to the Tribunal in cases where the RMO makes a determination under section 86. In carrying out their responsibilities under section 85 of the legislation, MHOs already provide opinion, by way of a short written report in this Partnership Board area, to the RMO on the necessity or otherwise to extend an Order. It seems perfectly sensible that this report also be made available to the Tribunal.

Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions?
We agree with the proposal to amend sub-sections 36(2) and 44(2) by including a reference to section 113(5).

We also agree with the Mental Welfare Commission’s concerns that notifications given under section 37 to persons listed under sub-section 38(4) can be inappropriate as information provided is of a sensitive nature. As such, discretion should, in our view, be afforded to hospital managers as to whether notice in terms of sub-section 38(3)(b) is given to these specified persons.

In relation to notifications of Emergency Detention Certificates (EDC) having to be made to the Mental Welfare Commission, and the Commission’s view that this is unnecessary, we leave that to the MWC and SG. We would, however, wish to be reassured that the Commission will continue to monitor and collate information on the number and circumstances of EDCs taken out without MHO consent.

The intention to provide a copy of the Short Term Detention Certificate (STDC) to those people who have to be notified of the event under section 46 of the legislation seems not unreasonable given the nature of the relationships of those to be so notified.

Question 7: Do you have any comments on the proposed changes to the suspension of certain orders etc. provisions?
We agree that provisions set out in sections 43 and 56 of the legislation, should also apply to Interim Compulsory Treatment Orders (ICTOs) and Compulsion Orders (COs).
Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients' provisions?
The proposal that the MHO should notify the MWC after successfully applying for a Removal Order from the Court is in accordance with other parts of the legislation. We agree such provision should be made. The MWC should make clear as soon as reasonable what information it requires under this notification. The Commission should consider producing a specific form to enable consistent reporting across Scotland.

We agree with the proposals that would extend the time a nurse of the prescribed class could detain a patient already in hospital from 2 to 3 hours. This, in our opinion, would better enable the examination by a medical practitioner. We also agree that the detention should apply regardless of whether a doctor is immediately available or not to carry out the examination. We are of the view, however, that nurses using the power, when contacting medical personnel, should also alert the appropriate MHO service. This would allow for a more efficient response should the situation eventually lead to consideration being given to lengthier detention which would require MHO consent.

Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions?
The provision surrounding section 213 contained in the draft Bill clarifies the reference position to the Tribunal and is, therefore, welcome.

The intention to place timescales within which the Tribunal is to hear certain applications are measures that will better meet the general principles of the legislation. Measures to be taken if the Tribunal fail to meet timescales appear reasonable.

Question 10: Do you agree with the proposed amendments to the support and services provisions? If you disagree please explain the reasons why.
In relation to those people with communication difficulties, we fully agree with the intention to include a duty of service provision to those subject of applications, or being considered for an application. As matters stand, where provision is only available to those already subject of orders, in inequitable.

This is clearly an anomaly that requires change. This Partnership Board agrees that facilities which help promote mother/child relationships should not simply be for those with a diagnosis of post-natal depression and should include all mothers who are suffering from mental disorder.

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border and absconding patients provisions? If you disagree please explain the reason(s) why.
The management proposals (as set out in paragraph 43 of the consultation paper) for those subject of a Transfer for Treatment Direction (TTD) who will
require to be made subject of a civil order at the end of their sentence, are sensible arrangements to make.

The intention that Scottish Ministers will require MHOs to become involved in the transfer for treatment process is a reasonable arrangement when considering other contexts where people are to be made subject of mental health orders in other parts of the legislation where decisions are not Court or Tribunal based. We, therefore agree with the proposal.

Whilst annual figures currently indicate a relatively low number of prisoners across Scotland becoming subject of the provision, it will, nonetheless, put yet further pressure on the MHO services in which prisons are located. We assume MHO involvement will fall to the local service as being the only practical option for operating the proposed requirement.

Other intentions under this section of the consultation document involving cross border and absconding patients, appear sensible measures to take in trying to ensure the proper care and treatment of those found in these situations.

**Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?**
This Partnership Board notes the minor amendments being proposed to clarify particular elements contained in certain forensic orders. We are of the view that intentions will achieve this.

The more substantive proposal, that would allow Assessment Orders to be extended by a further 21 days as opposed to the existing 7 days, is to be welcomed. The change will allow a more reasonable timeframe in which to collate all relevant information for the Court to consider.

**Question 13: Do you have any comments on the proposed amendments relating to the “variation of certain orders” provisions?**
The proposed amendment under this section, which would allow the Court to vary an order in respect of changing hospitals for treatment purposes, is a practical step that will allow early response to any unforeseen change in the assessment process.

**Question 14: Do you agree with the proposed approach for the notification element of the VNS?**
We agree with the proposed approach as outlined in the consultation document.

**Question 15: Do you agree that victims should be prevented from making representations under the existing mental health legislation provisions once they have the right to do so under the proposed Victim Notification Scheme?**
It would appear reasonable, and indeed sensible for all concerned, to allow a victim just one route to make representations against a mentally disordered offender.
Question 16: Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to mentally disordered offenders? This Board agrees with the proposed approach.

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the “protected characteristics” listed above. This Board, in viewing the proposals in a generally positive light, do not believe there are significant impacts on which to comment.

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible. As indicated in the introduction, the Bill proposes additional duties and responsibilities for local authority MHO services. The proposed changes, while welcomed in the interests of good practice in strengthening and extending safeguarding functions, will place further burden on local authorities. This ever increasing burden on MHO service’s needs, in our view, to be given urgent consideration by the Scottish Government if wider statutory obligations are to be met.

In other areas, a more efficient service should accrue savings in time for those operating the legislation.

North Lanarkshire Mental Health and Learning Disability Partnership Board
August 2014
The College of Occupational Therapists

Mental Health (Scotland) Bill

The College of Occupational Therapists (COT) is pleased to provide written evidence for the Bill. The College of Occupational Therapists is the professional body for occupational therapists and represents over 28,000 occupational therapists, support workers and students from across the United Kingdom, of whom around 3000 are in Scotland. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health and Care Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation can affect physical and psychological health.

In general COT supports the proposed amendments all of which are reasonable and which should lead to genuine improvements for people who use services including their families and carers. We support the overarching objective of the Bill to help people with mental disorder access effective treatment quickly and easily. We believe this is the correct policy direction and occupational therapists have been working towards ensuring that their services are accessible particularly in order to address health inequalities.

COT believes that the proposed amendments in Part 1 of the Bill are sensible and will enhance this section of the legislation. We also believe that the minor, technical changes set out in Part 2 of the Bill regarding those involved in criminal proceedings are relevant and required. In addition the victim notification scheme in Part 3 is timely and will address current difficulties in this area. COT feels that the McManus Report has been adequately addressed.

However, while COT is in general agreement with the direction of the amendments we feel an opportunity has been lost by not considering how extending professional roles could also contribute to ensuring rapid access to effective interventions. During the 2009 Consultation on the Review of the Mental Health (Care and Treatment) Scotland Act 2003, COT asserted that extending traditional roles under the Act to involve a wider group of professionals would be another method to enhance the efficiency of the Act and improve service user experience. This point was not addressed at the time and has also been neglected in this call for evidence.
In England and Wales, occupational therapists, as well as nurses and psychologists are now able to take on roles under the Mental Health Act (1983) previously held by social workers and doctors. These changes to mental health legislation have ensured that we can deliver modern mental health services fit for the 21st century, staffed by healthcare professionals that are employed not because of their job title but because they are competent practitioners who are the best people for the job. Cross boundary working of this nature has been supported by service user and carer groups and the professional colleges.

The Draft Mental Capacity Bill (Northern Ireland) will amalgamate both capacity and mental health legislation and is currently out for consultation. It will include a clause which will allow for role extension for professionals at a future date. In part, this is an acknowledgment that workforce predictions indicate a shortfall due to retirement of certain professional groups with statutory roles under mental health legislation.

COT would like to see a similar clause inserted into the Mental Health (Care and Treatment) Scotland Act 2003 which would allow for professional role extension at a future date as the need arises. This pre-emptive action would ensure that Scotland’s mental health services are primed to be able to continue to offer timely access to effective treatment as workforce and population demographics change.

College of Occupational Therapists
August 2014
The Royal College of General Practitioners Scotland

Mental Health (Scotland) Bill

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 5000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

Comments

Mental Health Context

GPs provide general medical care to patients from cradle to grave. In cases of severe and enduring mental illness their psychiatric care is usually undertaken by specialist psychiatric services. Increasingly this is undertaken in the community when GPs will have continued input into their care. GPs will often be the first to refer patients to these services, be called to attend urgently, be asked for medical reports and have a role as a patient’s advocate.

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

RCGP Scotland approves of the objective of allowing people with mental health problems to access proper care and treatment.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

The amendments appear reasonable and proportionate.

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

No.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

This scheme appears reasonable but must ensure it does not further ostracise people with mental health problems who are attempting to re-enter society.

The Royal College of General Practitioners Scotland
August 2014
Mental Health (Scotland) Bill

Dr Andrew Watson (Individual)

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

Yes.

Although in my view the overall direction of mental health law in Scotland should be to merge the adults with incapacity act with the mental health act. Starting with an assessment of capacity, and then proposing individual care plans overseen by the tribunal and MWC, would be a much easier system to understand and end the stigma that a subset of disorders are targeted by one law: the MHA.

- Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

I have concerns that in practice extending the 5 day extension period to 10 working days will mean that many patients will be in effect under a 6 week order. I have a number of patients who rightly allege that the current law means that a stdc is not just a 28 day order, and this will worse in under these amendments. On the other hand, if the extra time means that interim orders, in my experience usually granted because the solicitor representing the patient says that they have not had enough time to either get instructions or an report, are reduced then the increase in the extension period might be justified. If new guidance accompanying the amendment made clear that 10 workings days is enough for a lawyer to take instruction and obtain a report, if needed, in almost all cases I would support this in order to reduce the number of interim orders made.

Currently if a patient on a community CTO is admitted to hospital under a STDC, there is no extension period allowed at the end of the STDC for a tribunal to hear an application to vary the community order: it has to happen within the 28 days. It is not uncommon that the decision to vary the order is made after a couple of weeks of the STDC and this can cause real problems arraigning a hearing in time. I think the committee should consider whether to extend the provisions of section 68(2)(a) to applications to vary a community CTO to a hospital based one.

I support the other amendments offered, especially the ability to choose not to have a named person and the extension of nurses holding power to 3 hours and efforts to increase the uptake and availability of advance statements.
• Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

No

• Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

I support this.

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

No

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

As stated above I would keen to see a full review of both the mental health act and the adults with incapacity act to investigate whether having two laws that cover the care of people who lack decision making capacity due a mental disorder is necessary (see http://bjp.rcpsych.org/content/188/6/504.long for more details regarding this idea).

Dr Andrew Watson
Consultant Psychiatrist IPCU, Royal Edinburgh Hospital
Hon. Snr Lecturer in Psychiatry, University of Edinburgh
August 2014
CONSULTATION QUESTIONS

The Following specific consultation questions are asked:

1. Do you agree with the general policy direction set by the Bill?
2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
3. Do you have any comments on the provisions in Part 2 of the Bill?
4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

POLICE SCOTLAND RESPONSE

1. Police Scotland notes and has no objection to the general policy direction set by the Bill.
2. Police Scotland notes the changes in Part One of the Bill. With reference to the limit of 200 days per annum introduced for home or community leave, I should be grateful if you would clarify that such leave will also be subject to the victim notification provision introduced in Part 3.
3. Police Scotland notes and has no objection to provisions in part 2 of the Bill.
4. Police Scotland supports the introduction of a Notification Scheme for victims of mentally disorder offenders similar to the arrangements in the Criminal Justice Act 2003, bringing the rights of victims of mentally disordered offenders into line with the victims of other offenders. At this stage, I do not see a direct role for Police Scotland in managing and conducting the notifications and would anticipate that the State Hospital, Scottish Prison Service and Scottish Court Service would manage such notifications in line with existing practice.
5. Notwithstanding the foregoing, we are aware that the Scottish Government is to lead a short life working group to consider arrangements for the introduction of the Notification Scheme. We anticipate that Police Scotland will be involved in the Multi Agency Public Protection Arrangements (MAPPA) for certain mentally disordered offenders for whom MAPPA arrangements will apply, and would like to be assured that the police service will receive appropriate
notifications of release, including on temporary home or community leave, using agreed protocols.

6. The review seeks to strengthen safeguards for individuals undergoing continuing Mental Health treatments and does not affect the emergency powers utilised by the police.

Police Scotland
August 2014
Tom Todd (Individual)
Mental Health (Scotland) Bill

Summary

A number of opportunities are described to improve details of The Bill. These relate to the fact that many people who suffer from a mental disorder have the disorder only temporarily, and at other times are capable of making their own decisions in relation to how they wish the disorder to be managed.

Comments

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

The overarching objective of the Bill is stated as: ‘to help people with a mental disorder to access effective treatment quickly and easily.’
I agree with this.
In doing so, I believe that The Bill, either implicitly or explicitly:

a) has, as a key objective, the building of trust between the person with the mental disorder and those assisting in accessing and providing treatment;

b) recognises that treatment shall be provided within the scope of Human Rights legislation and guidance;

c) recognises that treatment that ‘effectively’ addresses one issue may lead to expression of another undesirable issue. In such instances, evaluation of ‘overall effectiveness’ may not be able to be agreed upon objectively. For example, administration of medication associated with reducing acute episodes of mania may also be associated with the emergence of chronic akathisia. In some instances, treatment that is considered ‘effective’ with respect to diminution of symptoms associated with the mental disorder may be considered inappropriate as a result of the association with other effects produced.
The subjective views of individuals being treated shall be considered paramount, and particularly when expressed in an advance statement.

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

95.
I would like to draw attention to terminology used in Paragraph 95, where it is stated that ‘the individual has….thus shown a willingness to participate in their treatment’.
By means of the advance statement, the individual being treated is explicitly expressing their right to say how (and in certain circumstances if) they want to be treated, in the same way that someone suffering from, say cancer or a
broken leg, might. The use of the word ‘willingness’ is therefore inappropriate and may show that the writer hasn’t appreciated the rights of the individual to unequivocally let their wishes be known. To be clear: they are not showing a ‘willingness’, but expressing their wishes, consistent with their Human Rights. Those giving the treatment should then be obliged to either respect those advance statement details (Rights), or be able to offer a rationale as to why they did not.

96. The above comment for 95. also applies to Paragraph 96, where it is stated ‘…where an individual has completed an advance statement and thus shown a willingness to participate in their treatment.’

It is further recommended that Paragraph 96 should be amended to add that ‘there shall be an obligation on those making assessments for potential provision of treatment to access and fully respect details in advance statements, or be able to provide a clear, and legal, rationale as to why they did not.’

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

No.

Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

No.

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

No.

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

No.

Tom Todd
August 2014
South Lanarkshire Council

Mental Health (Scotland) Bill

Introduction
South Lanarkshire Council welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill and would support the general policy direction set by the Bill.

The Bill proposes further increases to the existing duties and responsibilities of our Mental Health Officer Services which need to be viewed in the broader context of our national MHO workforce and workload capacity. Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Comments on Part 1
The proposed amendments to the Advance Statement are welcomed. Consideration should be given to the potential to introduce a recommended proforma which incorporates an advisory note to the effect that it requires to be submitted within a specified timeframe following completion to be effective, will require to be reviewed annually or where there are a change of circumstances and that it revokes any preceding statement. The proforma should be signed, dated and include reference to the fact that the Health Board must forward the proforma to the Mental Welfare Commission to be added to the register.

Clarity will be required on the central point within Health Boards to which the proforma should be submitted.

There remain questions around the potential need for 24 hour accessibility to the Advance Statement for those parties who require access and a few data protection considerations that will require to be addressed in the operationalisation of the register.

The introduction of an opt out system is welcomed as is the named person’s consent to undertaking the role. There is an assumption that issues around capacity in this area will be addressed within the Code of Practice.

Consideration should be given to the expansion of the proposed Advance Statement register to incorporate a Named Person Register.

The proposed Tribunal rules which will be subject to a separate consultation are welcomed in relation to mentally disordered offenders or where there may be victim considerations. There are however concerns that the proposal
erodes the rights of the Named Person and this will require to be addressed within the regulations.

Whilst acknowledging the difficulties experienced to date with suspension of detention measures, particularly immediately following the Acts inception, the proposal to remove the 9 month restriction in any 12 month period was rejected. It was the consensus that this was a retrograde step which would replicate the issues identified with Section 18 Leave of Absence under the 1984 Act.

It was suggested that an upper limit of 6 months in any 12 month period be considered with a disregard for short periods such as one day, one overnight, one weekend in the cumulative period.

There were also a few concerns that RMOs can add more restrictive conditions during periods of Suspension of Detention than those originally approved by the Tribunal.

The Part 13 proposals were supported but would require clarification on the thresholds and it was suggested that the upper time limit of 6 months suspension of detention be equally applicable under section 224.

Whilst elements of the section 87 proposal are unquestionably good practice, there are however major workload concerns for the MHO service.

The proposed changes to section 87 would require an additional 1789 reports by MHO’s each year (1789 over the period 2012/2013, Mental Welfare Commission figures). There may be considerations around whether the requirement for an MHO report is limited to extensions but not variations of the order or alternatively limited to those orders where there is likely to be a hearing (issue related to diagnosis, MHO disagrees with the proposed action, or, where there is a revocation of the application).

The introduction of a recommended form would be of benefit in this area together with clarification around the role of the SCR, section 57c and section 59.

Within the current Act, MHOs should complete an SCR following any relevant event or a letter to advise that the completion of an SCR would serve no practical purpose. Good practice would also suggest that an SCR is completed at least annually for individuals on long term orders and that an SCR should be completed at each renewal of order for individuals who are parents. The Mental Welfare Commission annual report notes a sizeable deficit in the report submissions nationally.

There are concerns around the proposal to place further administrative duties around notification on MHOs which may sit better within the MHTS. Concerns were also expressed around thresholds for significant harm and the need to limit the information in the MHO report given the proposed circulation.
Timeous notification to MHOs from RMOs of plans to extend a CTO also require to be addressed.

Questions were raised around whether these proposals would also apply to Compulsion Orders.

Whilst the proposals to the emergency, short term and temporary steps provisions were viewed as a positive development, it was felt that hospital managers would require a statement from the RMO / GP to advise of sensitivities in order to facilitate the exercising of their discretion.

Whilst there were no concerns with the notification of the granting of the order to the various parties, concern was noted around the circulation of the full papers, particularly if the default Named Person role is retained.

The proposal to place a duty on the MHO to notify the Mental Welfare Commission when making an application for a removal order to enable the Mental Welfare Commission to consider whether it should make a section 295 recall or variation of the removal order was viewed positively.

The proposal to extend Nurses holding power from 2 to 3 hours to enable an informal patient to be detained for the purposes of enabling medical practitioner examinations irrespective of whether a doctor is immediately available or not was viewed positively.

It was noted however that Nurses should notify both the RMO and the MHO at the start of the holding power to facilitate attendance at the earliest opportunity.

The removal of the restriction for the convener of the tribunal panel to be either the tribunal president or to be selected from the Shrieval panel was viewed positively in relation to cost efficiencies and increased flexibility of scheduling hearings.

Whilst this was viewed as good practice, concern was noted around the notification to Scottish Ministers of the making of a CTO application to follow a TTD, although it was generally conceded that this was more related to any potential intervention in the hearing process which could be dealt with within the Code of Practice.

The proposal to involve the MHO in the process for making a decision under section 136, TTD was viewed positively. Mental Welfare Commission figures suggest that there were 45 of these orders in the last financial year.

Operationally local authorities would require to put in place arrangements for the responsible authority to respond to the request in relation to prisoners whose ordinary residence was in their area with the hosting local authority providing a backup MHO service for those instances where the relevant local authority MHO is unable to respond within the specified timeframes.
The proposal to extend cross border transfer to include patients from outwith the UK from other EU member states was welcomed but would require further guidance.

**Comments on Part 2**
No comments to be added on the provisions in Part 2 of the Bill on criminal cases

**Comments on Part 3**
The proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders is welcomed although will require clear guidance on definitions, entry and exit points, roles, responsibilities, boundaries, accountabilities and any inconsistencies in applicability addressed.

There are questions around whether this should be restricted to CORO patients only and particular offences of a serious nature which will require further clarity and guidance.

There are also questions around transition points from the criminal procedures elements of the Mental Health Act to the civil elements such as TTDs to CTOs and how this is dealt with for both patient and victim or their relatives.

The proposal that victims should be prevented from making representation under the existing Mental Health legislation once they have the right to do so under the proposed Victim Notification Scheme is problematic and inconsistent for example, the RMO would notify victims when orders are being suspended but not when being revoked.

From the limited proposals noted in the bill it is difficult to fully ascertain the potential ramifications of extending the scheme but it was agreed in principle that the extension of the scheme was welcomed.

There was general consensus that this is both a complicated and complex area involving the balancing of the rights of the patient and the rights of the victim. It was noted that the proposal may result in those with a learning disability or lacking in capacity being treated less favourably which was of concern.

More detailed proposals and notional guidance on how the VNS may operate in practice is required to facilitate discussion in the first instance.

**General Comments on the Bill**
It was generally agreed that the proposals were positive in most areas although there was concern that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.
The Bill proposes further increases to the duties and responsibilities of our Mental Health Officer Services which equally need to be viewed in the broader context of our national MHO workforce and workload capacity.

Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Notwithstanding the year on year increase in MHO workload demand, which is not matched by any increase in the existing MHO infrastructure, the additional roles and responsibilities for MHOs contained within the proposals will incur further significant costs to local authorities which needs to be considered by the Scottish Government.

South Lanarkshire Council
August 2014
Mental Health (Scotland) Bill

Question 1
Do you agree with the general policy direction set by the Bill?
Response: Yes. The general policy direction set by the Bill is appropriate to the objective of helping those with a mental disorder access treatment quickly and easily.

The Millan Principles have provided an exemplary ethical underpinning of the Mental Health (Care and Treatment) (Scotland) Act 2003 and we would strongly support the view presented in the Bill that all matters regarding mental health should continue to be underpinned by these principles.

It is important that the Bill is compatible with rights under the European Convention on Human Rights. Maintaining a rights based approach that applies the principles of beneficence, participation, person-centeredness and the use of least restrictive alternatives are crucial to any changes proposed within the Bill.

Question 2
Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
Response: We are encouraged by the proposal to establish a register of advanced statements to be held by the Mental Welfare Commission (Section 276B). Such statements are an important part of encouraging the participation of service users in their care and treatment. We note advance statements are presently completed by a relatively small number of service users, and feel the Bill could make further provision to address this by use of the Register to facilitate an increase in the making of advance statements by service users. We recommend that an annual report be made publicly available providing national data relating to the numbers of advance statements made by service users, including reference to health board, demographic data and ongoing status with regards to the Act.

Proposed Changes:
1. Measures until application determined
Increasing the time for applications for compulsory treatment orders from five to ten days
Response: We support the proposed changes to the timeframes for compulsory measures on the basis that these accord with the least restrictive
principle. Although this may result in extended detention for some patients who then have their detention revoked, on balance it would seem that more people are likely to benefit from the additional time this will offer to patients and their representatives to prepare for a tribunal.

2. Information where order extended
Extending a compulsory treatment order, the mental health officer should submit a written report to the Tribunal
Response: This proposed change appears to enhance the support of patients’ rights through the submission of the mental health officer’s opinion in a written report separate from the responsible medical officer.

3. Emergency detention in hospital
Subsequent detention immediately following Section 113(5) of the Act
Response: The proposed change appears to present an appropriate course of action.

4. Notification of emergency detention
Notifying the Commission
Response: The proposed change to remove section 38(3)(a) appears to streamline the process of notification and is more in line with data protection legislation.

5. Short term detention
The subsequent detention of patients already within a detention regime should be governed by that regime not another
Response: The proposed change appears to present an appropriate course of action.

6. Suspension of orders on emergency detention or short term detention
Emergency detention and short term detention while subject to compulsory treatment
Response: These changes appear to be more supportive of continuity in the care and support being offered to patients.

7. Suspension of detention for certain purposes
Seeking approval from Scottish Ministers for suspending detention
Response: While there may be some reasonable concerns regarding the removal of this additional safeguard, on balance, if current implementation regularly reflects the opinion of the responsible medical office, then this proposed change would appear to support a more flexible and responsive approach to meeting patient needs.

8. Maximum suspension of detention measures
Suspension of detention to allow extended time out of hospital and in the community
Response: When appropriate, this proposed change appears to be more in line with the Millan Principle of least restrictive alternative.
9. Orders regarding levels of security
Being held in conditions of excessive security
Response: This proposed change appears appropriate and again appears to reflect the Millan Principles, however, is there a suggested time frame for the implementation of the aforementioned secondary legislation?

10. Removal and detention of patients
Notifying the Commission when an application for a removal order is made
Response: This proposed change provides an additional safeguard for patients and upholding their human rights.

11. Detention pending medical examination
Extension of Nurse’s Power to Detain
Response: Allowing detention pending medical examination for three hours rather than two appears an appropriate timescale, however, we acknowledge that for some patients the further loss of liberty may cause additional distress.

12. Time for appeal referral or disposal
Reduction of time in which to lodge an appeal against the decision to transfer
Response: This proposed reduction from 12 weeks to 28 days appears to still afford sufficient time for an appeal to be lodge and is more in line with the appeals process in other parts of the Act.

13. Periodical referral of cases and recording where late disposal
Shortening the length of time before a case is considered by the Tribunal
Response: This proposed change appears appropriate and emphasises the accountability of the Tribunal to act in a timeous manner.

14. Representations by named persons
The appointment of a named person
Response: We fully endorse the proposed change. If a patient decides not to nominate a named person then it seems unreasonable that the Tribunal should appoint someone against the patient’s wishes. Providing written, witnessed consent by an individual who agrees to act as a named person should help make the process more robust.

15. Advance statements
Copy kept in medical records and a central register kept by the Commission
Response: We fully support the proposed changes as a way of strengthening accountability and promoting patient participation in decisions about how their care needs are met.
16. Communication at medical examination
Provision of assistance with communication difficulties at application for orders
Response: This proposed change appears to be a sensible approach that demonstrates cognisance of disability awareness and the individual requirements of patients throughout the process of application for and implementation of detention orders. It supports equity in the treatment of and engagement with patients with communication difficulties.

17. Services and accommodation for mothers
Extension of the provision of accommodation for mothers with mental health problems
Response: Given the importance of the early years in shaping an individual’s development and well-being, this appears to be a more sensible and inclusive approach than the current position.

18. Cross-border and absconding patients
Treatment of patients who abscond from detention in another jurisdiction
Response: If, as would be expected, treatment is applied in line with the Millan Principles this should be seen as being in the best interests of the patient and we would be in favour of this proposed change.

19. Arrangements for treatment of prisoners
Transfer from prison to hospital
Response: We agree that the additional contribution of a mental health officer would appear to strengthen the process of decision making regarding the transfer of prisoners from prison to hospital.

20. Compulsory treatment of prisoners
Convenor of a Tribunal Panel
Response: We would support this proposed change if it helps to expedite the scheduling of such cases.

Question 3
Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
1. Calculating time periods
Calculations changed to mirror time periods in criminal courts
Response: This appears to be a sensible and rational proposal which should lessen the risk of calculation errors.

2. Extension of Assessment Order
A further assessment period of 14 days may be granted by the court
Response: We would agree with this proposed change if it is considered necessary to facilitate a more complete and accurate assessment. We consider the proposed 14 day extension more reasonable than the original suggestion of a 21 day extension.
3. Variation of interim compulsion order
   Admission to a different hospital
   Response: This appears to be a reasonable change to the current position.

Question 4
   Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
   We are, in principle, in support of the introduction of a victim notification scheme for mentally disordered offenders due to the need to consider the victim as an important stakeholder in the process of rehabilitation and treatment. However, it is important that such a scheme should acknowledge the status of the perpetrator as mentally disordered at the time of the offence and accordingly an appropriate balance needs to be struck between the rights of the victim and those of the patient.

1. Information and representation
   Limited information to qualifying victims
   Response: This proposed change appears to support victim’s rights by bringing offences carried out by people with mental disorders into line with other criminal offences. While the victims notification scheme implements the EU Directive on the rights and standards for victims of crime this should be interpreted alongside the data protection act. Clear and robust safeguards in relation to data protection and the vulnerability of patients are necessary to ensure the consistent and efficient implementation of this proposal.

   With the extensive use of online communication and social networks how are patients to be protected from inappropriate sharing of information?

   What are the views of the Information Commissioner’s Office in relation to common law on confidentiality and the Data Protection Act (1998)?

2. Right to information: offender imprisoned
   Notifying victims of unescorted suspension of detention
   Response: We would support this proposed change as there appears to be a sound rationale for the intention of protecting the well-being of victims while acknowledging the difficulty of balancing the rights of both the patients and the victims.

3. Right to information: compulsion order
   Notifying victims of periods of detention
   Response: We would support this proposed change as above in Question 4.2.

4. Right to make representations
   Victim’s right to make representation before decisions are taken regarding release, suspension of detention or discharge
   Response: We would support this proposed change as above in Question 4.2 and concur with the view that it would be unnecessary and disproportionate to include individuals who “have often committed only minor offences.”
Question 5
Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
Response: We feel the McManus report has significantly informed the formation of the Bill, and have no further comment in this regard.

Question 6
Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
Response: There are no further comments beyond the responses to questions 1 to 5 above.

Glasgow Caledonian University School of Health and Life Sciences
August 2014
The Faculty of Advocates

Mental Health (Scotland) Bill

The Faculty welcomes the opportunity to provide written evidence commenting on the Mental Health (Scotland) Bill, in the form it has been introduced.

We provided comments in response to the Scottish Government consultation exercise issued in December 2013, and a copy of the Faculty's response is attached for reference. We note that parts of the Bill as introduced are in much the same form as the consultation draft, but there are a number of important differences. We discuss some of those below.

Question 1: Do you agree with the general policy direction set by the Bill?
Insofar as the policy of the Bill is that set out in paragraph 15 of the Policy Memorandum, the Faculty is broadly supportive, and we are certainly supportive of the broader aim of the 2003 Act set out in paragraph 14.

Question 2: Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
2.1 We welcome the decision not to proceed with the proposal in the consultation draft which might have resulted in patients being detained on the basis of only one medical report. For the reasons which are set out in the Faculty response to that consultation, we considered that would have been an undesirable change.

2.2 The Faculty also welcomes the more nuanced approach to the maximum period for suspension of detention proposed in section 9. While this may involve a marginal increase in effort in record-keeping, it seems to us an important safeguard for patients and may be relevant to consideration by the Mental Health Tribunal for Scotland of variation of hospital-based CTOs to community-based CTOs for patients who are able to spend substantial periods of time in the community.

2.3 We note the provisions proposed in section 1 which will double the existing extension period from 5 to 10 days for patients detained on Short Term Detention Certificates where an application for Compulsory Treatment Order has been made. This did not feature in the most recent consultation, though it was canvassed in the McManus review. We note the rationale given at paragraphs 18-20 of the Policy Memorandum, namely “ensur[ing] patients have sufficient time to prepare for hearings, even those requiring to be held at short notice, and that the Tribunal has all the information needed...” The experience of our members practising in this area is that the Mental Health Tribunal for Scotland makes strenuous efforts to facilitate hearings within the
existing timescale, though they are not in control of the production of reports and the like. It is our experience that pressure on the time of medical professionals is sometimes an issue in scheduling Tribunal business. We note that the section attempts to balance the significant extension (a Short Term Detention Certificate lasts for 28 days, so that the extension period of 10 days has to be seen in that light) by reducing the period of 6 months for which a Compulsory Treatment Order lasts by the same period. Overall, we consider that this is a reasonable way of balancing the liberty of patients and the practicalities of managing the tribunal process.

2.4 We note the provisions of sections 11 and 12, which were not in the consultation draft, and have, we assume, been brought forward by the Scottish Government following its separate consultation about section 268 of the 2003 Act in light of the decision of the UK Supreme Court in the case of M v Scottish Ministers.\footnote{M v Scottish Ministers [2012] UKSC 58; 2013 SC(UKSC) 139; 2013 SLT 57.} A copy of the Faculty’s response to that consultation is attached. The Committee will no doubt be aware that case came before the courts because section 268 was enacted envisaging that patients detained other than at the State Hospital should have the same right to challenge the level of security in which they were detained, but that the coming into operation of that section required the Ministers to lay regulations before the Parliament and that had not been done. Aspects of the proposed sections 11 & 12 will require regulations too, and the Committee will no doubt wish to ascertain the Ministers’ proposed timetable for those.

2.5 The Faculty has some concerns about the proposed form of section 26. As we indicated in our response to the consultation draft, it seems to us that a requirement that the MHO consent to a transfer for treatment direction goes a good deal further than the stated policy aim of ‘involving’ the MHO in the process. More than that, however, our concern, based on the experience of members practising in this area, is that MHOs may not readily be available in the prison estate: they are skilled professionals with a large caseload. There is a risk that in some cases treatment for acutely unwell prisoners will be delayed. It might be said that the involvement of the MHO is intended as a safeguard for the prisoner/patient; while there is some truth in that, the prisoner is already subject to detention, albeit by order of the court.

Question 3: Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
The Faculty has no comments on those provisions.

Question 4: Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
4.1 The Faculty is of the view that in general, the scheme in Part 3 appears to strike a careful balance between the rights and interests of the various individuals involved.
4.2 There is a small but potentially important practical matter which seems to us may arise under part of what is proposed in section 45, which will introduce new section 17B into the Criminal Justice (Scotland) Act 2003 about making representations. We recognise the importance of the making of representations, and equally that it may not always be practicable. It is proposed in section 17B(6) that the Scottish Ministers need not afford an opportunity to make representations if it is not reasonably practicable. That is a sensible provision, however the Ministers are not the only decision-takers mentioned in section 17B, and it seems to us that consideration should be given to extending the reasonable practicability provision to the Tribunal and to MHOs. Since the Scottish Ministers may be the first port of call for persons seeking to make representations, the public interest would be represented in the decision making process. Otherwise, it is possible to conceive of situations in which the Tribunal or an MHO might be prevented from taking a decision within a reasonable time simply because it had not proved possible to obtain representations from an affected person - that is undesirable from the point of view of certainty of decision making and the need to respect the rights of patients as much as other potentially interested persons.

Question 5: Is there anything from the McManus Report that's not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
In our view, there is nothing from the McManus review which has not been otherwise addressed which merits primary legislation.

Question 6: Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
The Faculty has no other comments to make.
The Faculty welcomes the opportunity to comment on these proposals. We have addressed the questions in turn, commenting on those of which our members have direct experience and those which appear to us to raise issues of principle or practicality.

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions? (Chapter 2)

Comment

We have no comments on the subject matter of Q1.

Question 2: Do you have any comments on the proposed amendments to the Named Person provisions? (Chapter 2)

Comment

While the Faculty understands the rationale for the proposed requirement that Named Persons obtain leave, we have a number of concerns about its scope.

As a preliminary, we would observe that the draft Bill contains no readily identifiable test for granting leave, nor is there any procedure for dealing with the refusal of leave. The former is likely to give rise to appeals, while the latter may do so.

Further it seems to us that the list of cases in draft section 19 is rather uneven. The requirement to obtain leave before making certain types of application would seem undesirable in certain circumstances. In particular we have concerns about the need to obtain leave in cases falling under section 50, which, by their very nature, require speed of action.

Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions? (Chapter 2)

Comment

The Faculty understands that there has been concern in some quarters about the proliferation of reports that can exist in some cases. We are however concerned that the effect of the changes is that some patients can be detained on the basis of one medical report. The proposal within the Bill for dispensing entirely with a second medical opinion based upon the MHO’s belief that the patient does not have a GP or that it is not practicable to obtain a second opinion subject only to a requirement to record the reasons for reaching that view does not appear to be a sufficiently robust safeguard. The requirement that there be two medical
reports has, in one form or another, been part of the landscape in this area of law for a long time, and, we suggest, for good reason. If it is to be dispensed with, the Bill should be fortified to spell out that this should be done only in truly exceptional cases.

Further, it appears to us that the observation at para 15 of the consultation that “If no GP can be identified then the patient would retain the right to instruct an independent medical report as a protection” is not really an adequate answer. That is a right which any patient ought to have, and it is no answer to a proposal which appears based on no more than expediency. The more so as it may be that patients without GP registration may – and we stress may - be drawn disproportionately from already disadvantaged groups. That ought to be explored further and a proper evidential base obtained before a proposal in this form is taken further.

Finally, it would, of course, be open to the Tribunal to instruct a report if it were not content with an application being presented on the basis of only one report. However, we suggest that reliance on this as a matter of routine rather than as an exceptional power would be undesirable for two reasons. Firstly, budgetary: the cost would be unfairly shifted to the Tribunal. Secondly, if the second medical report was, in essence provided at the instance of the Tribunal, there may be a risk that the Tribunal could be perceived as supporting the application rather than determining it. That is plainly undesirable.

Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions? (Chapter 2)

Comment

Revision of the suspension of detention provisions seems to us entirely sensible.

We note however that the draft bill departs entirely from the careful scheme recommended by the McManus review, about which there was then detailed consultation. It does not appear that any of the consultation responses has been reflected in the Government’s proposals, nor does the consultation document give any explanation of why the Government has departed from that.

The Government expressed the view that “Given the provisions within the Act for review of orders, and indeed for variation to community based orders, it is felt that the 9 month limit could now be dispensed with”. However the provisions for the review of orders and variation to community based orders had their origins in the Millan Report and were legislated for in the 2003 Act – as was the 9 month time limit for suspension of detention (which time limit did not exist before the 2003 Act). The existence of the provisions for the review of orders and variation to community based orders cannot logically be a reason for abolishing the 9 month limit now any more than it would have been a reason for not implementing the 9 month limit in the first place.
The Millan Report recognised that there was a potential for abuse (Chapter 6, paragraph 73), saying “Although we have no evidence to suggest abuse of the current arrangements, we would not wish the potential for abuse to remain, particularly when an alternative approach is available by means of a community order”. It hardly seems consistent with that approach to remove the limit entirely.

It might be viewed as inherently desirable that a patient who can, and is, spending substantial amounts of time in the community should be subject to a community-based CTO rather than being subject to a hospital-based CTO, and depending upon the discretion of the RMO for his or her liberty.

Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal? (Chapter 2)
Comment
None

Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions? (Chapter 2)
Comment
None

Question 7: Do you have comments on the proposed changes to the suspension of certain orders etc. provisions? (Chapter 2)
Comment
None

Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions? (Chapter 2)
Comment
None

Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions? (Chapter 2)
Comment
As we understand matters, the Tribunal as a matter of fact acts promptly in appropriate cases and seeks to deal with all matters within a reasonable time. It is in any event part of the obligations of the Tribunal in terms of article 5(4) of the European Convention on Human Rights that cases relating to detention are reviewed speedily. The requirement for the Tribunal to “do their utmost” seems to us to add comparatively little.

Moreover, by imposing such an obligation upon the Tribunal, another procedural requirement would be imposed – a failure to comply with which would arguably be a procedural impropriety and might result in procedure before the Tribunal beyond the simple recording of why steps
were not undertaken with the utmost speed. Further, such a procedural impropriety would give rise to a right of appeal, since, quite properly, procedural impropriety is one of the enumerated grounds of appeal in section 324(2) of the 2003 Act.

There may also be an increase in the number of appeals as a consequence of the reform to timescales, though we deal with these in more detail at 18, below.

Question 10: Do you agree with the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why.
(Chapter 2)
Comment
None

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why.
(Chapter 2)
Comment
Insofar as the Bill’s stated purpose of “involving” the MHO in the transfer of prisoners to hospital is concerned the Faculty would question whether the terms of the proposed legislation accurately reflects that intention.

As section 23 is currently drafted, it appears that the involvement of an MHO is mandatory and a prerequisite to transfer. That appears to go a good deal further than “involvement”, and our concern is, based on the experience of members practising in this area, that MHOs may not be readily available within the prison estate. In order to be able to provide prisoners with appropriate care in cases of urgency it might be preferable for the Scottish Ministers to retain a greater degree of discretion in the involvement of an MHO or his consent.

We have no comment in relation to the cross-border or absconding provisions.

Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?
(Chapter 3)
Comment
The provisions in relation to time limits in the criminal courts provide a helpful clarification. Otherwise we have no comment.

Question 13: Do you have any comments on the proposed amendments to the “variation of certain orders” provisions? (Chapter 3)
Comment
In light of what has been stated to be the experience of the Government in relation to these difficulties, the proposals seem entirely sensible.
We note that paragraph 62 of the consultation appears not to be addressed in any of the consultation questions. We have no comment to make on those proposals.

Question 14: Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be. (Chapter 4)

Question 15: Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer. (Chapter 4)

Comment

We have chosen to respond to these two questions and question 16 together. The Faculty is of the view that the scheme as proposed appears to strike a careful balance between the rights and the interests of the various individuals involved.

Question 16: Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to Mentally Disordered Offenders? If not, please explain why not and please outline what your preferred approach would be. (Chapter 4)

Comment

See above.

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics". (Chapter 5)

Comments:

None

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible. (Chapter 5).

Comments:

It appears to us that the possibility of granting a CTO on the evidence of one doctor may result in more appeals with a consequent increase in legal costs. It may also result in an increase in the costs to the Tribunal, as the Tribunal may be disinclined to grant a CTO on the evidence of one doctor alone and may make increased use of the power to obtain an independent report. As a result there may simply be a shifting of costs around the system.

The requirement on the Tribunal to determine cases with utmost speed might also result in an increased number of appeals and consequent costs to the Tribunal, court service and parties, for the reasons given in our answer to Q9.
Similarly, the reform of time limits may well result in an increase in legal costs. At the present juncture a large number of appeals are not instigated because the existing time limits permit a further application in comparatively early course (whether or not an application is in fact presented), and there is therefore no real practical benefit in the instigation of an appeal. By the time any appeal would be heard there could have been a new application in any event. This is particularly true in relation to cases involving restricted patients, where any appeal is heard by the Inner House of the Court of Session, which, while some progress at reducing the times involved has been made, typically takes place a number of months after the original decision.

Appendix 2 - Faculty of Advocates response to Scottish Government consultation on section 268 of the Mental Health (Care and Treatment)(Scotland) Act 2003

CONSULTATION QUESTIONS

1. Proposals for regulations

Our first proposal for legislative change is that we bring forward regulations in the following terms:

Section 268 of the 2003 Act gives a right of appeal against levels of excessive security for qualifying patients in qualifying hospitals. We propose that a qualifying patient would be -

• an individual who is subject to an order requiring them to be detained in a hospital which operates a medium level of security; and

• who has a report from an approved medical practitioner (as defined by section 22 of the 2003 Act, who is not the patient’s current RMO,) which supports the view that detention of the patient in the qualifying hospital involves the patient being subject to a level of security which is excessive in the patient’s case.

A qualifying hospital would be one of the following-

• the Orchard Clinic in Edinburgh, and the regional medium secure component of Rohallion in Tayside and Rowanbank in Glasgow

Please tell us about any potential impacts, either positive or negative you feel these proposals for regulations may have.

Comments
The Faculty welcomes the opportunity to comment on these proposals. We begin with a number of general points.

We consider that section 268 and associated sections properly reflect the general scheme of the 2003 Act, and in particular that individuals should be subject to the minimum restriction on liberty necessary in the circumstances of the individual case. We suggest that it is desirable in principle that individuals who are detained in conditions of excessive security are afforded the opportunity to challenge their detention and to obtain an effective remedy, whether or not they are detained at the State Hospital.

We would also observe that affording patients at the State Hospital a right to challenge the level of security imposed upon them without affording an equivalent and effective remedy to patients at lower levels of security may amount to discriminatory treatment within the scope of Article 8 taken together with Article 14 of the ECHR.

Section 264 appears to have achieved its aims. It has been effective in moving on patients from the State Hospital who no longer require the conditions of special security there. Section 264 is perceived as being a driving force behind patients being moved from the State Hospital. Its effectiveness is not necessarily limited to the making and granting of applications. The Faculty’s view, informed by the experience of members practising in this area, is that the fact that section 264 exists is perceived as being a positive influence on moving patients to lower security levels without the need in some cases for an application to be made at all. It helps to support a culture whereby the Responsible Medical Officer requires to keep in mind the level of security at which the patient is detained.

Against that background, the effective implementation of section 268 is a welcome step.

It is perhaps stating the obvious to point out that making regulations for the purposes of section 268 would assist patients who are detained in conditions of excessive security outwith the State Hospital to move on through the mental healthcare system – which is the entire point of the excessive security provisions of the 2003 Act.

We would also observe that if there is no problem with entrapment at the level of medium secure facilities then there are unlikely to be supportive medical reports on which to base applications. In short, if there is no difficulty then the mechanism would be little used. On the other hand if there is a difficulty then those patients who are suffering as a consequence will be able to seek effective relief.

The impression of some members practising in this area is that there has been, to a certain extent, a “displacement” of the problem of excessive security from the State Hospital to hospitals with lower security levels.
There is an effective driving force for those patients detained at the State Hospital. There is no effective driving force for those patients detained in medium security.

Turning to the detail of the proposals, while the Faculty favours the proposal that a supportive report from an authorised medical practitioner should accompany an application, it is not apparent why the patient’s Responsible Medical Officer should be precluded from providing a report. Although perhaps uncommon, it is not difficult to envisage circumstances in which a patient’s Responsible Medical Officer might be of the view that a patient was perhaps detained in conditions of excessive security, but might conclude that he or she was not in a position to obtain appropriate alternative facilities. In those circumstances it would seem unnecessary to require a different authorised medical practitioner (who would almost certainly be less familiar with the patient and his or her case) to become involved and provide a report. It is possible that this would result in an overall costs saving in some cases.

Equally, it is not apparent why the proposed regulations are restricted to patients at medium secure facilities. It seems likely that any “displacement” of the issue that has happened from the State Hospital to the medium secure units is also likely to occur at lower levels. Members of Faculty have experience of patients at lower levels of security having difficulties with being detained at excessive levels of security - particularly in moving from locked wards to open wards, and from hospitals into the community. We note that the patient in the case of RM sought to move from a locked ward in a low security hospital to an open ward also in a low security hospital.

It is at least possible that limiting review of excessive security to patients in medium secure facilities will not necessarily solve the problem but merely result in a further displacement of the problem to the next lower level of security i.e. in the case of the proposed regulations to the level of low security.

2. Our second proposal is that we do not bring forward regulations but instead repeal section 268 at the earliest opportunity. At the same time we will consider the review undertaken by the National Forensic Network of patients detained in the high, medium and low secure estates, which we hope will clarify whether there is an issue with entrapped patients held in these settings. The outcome of this could result in changes to primary legislation in early course. To take that proposal forward we seek views on the following:

• The current appeal provision in section 268 is restrictive and in particular does not allow for a change in security levels within the same hospital setting. Is there a need for a wider provision for an appeal against excessive levels of security?

Comments
First of all, we would observe that although the proposals are suggested in the alternative there is nothing to prevent the Government from implementing the regulations in terms of the first proposal and also undertaking a review to increase mobility through the secure forensic estate more generally. It is our view that this would be a desirable approach, and the Faculty would not support repeal of section 268 without a workable alternative scheme being implemented as a replacement.

We agree that, as section 268 is presently drafted, it is questionable whether patients can be transferred intra-hospital in pursuance of the excessive security provisions. For example, the Rohallion clinic is composed of both a medium secure and low secure element, though both would be likely to be the same hospital in terms of the Act.

It would seem that comparatively simple amendments to the 2003 Act would permit this. If the provisions in respect of orders authorising detention could authorise detention in specified parts of a hospital rather than necessarily just a hospital and that the duty in section 268 et seq was to find an appropriate part of a hospital, where security was not excessive, then transfer within the same hospital would be possible and could be regulated by the Tribunal. Other provisions (in respect of appeals against transfer, for example) might also be so amended.

As noted above, members of Faculty have experience of patients who were detained within lower security levels who had problems with the levels of security that were imposed upon them by virtue of being in one ward rather than another (as in the case of RM). In our view, the amendments proposed would have the effect of permitting transfer from one part of the hospital to another.

Also as noted above, members of Faculty have experienced cases in which patients are considered to be suitable for community care by their hospital care team or by the Tribunal, but adequate provision is not provided by the local authority in respect of that care. At the moment the only effective mechanism to try to enforce the obligations of the local authority is by judicial review. It is a matter for consideration whether a procedure, based on section 268, might usefully be introduced to the 2003 Act for the benefit of such patients.

• If an additional appeal provision is created, do we need to provide for a preliminary review to consider the merits of the appeal before proceeding to a full hearing?

Comments

It is not entirely clear what is envisaged here. It would appear to be an unnecessary procedural step. If there were to be a precondition such as an expert report as proposed in the first option in the consultation, there would seem to be no need for a preliminary review.

• Compulsory Treatment orders, compulsion and restriction orders and transfer treatment directives are currently reviewed by the Mental Health Tribunal at least once every two years. Levels of security are not necessarily discussed at these reviews. Should there be a requirement for the Tribunal to
consider levels of security as a matter of course, with an accompanying right of appeal if the question of level of security has not been considered?

Comments

In our view, there is something to be said for the idea that there be automatic review of levels of security as a part of the periodic review of compulsory treatment orders, compulsion and restriction orders and transfer for treatment directions. In the experience of members of Faculty practising in this area, it is those patients with least capacity or those with the most profound difficulties who benefit most from the automatic review provisions. It would be unfortunate if those patients were unable to benefit from provisions for review of excessive security.

In our view, introducing automatic review of security levels would require amendment of the 2003 Act. Moreover, it would only be worthwhile if there was some sort of enforcement mechanism – there is little point in the Tribunal requiring to consider the issue of excessive security if it is unable to provide a remedy for it.

However, such automatic review does not fit with the requirement within the current proposal for regulations requiring an applicant to obtain a supportive expert medical report, nor would it seem to fit with the idea of a preliminary review (if that proposal were implemented). It also seems likely that any amendment would require to address the powers of the Tribunal dealing with the review.

Can more effective use be made of recorded matters by the Tribunal with regard to levels of security in Compulsory Treatment Order cases?

Comments

While in general the ability for the Tribunal to make a recorded matter is a welcome facility, we would observe that in the experience of some members of Faculty, recorded matters are not seen as being an effective remedy for patients in this context, largely because there is no enforcement mechanism.

We would also observe that they are not applicable to patients subject to transfer for treatment directions, hospital orders or compulsion orders (with or without a restriction order).

Are there other changes to the review system that you consider may help to support and develop further the effective movement of patients through the secure system?

Comments

We have little doubt that the extension of the right of appeal against excessive security to a greater number of patients would help to support and develop the flow of patients through the system. In that context the regulations proposed are a welcome step.

The extension of a scheme such as that in sections 264 and 268 to patients
who are seeking to move from hospital into the community would also assist in the flow of patients through the secure system.

Any further comments

Comments

Any provisions that require amendment of the 2003 Act, or otherwise require Parliamentary authority, might usefully be included in the forthcoming Mental Health Bill.
Scottish Ambulance Service

Mental Health (Scotland) Bill

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

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
   No.

3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
   No.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
   No.

5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
   No.

6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
   No.

Scottish Ambulance Service
August 2014
Royal College of Psychiatrists in Scotland

Mental Health (Scotland) Bill

1. The Faculty of Forensic Psychiatry of the Royal College of Psychiatrists in Scotland generally welcome the Mental Health Bill which mostly arises from Professor McManus's review of the civil aspects of the Mental Health (Care and Treatment)(Scotland) Act 2003. Members of the Faculty thought that the McManus review could usefully have been extended to Forensic aspects of the 2003 Act. The Bill includes important new legislation for mentally disordered offenders but has not had the benefit of a thorough examination of the legislation.

2. Part 1 of the Bill generally has amending legislation improving certain aspects of functioning of the civil provisions of the 2003 Act. The particular area relevant to forensic practice is section 11 of the Bill which directly arises for the Supreme Court's judgement in the RM case. Appeals against excessive security were first introduced as a concept by the Millan Committee. A Faculty member, Dr Maureen Sturrock, was a member of the Millan Committee. There had been substantial policy with regards to mentally disordered offenders, not least the Scottish Office policy statement 1999MEL(5) but there had been a very disappointing implementation of that policy. Scottish Government initially withdrew the excessive security provisions of the 2003 Bill but they were put back in by the Parliamentary Health Committee as being an essential element to ensure appropriate service provision in forensic mental health care. Unusually the 2003 Act set a date for implementation of the excessive security appeals from the State Hospital at Carstairs.

A similar issue with regards to the provision of appropriate services for mentally disordered offenders occurs now. Whereas many Faculty members would identify that excessive security appeals have been important in driving forward the medium secure psychiatric estate (we now have a full national provision of medium secure units in Edinburgh, Perth and Glasgow) there is very poor development in the low secure estate. Nationally there is a need to provide low secure pre-discharge units for patients requiring complex risk management supervisory frameworks in the community - who are on extended periods of overnight testing out in the community and do not require to return to a medium secure unit meantime.

There is also a need to provide for low secure rehabilitation units where patients require day to day close behavioural management to respond to challenging behaviour. Many Health Boards are using the private sector or sending patients to England because of lack of appropriate facilities in Scotland. Many areas have well worked out proposals for providing such low secure units but in an environment of competing pressures for resources Forensic Psychiatry has yet again not been seen to be a priority. Many Faculty members therefore welcome an extension of appeals against excessive security to medium secure units as a way to drive forward low secure proposals. Unfortunately uncertainty following the RM judgement has led to something of a planning blight whilst guidance is awaited. The Faculty would encourage explicit extension of the excessive security appeals to medium secure units with a date of commencement. The worst possible outcome would be a lengthy period of time waiting for regulations, during which there would inevitably be a continuation of planning blight. The regulations will also need to take into account the different characteristics and security levels of the three medium
secure units and perhaps direction is required to harmonise certain aspects of the three units to ensure consistency with Scottish Government guidelines for medium security.

It would also be correct to say there is a sizeable number of Faculty members who would like to do away altogether with excessive security appeals. Those colleagues often will come from areas where there is a better provision of low secure forensic units. As a general comment Faculty members would welcome any move to expedite excessive security Tribunals in contexts where they are very unlikely to succeed. For example, where there is no evidence being put forward that a state of excessive security exists. The success of such an application without supporting expert opinion is very remote yet considerable resources are taken up with such appeals. Overly speculative appeals, sometime encouraged by legal agents (who may raise an appeal without supporting evidence), can be very stressful for patients and damage therapeutic relations – they are not simply pointless but may do harm in contravention to the principles of the Act. Perhaps a mechanism could be put in place that such applications could first be considered by the duty MHT Convenor before proceeding to a full hearing. The Faculty is also concerned that Scottish Legal Aid Board rules enable doctors without appropriate qualifications to provide reports for such cases. The Faculty has made representations to the Scottish legal Aid Board to ask them only to approve payments to psychiatrists with relevant qualifications.

3. In terms of part 2 of the Bill on criminal cases this is mostly tidying up legislation with regards to calculation of timescales. This is welcome as there have been a number of unfortunate cases where the courts have not kept to the correct length of time. Unfortunately there has been no fundamental re-examination that the length of a Section 52D is correct at 28 days plus a week’s extension. Essentially the clinical team at the end of that 4 or 5 week period must decide whether treatability criteria exist. Faculty members welcome the proposed extension of the provisions of Section 52D for a further period of time in certain cases but 14 days appears completely arbitrary – certain members would like the ability to extent this further by a second 14 days in cases where it is difficult to establish whether 52g criteria exist.

There is also a more fundamental question about the lack of female high secure resources in Scotland and any child and adolescent forensic inpatient resources to allow for pre-trial patients to be assessed on Section 52D. This has the potential for leading to miscarriages of justice. There have been proposals before Scottish Government for at least the last 10 years about designating part of one of the secure schools as having hospital inpatient status. This would allow for children in their adolescence to be properly assessed in terms of their mental health needs prior to trial. There have been very unfortunate cases where this has not been possible or older children have been admitted to facilities such as the State Hospital at Carstairs.

There is also an issue with regards to high secure female provision. With the State Hospital at Carstairs closing a male ward there would appear the ideal opportunity to revisit the arrangement that high secure female patients are transferred to Rampton Hospital in the English East Midlands. The main problem is that remand patients on Section 52 cannot be moved outside the jurisdiction. This creates an inequity for female patients in terms of proper assessment prior to trial. It also creates a potential inequity in that high secure Scottish female patients do not have the safeguards of the 2003 Act which are generally considered to be superior to those in England.
There is a further issue with regards to jurisdictional matters with regards to the Northern Irish patients. The State Hospital is the high secure hospital for Northern Ireland. There is no ability for a Northern Ireland remand patient to be admitted to the State Hospital at Carstairs (for similar reasons to why remand child patients or female patients requiring high security cannot be moved outside of a Scottish Jurisdiction). Northern Irish patients have historically been managed at the State Hospital, Carstairs but they have the disadvantage that they may have had no period of assessment prior to final disposal from the court. There has already been one case of a patient who has successfully appealed his disposal to the court of criminal appeal in Northern Ireland. There are already cases where patients are admitted from Northern Ireland who cannot return to Northern Ireland because they now fail to meet Northern Irish detainability criteria although they continue to meet Scottish detainability criteria. That matter will get worse if the proposed new legislation in Northern Ireland is passed. The lack of the ability of admitting Northern Irish patients under Section 52 creates an inequity and it would be timely to reconsider the whole arrangement for admitting Northern Irish patients.

If of course the independence vote is passed there would need to be careful thought as to the repatriation of Scottish patients in England and the feasibility of continuing any arrangement with Northern Ireland. If the United Kingdom continues then there may be a case for considering UK wide legislation allowing remand patients to move between UK jurisdictions to allow for appropriate assessment.

The Bill creates a new requirement for MHOs to consent to Transfer for treatment Directions – prison transfers to psychiatric hospital for treatment. We have concern this measure may create unnecessary delay in transferring acutely unwell prisoners. The MHO resource is highly variable across the country and in certain cases it may be difficult to get an MHO quickly The Bill does not specify that the MHO has to see the prisoner, or that they have other statutory duties. To avoid wrangles between local authorities as to who should provide an MHO it may be worth specifying for the purpose of this aspect of the legislation is should always be the local authority in which the prison is situated who must provide an MHO. All areas have out of hours and emergency rotas but getting an MHO from another part of the country will cause delay. We question whether this particular provision is necessary and mechanism should be in place for urgent transfer without consent if required. It would be inequitable for an ill prisoner to have a delay in necessary urgent treatment because their need is to do with their mental health and not physical. Perhaps different arrangements should be in place for those prisoners who consent to psychiatric hospital treatment and those who lack capacity or object.

4. Part 3 of the Act introduces a victim notification scheme for mentally disordered offenders. Generally this is welcomed by Faculty members who have been asking for improvement in how victims are dealt with for at least the last 10 years. The current system is haphazard and lacks consistency. We welcome the appointment of the Chair of the Forensic Faculty, Dr John Crichton as convenor of the expert group to consider how this part of the Bill would be implemented. That group has been set up by Scottish Government in conjunction with the Forensic Mental Health Managed Clinical Care Network. The group has already met and a number of sub groups looking at aspects of victim notification have begun. Dr Crichton will be in a position later this year to report to the Committee the progress of the group and any particular issues with regards to the legislative proposal that has arisen through the groups’ scrutiny.
5. As previously remarked it is a matter of general regret that the McManus report was not tasked with reviewing the forensic aspect of the 2003 Act. The Bill contains very important provisions for forensic psychiatry but these have occurred because of pressures rather than a reflective review process. Although the forensic aspects of the 2003 Act are largely welcomed by Faculty members it is perhaps timely to reconsider that legislation brought in by the Scottish Parliament on its first day of sitting. On the 8th September 1999 emergency legislation was brought in because of the Noel Ruddle case. MSP Dennis Canavan made certain far sighted remarks that emergency legislation had a habit of sticking. The provisions of the 1999 Act survived intact in the 2003 Act with the serious harm test being extended to all restricted patients. The Act has been successful in terms of public safety but has not been successful in terms of appropriate placing of offenders who should not be in hospital.

As was the case in 1999 there are a small group of patients, somewhere between 5 and 10, who received a Compulsion Order and Restriction Order disposal (or its equivalent) and have subsequently been discovered to be inappropriately placed within a mental health setting. The most common reason for this is that the initial diagnosis has proved not to be correct. One proposal discussed by Faculty members would be to enable a shrieval Tribunal to review the original reasons why a CORO had been put in place and if those reasons had fundamentally changed such as the diagnostic category under which the patient belonged then there would be an ability to refer the case back to the sentencing court for a more appropriate disposal. Not only would this be welcomed by Mental Health Services who can then more appropriately target resources but it would be welcomed by patients who often find themselves stuck in a mental health system not designed for their needs. Change in this area is already occurring with that small number of patients pursuing new disposals through the courts but the process of going through the Criminal Cases Review Commission and the Criminal Court of Appeal takes a very long period of time and is costly. Committee members may be aware of the case of Alexander Reid who has eventually been transferred satisfactorily to prison but not before enormous expense and time both in terms of his inappropriate stay within a forensic mental health setting but also in terms of very lengthy court proceedings. There are a small number of other patients on the same pathway as Mr Reid and the Bill provides an opportunity to bring in primary legislation to allow a mechanism for a common sense transfer of inappropriately placed patients in mental health to a more appropriate custodial setting.

Alternatively a fairer way to consider restricted cases at Tribunal would be to harmonise the entry and exit criteria. Restriction Orders continue to be a ‘lobster pot’ – easier to get onto than off.

There is also something of an opportunity missed not to put the status of the Conditionally Discharged Restriction Order on a clearer statutory footing. There remains confusion regarding the ‘serious harm test’ and the process of derestriction with the Faculty criticising the process of derestriction as described in the Scottish Government Memorandum of Procedure for Restricted Patients. The Faculty question the conflation in current Government guidance between the ‘serious harm test’ and the ‘significant harm test’.

6. We have no further comments about the Bill.

Royal College of Psychiatrists in Scotland
August 2014
Victim Support Scotland

Mental Health (Scotland) Bill

Victim Support Scotland is the largest voluntary organisation in Scotland supporting people affected by crime. We provide practical help, emotional support and essential information to victims, witnesses and others affected by crime, both in the community and in every Sheriff and High Court in Scotland. The service is free, confidential and is provided by volunteers. Victim Support Scotland welcomes the opportunity to provide written evidence to the Scottish Parliament’s Health and Sport Committee on the Mental Health (Scotland) Bill, with specific reference to the rights of victims of mentally disordered offenders (MDOs).

Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

Information for Victims of MDOs

It has been acknowledged\(^1\) that victims of mentally disordered offenders (MDOs) are given less information about the offender than other victims, which will include the offender’s whereabouts, the reasons behind the crime, and details on the release of the offender into the community. This is very frustrating for victims and the fear of not knowing when the offender will be released may serve as an impediment to the victim’s recovery process. If victims feel that they are not being kept informed of what is happening in their case, this can result in a lack of confidence in the criminal justice system as a whole, possibly affecting the likelihood of future engagement with the system.

The right to information is one of the most important rights for victims of crime. This is found in Article 6 of the 2012 EU Directive establishing minimum standards on the rights, support and protection of victims of crime\(^2\), and is now included as a statutory right under section 6 of the recent Victims and Witnesses (Scotland) Act 2014\(^3\). The provision of information to victims is vital for a number of reasons. Firstly, the provision of case-specific information can help victims to understand the role that they are expected to play. Secondly, keeping the victim informed at all stages of the criminal justice system, including after the trial, will ensure that the victim feels that their interests are respected and taken into account. It is not merely the sentence that determines the victim’s sense of justice; it is also influenced by the manner in which they are treated throughout the process.

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the entire criminal justice procedure. Finally, the provision of information can assist victims of crime when planning their safety. Everybody has a right to feel safe in the communities in which they live. For victims, having been the target of a criminal offence, their sense of safety has often been jeopardised by the event; many victims are worried about meeting the offender in the street or in the local community. They therefore often want to know if the offender has been released, either with or without conditions. If they are aware that the offender is released back into the community, either temporarily or permanently, they may choose to take steps to increase their own sense of safety. Without information about the whereabouts of the offender, the victim is unprepared for the risk of meeting the offender in the community.

Taking all of these points into consideration, Victim Support Scotland welcomes the Bill’s provisions for the introduction of a Victim Notification Scheme for victims of mentally disordered offenders (MDOs).

Criminal Justice Victim Notification Scheme Proposals

The expansion of the Criminal Justice Victim Notification Scheme (CJVNS) to include victims of MDOs sentenced to imprisonment and subject to Hospital Direction (HD) or Transfer for Treatment Direction (TTD) will bring the reassurance and peace of mind associated with the provision of information regarding an offender to a greater number of victims than is currently the case. This proposal will also minimise the administrative burden placed on victims as it will avoid the need for them to join two separate schemes. To further alleviate this burden, Victim Support Scotland supports an opt-out scheme for all Victim Notification Schemes, whereby the information is provided unless the victim has stated that they do not wish to receive it.

VSS welcomes the recent implementation of section 27 of the Victims and Witnesses (Scotland) Act 2014, which amends the CJVNS to allow victims of any offence to be part of the scheme, rather than solely prescribed offences as is currently the case. We also note the Scottish Government’s commitment to lowering the threshold of sentence length to 12 months through their current order making powers within the Criminal Justice (Scotland) Act 2003.

Separate VNS Proposals

Additionally, the Bill’s proposals to establish a Victim Notification Scheme for victims of offenders subject to a compulsion order and restriction order (CORO) is a major step forward in establishing a system of information provision as specified in the Victims’ Directive. Being a victim of crime can be a particularly distressing and challenging experience if the crime has been perpetrated by an

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4Victims and Witnesses (Scotland) Bill Policy Memorandum, paragraph 52
http://www.scottish.parliament.uk/S4_Bills/Victims%20and%20Witnesses%20(Scotland)%20Bill/b23s4-introd-pm.pdf
individual whom society believes needs care, support or treatment; victims can often be more fearful in these circumstances and are in particular need of reassurance and protection. As such, VSS strongly supports the introduction of a VNS for victims in such situations.

We note that the VNS proposed by the Bill as introduced does not include victims of offenders who are subject to a compulsion order under section 57A of the Mental Health (Care and Treatment) (Scotland) Act 2003. In accordance with article 6 of the Victim’s Directive, it is the view of Victim Support Scotland that victims should be able to access information about the release or escape of prisoners without limitations or exclusions, meaning that all victims, regardless of sentence length or whether or not the offender is mentally disordered, should receive the same amount of information. We believe that the Bill should go further in ensuring that information is provided to victims of offenders subject to compulsion orders (COs); our suggestion is that the Victim Notification Scheme that is currently proposed to cover only offenders with a compulsion order and restriction order should be expanded to include offenders with a compulsion order if and when this order is extended on review at the six month point.

**Victims’ Representations**

Victim Support Scotland believes that victims should be consulted and given the right to provide information before any key decisions are taken in the case. As such, we agree with giving victims an opportunity to make representations to decision-makers about the effect of the decisions to be made and any other concerns they have as this ensures that the victim gets the opportunity to make their voice heard and give an input into the decisions made. In addition to the impact of the crime and any additional information that may be of interest, the victim should also be able to raise any concerns they have regarding their own safety and security following the release of the offender. Conditions restraining the offender from contacting the victim or entering certain geographical areas, for instance where the victim lives, should be set if deemed appropriate.

As previously indicated\(^5\), Victim Support Scotland believes that in order to ensure that all victims are given equal opportunity to participate, all victims should be able to give information orally, in person or by pre-recording, in relation to any key decision about the offender. Regardless of the type of order the MDO is subject to, victims should be given the chance to provide information in the manner of their choosing.

Victim Support Scotland would like to highlight the need for further clarity regarding the right for victims to make representation. To ensure transparency and accountability, the circumstances under which representation is allowed should be made clear and communicated to victims in a timely manner. We

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\(^5\) Victim Support Scotland (2013) *For Justice. The Victims and Witnesses (Scotland) Bill 2012: A Response from Victim Support Scotland* Link no longer active
believe every victim should have the ability to make their voice heard throughout the assessment process and that their voice should be considered and taken into account as an integral part of the decision-making process.

Conclusion

Victim Support Scotland supports the general principle of Part 3 of the Bill, as regards the introduction of a Victim Notification Scheme for victims of Mentally Disordered Offenders. In order to maximise the number of victims who would benefit from these proposals, we suggest that the scheme should also cover victims of offenders subject to compulsion orders which have been extended at the six month review. We look forward to further discussions on how victims of MDOs can access their rights to information as detailed in the Victims’ Directive, and are pleased to be currently working in partnership with other relevant agencies in developing practical suggestions and options for the implementation of the updated legislation.

Victim Support Scotland
August 2014
Patricia Whalley (Individual)

Mental Health (Scotland) Bill

Firstly, it is an excellent Report and addresses most of the concerns raised since 2005.

Two main points for consideration:-
Advanced Statements: It would be helpful if there were two sections on the one form.
Perhaps, A) Dealing with Treatment
B) Named Person.

This is important when the Advance Statement is overridden for Treatment purposes but allows for Second Opinion/ Tribunal Members to understand the Patients genuine wishes when well re a Named Person. The default position being family member, friend etc is totally unacceptable and could disrupt roles, relationships and boundaries. Perhaps some patients don't consider they need or wish a "Carer" especially given the episodic nature of Mental Disorder.

I agree with the default position being legal/advocacy.
Secondly, mainly with the Implementation of CTOs. In some cases these are reinstated year after year with Tribunals every two years. I agree with a "Paper Renewal/Extension", the Patient being offered the Right of Appeal with a Tribunal but after a number of Tribunals it can be the case that the desire to get on with life out ways the wish to attend yet another Tribunal. The Mental Welfare Commission/or Second opinion could supervise this procedure to protect vulnerable groups.

Patricia Whalley
August 2014
Greater Glasgow and Clyde Area Psychology Committee

Mental Health (Scotland) Bill

Question 1
Do you agree with the general policy direction set by the Bill?
• GG&C Area Psychology Committee agrees with the general policy direction set by the Bill, that the provisions in the Bill have been extensively consulted on, that recommendations of the McManus Report have been adopted, and that consultations from the Victim Notification Scheme have been appropriately consulted on, considered and incorporated.

Question 2
Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
• GG&C Area Psychology Committee welcome specific changes as set out in Part 1 of the Bill, specifically
  - Section 22 and 23 of the Bill which proposes a slight widening of the existing provisions relating to the provision of assistance with communication at medical examinations and services and accommodation for mothers with mental health disorders beyond post natal depression
  - Section 21 of the Bill proposing the registering of Advance statements and the improvement in communication of these documents by ensuring Health Boards place a copy of the statement in the person’s medical file

Question 3
Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
• GG&C Area Psychology Committee has no comments on the provisions in Part 2 of the Bill on criminal cases
Question 4

Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

- GG&C Area Psychology Committee welcomes specific changes as set out in Part 3 of the Bill, specifically Section 43-46 of the Bill where additions have been made to include victims’ rights to receive information and the nature of the information which is to be made available.

Question 5

Is there anything from the McManus Report in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

- GG&C Area Psychology Committee believes that all the issues raised by the McManus Report have been addressed in the Bill.

Question 6

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

- GG&C Area Psychology Committee have no further comments to make about the Bill.

Greater Glasgow & Clyde Area Psychology Committee
August, 2014
The ALLIANCE

Mental Health (Scotland) Bill

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 700 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

The ALLIANCE welcomes the Health and Sport Committee’s call for evidence on the Mental Health (Scotland) Bill. Following publication of the draft Bill earlier this year, the ALLIANCE convened a small group of members who are keen to help shape policy that produces the best outcomes for Scotland’s people and communities.

Consultation Questions

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

No. Generally, the provisions included in the Bill do not appear to be person-centred in their approach and make a number of administrative duties in isolation of the person and their rights. This is out of step with both the international context – for example, the Convention on the Rights of Persons with Disabilities (UNCRPD)\(^1\) and the recent direction of travel in Scotland, e.g. the Mental Health Strategy for Scotland 2012-15\(^2\), development of the recovery approach, the emphasis placed on person-centredness in the broader 2020 Vision and the Route Map to the 2020 Vision\(^3\) and the Scottish National Action Plan on Human Rights\(^4\).

The provisions of the Bill must reflect the shift in policy towards co-production and people being equal and active partners in their health and care. Co-production can describe partnership at the individual level but it is also about involving people in decisions about the design and delivery of services. This is an essential mechanism for producing models, services and systems that are person-centred.

We must ensure a balance continues between a person being supported to make their own decisions against decisions being taken away from them. Moves towards the empowerment of people’s voices must apply equally in

relation to people with mental health problems as it does to all other groups of people who use health and social care services.

Our members have expressed a general concern that if the provisions are enacted they are likely to lead to a loss of rights for people with mental health problems with very little justification.

2. **Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?**

**Advance statements**

Our members have expressed concern about the legal status of advance statements and whether medical staff paid attention to what was included in them. Placing a copy of this in the person’s medical records, as proposed by the Bill, will not make certain that it is proactively used and a further duty is required to ensure that this happens. Behaviour in relation to advance statements needs to be better researched and monitored so that they can play a much bigger role for people who would benefit from having one.

Advance statements should be promoted as a positive means of the individual saying what helps and what doesn’t help them to be well as part of a recovery plan. However, people are not always clear and confident about the legislation and can hide behind it and this encourages risk adverse behaviour. We should be countering this by linking tools like advance statements to the self management agenda and recovery approach and encouraging people positively to take ownership and responsibility for their condition. People must be able to have confidence that they will be supported to do this and that their views and wishes will not simply be overturned or ignored when they are unwell.

The low numbers of advance statements are a cause for concern and we believe that greater efforts are required into increasing their use. Anecdotal evidence suggests that take up is lessened because when people are well, often they do not want to think about the possibility of becoming unwell again. In addition to the points made above, the ALLIANCE believes that research and action must be carried out into:

- The barriers to completing an advance statement
- The number of advance statements that exist
- How many are overturned
• Actions that will encourage further take up of the advance statement process.

This must be followed by detailed recommendations and urgent action by the Scottish Government to increase the numbers of advance statements.

Advance statements can be a very positive tool but they need to be introduced to people as part of a collaborative goal setting process/personal outcomes focused discussion. This doesn’t happen enough at present and the system doesn’t encourage this type of interaction. Practitioners often do not have the skills or capacity for this type of personal outcomes approach or to encourage the writing of advance statements and often medical practitioners do not look at advanced statements until after treatment has been given. Practitioners need to be supported to adopt a personal outcomes approach and have conversations with people about what matters to them, the support they need and how they can put in place advance statements when they are well to ensure their views remain central at times when they are ill.

There is a fundamental inequity between people who have mental health conditions and others. For example, if someone has a terminal illness they have the right to refuse treatment, but this is not the case with a mental health diagnosis. Even where advance statements exist the views of the person are not always taken into account in decisions about treatment.

Role of the Mental Welfare Commission

The Bill proposes that a copy of advance statements be sent to the Mental Welfare Commission (MWC) who will hold a central register of advance statements. Many people do not understand the role of the Mental Welfare Commission – and believe that it deals with complaints. Whilst we recognise that the low take up of advance statements is an issue we are concerned that many people could be put off making an advance statement if these are shared through a central register managed by the MWC. It will be important to have clarity on how the advance statements will be held and who will have access to their contents. The person themselves should be allowed to decide who is able to access their advance statement.

Witnessing of advance statements

Under the Mental Health (Care and Treatment) Act 2003, all advance statements must be witnessed to certify in writing that the person making the statement has the capacity to do so. The Act set out that only the following witnesses were eligible:
Clinical psychologists entered on the British Psychological Society’s register of chartered psychologists
Medical practitioners
Occupational therapists registered with the Health Professions Council
Persons working in, or managing, a care service
Registered nurses
Social workers
Solicitors.

We believe that this is highly medicalised in its approach and wish to see these rules extended to consider reviewing the list of people eligible to sign such a witness statement. This should include peer support workers.

Named persons

Having a named person should be a safeguard and can bring forward valuable information, particularly when a person is unwell. However, the ALLIANCE is concerned that at present many people are asked about the named person when they are ill rather than when they are well.

In circumstances where the named person is informed of their right to legal representation and advice (subject to local advocacy advice criteria) this process can work quite well. However, this is often not the case and people need more information about the role of the named person. This is particularly the case for carers, many of who want named person status so that they are properly informed and included in discussions. However, carers should be respected and have their views taken into account, anyway, in line with the spirit of the principles included on the face of the 2003 Act.

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

No comments.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

The ALLIANCE is concerned about the possible inequity of these changes and the possibility of a perpetuation of the stigma that already exists about Mentally Disordered Offenders. Balancing the rights of these two groups – offenders and victims – is a difficult process – but this should be addressed in
the same way for all offenders, regardless of whether the offender is a Mentally Disordered Offender.

Further detail is required about how information will be disclosed to a victim as where people have to live in a certain place as a condition of their treatment there is a possibility that their right to privacy could be undermined by these proposals. The Scottish Government must outline how this will be respected.

The ALLIANCE believes that further consideration is also required on how disclosure of information about release would work in relation to the staged release/rehabilitation approaches that are increasingly common i.e. if someone was being allowed out a day at a time would the victim be informed on every occasion?

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

During our discussions with ALLIANCE members, many expressed concern that despite publication of the Limited Review of the Mental Health (Care and Treatment) (Scotland) Act in 2009 (the McManus Report), very few of its recommendations are included in the Bill and conversely, that there is a lot included in the Bill that was not included in the McManus Report.

The ALLIANCE is concerned that the consequence of this is that these proposals do not appear to be person-centred in their approach and make a number of administrative duties, apparently in isolation of the person and their rights. This is out of step with both the international context – for example, the Convention on the Rights of Persons with Disabilities (UNCRPD) and the recent direction of travel in Scotland, e.g. the Mental Health Strategy for Scotland 2012-15, development of the recovery approach, the emphasis placed on person-centredness in the broader 2020 Vision and the Route Map to the 2020 Vision and the Scottish National Action Plan on Human Rights.

There was a general concern expressed by members that if the proposals are enacted they are likely to lead to a loss of rights for people with mental health problems with very little justification. We would absolutely want to avoid a situation in which Scotland takes a regressive step in relation to rights and

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mental health, particularly when we are often held up as among the leading countries internationally in this regard.

Independent Advocacy

Given recommendations made in the McManus Report we are concerned to note that the command paper makes no reference to independent advocacy.

“The Government should by whatever means it sees fit, ensure that there is appropriate provision, with associated funding, across Scotland, of independent advocacy services by NHS Boards and local authorities to ensure that the requirements of s259 of the Act (Mental Health (Care & Treatment) (Scotland) Act 2003) are complied with in relation to all persons affected by mental disorder regardless of where they are and taking into account their specific needs.”

Limited Review of the Mental Health (Care and Treatment) (Scotland) Act, Review Group chaired by Professor Jim McManus, 2009

Advocacy helps people to express their own needs and make informed decisions as well as safeguarding people who are vulnerable or discriminated against or whom services find it difficult to support. Reference to independent advocacy would strengthen these proposals and safeguard the rights of people with mental health problems.

The 2003 Act set out a “right of access to independent advocacy” and there are organisations working across Scotland to support people with a “mental disorder”. However, despite the duty, access to advocacy varies from area to area and the duty is not being adhered to across the country. We believe that the Scottish Government needs to put in place stronger monitoring mechanisms and consequences for Health Boards and Local Authorities who do not meet this duty.

The ALLIANCE
August 2014

The ALLIANCE vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

10 http://www.scotland.gov.uk/Publications/2009/08/07143830/0
The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.

- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.

- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.
David Healy Background

My background is as follows. I am an internationally respected psychiatrist, and psychopharmacologist I have been a professor of psychiatry in Wales for the last 25 years, having studied medicine in Dublin, and at Cambridge University. I am a former Secretary of the British Association for Psychopharmacology, and have authored more than 200 peer-reviewed articles, 200 other pieces, and 22 books, including The Antidepressant Era and The Creation of Psychopharmacology from Harvard University Press, The Psychopharmacologists Volumes 1-3, Let Them Eat Prozac from New York University Press, and Mania from Johns Hopkins University Press, and Pharmageddon from California University Press.

I have been an expert witness in homicide and suicide trials involving psychotropic drugs, and in bringing problems with these drugs to the attention of American and British regulators, as well as raising awareness of how pharmaceutical companies sell drugs by marketing diseases and co-opting academic opinion-leaders, ghost-writing their articles.

I am a founder of Data Based Medicine Limited, which operates through its website RxISK.org, dedicated to making medicines safer through online direct patient reporting of drug effects.

Written Evidence

I was approached by Autism Rights to submit written evidence for the committee stage of the Mental Health (Scotland) Bill because of my professional profile. I agreed because of my concern at the reports and information I have received about the treatment of people who are on the autistic spectrum within the Scottish mental health system, including patients who have consulted me from Scotland. This information tallies with reports in the rest of the UK and indeed generally within Western mental health systems.

In spite of the stipulation in legislation, regulation and policy that patients and their carers should be actively involved in their treatment, families tell me repeatedly that the exact opposite is the case and I have witnessed the same in the clinical service in which I work and repeatedly in cases on which I consult that come from out of area but who have been affected by the adverse effects of psychotropic drugs.

Again and again, as an expert in the side effects of pharmaceutical drugs, I witness carers and patients pointing out that treatment is going wrong and coming to the correct diagnosis as to what is happening only to find that the psychiatrist or the services respond dismissively or punitively, even in Mental Health Tribunals.
This is a problem that affects anyone who is vulnerable to the many adverse effects that psychotropic drugs can have, be they elderly, patients with mental illness in general, or people who are on the autistic spectrum or who have a learning disability in particular. The responses to medication in these latter two groups are much more likely to “go wrong” but patients and their relatives are even less likely to be heeded when they try to point out the problems.

The Scottish Government states that the Mental Health (Scotland) Bill is intended to bring recommendations from the McManus Review into effect. I do not wish to give evidence about this Review, so I will restrict my evidence to questions 1 and 6.

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

I would have to say no.

My main concern with mental health legislation is that it ignores the reality that, for many, the treatments do not work as intended and when this is the case the results can be destructive to the person’s physical and mental wellbeing. This reality makes any provisions about the `medical necessity’ of treatment in a system that can enforce treatment questionable unless there is a properly independent system that can advocate for the patient and their carer. At present there is no such system.

Patients within mental health have less rights that prisoners within the prison system and the carers of these patients are often treated as being almost as “lacking in capacity” as the person put on treatment if they question doctors or other healthcare staff about whether the treatment is in fact delivering the intended benefits.

At present we have systems that are concerned to pick up the one person in 50 who might be abused by a relative but the systems put in place to prevent this happening – which amount to a radical dismissal of the views of relatives or carers - penalise the other 49 sets of relatives and carers who are in fact the people who deliver most of the care that is given to those who need it. Failing to capitalize on the unpaid labour of those who necessarily do most of the caring is a recipe for both financial and systemic bankruptcy.

I am an acknowledged international expert on antipsychotic, antidepressant, and mood-stabilizing drugs and regularly write about the absence of evidence for their effectiveness and the way that the current system of drug regulation covers up the problems with these drugs.

Most of the views that most doctors within mental health systems offer about the treatments they recommend stem from ‘ghost written’ articles. Almost everything at present go do with current drugs in use is ghost written whether it appears in the leading medical journals or not. This is both clinically and morally inappropriate and more to the point likely to lead to poor outcomes.

A further issue is that the non-publication rate in clinical trials for psychotropic
drugs approaches 50% of trials while there is a 100% lack of access to the data from trials in all studies – published or unpublished.

It is not generally known that 80% of the problems that are identified with drugs are identified by patients and their carers and sometimes their doctors, not by clinical trials. Randomised Clinical Trials (RCTs) are in fact not designed to pick up on adverse events and are the Gold Standard way to hide adverse events.

Quite apart from the sometimes tragic consequences of adverse events, there are compelling reasons to improve the quality of adverse event reporting. Adverse events are still the best way to discover new drugs, and it is perhaps no surprise as the quality of reporting has gone down, drug pipelines have dried up. There is at least some political awareness of the regressive nature of the pharmaceutical industry's reliance on `me too` drugs, but little awareness of the ultimately self-defeating effects of the industry's denial of adverse drug events on drug development.

I would strenuously make the case that the current drug regulatory systems are not serving either patients, doctors or pharmaceutical companies well and that is why I and some of my international colleagues have set up Data Based Medicine and the Rxisk website: to collate information on adverse drug events and apply this data to drug development and patient treatment based on individual needs and susceptibilities.

Given that the prescription of psychotropic drugs in Scotland is now among the highest rates of prescribing of such drugs in the world, and that these drugs can induce both suicidal and homicidal ideation, autistic spectrum disorders, learning disabilities and others problems, there are real dangers in continuing to ignore the tricks of the international pharmaceutical trade. It is neither humane nor economically sustainable to gloss over these dangers.

**6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?**

There is a growing international movement amongst those, like myself, who are psychiatrists and other professionals in the mental health field whose research leads them to conclude that the mental health system is in need of radical reform. It should not be possible to force medical treatment on anyone, especially where the efficacy of that treatment is in doubt and the adverse effects can be fatal.

Few if any patients – and this includes MSPs – are taking any medications with informed consent because it is simply not possible to access the data that would inform consent. Over-riding someone's inalienable right to determine what they take into their own body should not be done lightly but is in fact, especially within mental health, been done routinely.
It should be noted that psychotropic drugs are the leading cause of death in the mental health system. The adverse effects of these drugs can only be properly reported by patients and their carers, and yet these are the very people whose observations are often disputed by my fellow psychiatrists.

As legislators, MSPs have a duty to take a balanced selection of evidence. I would be very happy to elaborate on the points above both as they apply to the psychotropic drugs given to people within mental health systems and as they might also apply to any drugs given to MSPs at present. There is a pressing need for some healthcare system to find a way to ensure that the rights all patients are acknowledged to have in principle are realized in practice. No legislation anywhere to date has found an answer to this issue – because no legislators have in fact addressed it. I have a good deal more to offer on this issue if invited to attend and present or even just to answer questions.

Professor David Healy MD FRCPsych
Director of the N Wales Department of Psychological Medicine
August 2014
East Lothian Health and Social Care Partnership

Mental Health (Scotland) Bill

East Lothian Council welcomes the opportunity to respond to the Committee’s call for written evidence on the Mental Health (Scotland) Bill. This officer-level response reflects the views of our Mental Health Officers who are familiar with the legislation and its implementation, and is set out in the order of the questions sent by the Committee.

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

Considering that the overarching objective of the Bill is ‘to help people with a mental disorder to access effective treatment quickly and easily’, East Lothian Council can support the general policy direction set by the Bill. However, throughout our consideration of this issue, concerns were raised about the impact of the proposed changes on the Mental Health Officers’ workload capacity. It is acknowledged that the proposed changes enable further protection for the client, ensure a more informed assessment and are in keeping with good practice and are therefore supported, but Mental Health Officers feel that their capacity is already stretched. Accepting that this is a national issue, we would ask that this is addressed at a national level and careful consideration is given as to how local authorities can continue to meet their statutory duties in relation to this legislation, Adults with Incapacity (Scotland) Act 2000 and other key pieces of legislation.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Procedure for compulsory treatment

Increasing the 5 working day period to 10 working days – the proposed change raised some positive responses and some concerns. There was recognition that extending the time during which the CTO application can be determined or an interim CTO granted would allow more time for administrative tasks to be completed. It would also allow those participating in the tribunal time to consider the case and their position in relation to the application. This is particularly true when the input of a curator ad litem is required. Allowing time for better preparation for the tribunal does reduce the likelihood of a further tribunal being needed where interim CTOs are granted, avoiding an additional potentially stressful event for the client.

It was also noted that the duration of a short term detention is often just short of the amount of time required to make a safe assessment that further detention is not required. 28 days are sometimes not enough for treatment to be fully effective. A further 1 or 2 weeks can be enough time for an assessment to be made establishing, with confidence, that further detention is not required.
Within the existing timescales, CTO applications are sometimes made to enable a relatively short extended time in hospital with treatment before discharge home is planned. However, this extension could result in the period of time the client can be detained for under the Short Term Detention being increased from 28 days to 42 days, if the extended period of time includes 2 weekends. Enabling a period of detention for this length of time without the independent scrutiny the tribunal process affords needs to be considered very carefully. It might be anticipated that the number of appeals in relation to short term detentions would increase. This increase could potentially erode the impact of the benefits anticipated with the proposed extension. When considering the maximum amount of time the client could potentially be detained in hospital without the CTO application being heard, the client’s rights might be compromised.

Information where order extended – Where the Tribunal is required to review a determination, officers support the proposal that the MHO submits a written report to the Tribunal containing information set out in the new section 87A(4). Officers consider that this is in keeping with a multi-disciplinary approach and good practice, and provides further safeguard for the client. In light of the original CTO application being made by the MHO, raising the MHO’s input at this stage is considered appropriate.

Emergency, short term and temporary steps

The changes proposed in relation to emergency and short term detentions are supported.

While officers support that hospital managers can exercise discretion as to whether or not to give notice of certain matters to those listed in the Bill, to inform this decision guidance should be provided by those directly involved in the detention and best placed to do so - the RMO, MHO and/or the GP. We suggest that the code of practice should clarify this.

The suspension of certain orders etc.

The proposed changes in relation to the suspension of orders on emergency and short term detentions are supported, as are the proposed changes in relation to obtaining the Scottish Ministers’ consent to the suspension of detention.

While the MHOs cannot comment on the administrative implications of the proposed changes in relation to the maximum suspension of detention measures, they are supportive of the proposals insofar that they ensure close monitoring of the use of the suspension and time restrictions. This will help to ensure that individuals do not remain on inappropriate detentions and detention orders are varied appropriate to individual needs.

Orders regarding level of security

The proposed amendments in relation to rights of appeal against perceived level of excessive security for those held outside of the state hospital are
supported and considered to be in keeping with the principle of least restriction.

**Removal and detention of patients**

The changes proposed are supported though East Lothian Council MHOs ask that every effort should be made to minimise the length of time someone is detained pending medical examination to ensure that their rights are protected as best as is safely possible.

**Time for appeal referral or disposal**

The proposed changes are supported and believed to be in the client’s best interest to ensure that the best treatment option can be accessed promptly.

**Representations by named persons**

Proposing that the client only has a named person if they choose to have one is in principle supported. The named person can inform assessment and outcome, ensuring further protection for the client. However, when considering this issue, officers did express some concerns that those with a cognitive impairment might not be able to fully consider the need for or benefits of having a named person, or the implications of not having one. While it is anticipated that the Code of Practice will guide on this issue, from the amendments proposed, it is not clear how this will be addressed. Assurance that this group will not be vulnerable to discrimination is sought.

**Advanced statements**

The proposed changes are supported. It is recognised that when there is an advanced statement at present, local experience is that the tribunal considers its content carefully and with respect. However, at time of writing there are very few advanced statements. Holding the advanced statements centrally will give the statements more status and recognition, which will in turn filter out to more questions being asked if individuals do not have one. Enabling out of hours access to the advanced statement needs to be considered.

The importance of ensuring that the advanced statement is a meaningful document was once again raised. It is important that those supporting the client to create a statement can advise and guide appropriately. Training is necessary for those in this role, and those who witness the documents, to ensure that advanced statements can be promoted with confidence.

**Support and services**

The proposed changes to extend the existing provision of assistance to patients with communications difficulties are supported, as are widening the commitment to provide services and accommodation for mothers and their child who are admitted to hospital for any type of mental disorder. While we acknowledge that this will have significant impact on resources, officers also propose that consideration should be given to extending support beyond the first year of the child’s life to 2 years. The onset of post natal depression is not always immediately after the birth of the child and, irrelevant of diagnosis, the impact of separation on both mother and child beyond the first year is still significant.
Cross border and absconding patients
The proposed amendments to extend cross border transfer to include clients from out with the UK from other EU member states were positively received.

Arrangement for the treatment of prisoners
The proposed changes in relation to MHOs now contributing to the decision making of a patient being transferred from prison to hospital are considered positively. The MHO contributes to decision making at critical points throughout the implementation of this legislation and makes the initial CTO application. For them to contribute at this stage is in keeping with the principles of the Act and is considered appropriate.

Consideration will need to be given as to how the MHO from the responsible local authority will complete their assessment when the client resides outside of their area and travelling restricts the set timescales being adhered to.

Removing the obligation for the Convenor of a Tribunal Panel to be either the Tribunal President or to be selected from the Shrieval Panel should result in increased flexibility in being able to respond to requests for tribunals.

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

The proposed changes are supported.

Enabling the court to extend the period of time from 7 to 14 days to complete an assessment order is thought to be appropriate and enables a full and complete assessment by those best informed to carry this out.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

The introduction of a victim notification scheme for victims of mentally disturbed offenders is supported, although officers consider that this raises questions and would seek more clarity about the implications of this.

Officers have concerns about the monitoring and control of the information shared about the MDO. Clear guidance is sought through the code of practice to ensure that there is clarity about who shares information with the victim, what information can be shared and in what circumstances. Officers recognise the importance of the victim having their rights recognised and addressed to help their rehabilitation, but the Mentally Disturbed Offender’s needs and vulnerability also need to be considered. It needs to be recognised that these needs differ from an offender who is not mentally disturbed, and that the scheme cannot be directly transferred without safeguards in place to ensure the MDO vulnerabilities are not further compromised.
5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

Throughout our consideration of this, the purpose and use of the 2nd medical report was debated. At present the 2nd medical can be a valuable contribution to the decision making process, but it is also recognised that when it is completed by a doctor who is not familiar with the client, it serves a less useful function. The McManus report does consider the benefits of a clinical psychologist providing one of the medical reports. Where they are the lead clinician, likely to be most relevant to clients with learning disabilities, their involvement would be useful and informative and has the potential to ensure a better outcome for the client.

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

While the proposed changes were generally received positively by relevant officers, being considered to promote better practice and improved services for the clients, some issues were raised and which we would ask receive additional thought in relation to the need for further safeguarding. These issues are mentioned above: they are the proposed changes to procedures to appoint a named person, and mentally disturbed offenders whose vulnerabilities may be further exposed should the changes be made without clarity being provided through a detailed code of practice.

It is also hoped that the code of practice will address concerns about how the tribunal is led and how solicitors present in this environment. Some tribunals continue to be adversarial and subsequently intimidating to clients and named persons. The process should be inclusive, with the client truly being able to access and contribute.

Considering the effects on local government the Policy Memorandum acknowledges that there will be an increase in the MHO’s work load but ‘does not consider that the measures in the Bill have any disproportionate effect on local government’.

Figures are given of the number of cases which will require additional work by the MHO, should the changes progress. While these figures are not large they need to be considered over and above the current pressures from statutory commitments. The impact of the Adults with Incapacity legislation on the MHOs continues to grow, as does the Adult Protection legislation. The numbers of cases likely to be affected by the proposed changes cannot be considered in isolation and while our officers support the proposed increased role of the MHO, considering it good practice, the MHOs’ capacity to fulfil their statutory responsibilities is already stretched.

East Lothian Health and Social Care Partnership
August 2014
The State Hospitals Board for Scotland

Mental Health (Scotland) Bill

Introduction

The State Hospitals Board for Scotland welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill.

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

We support the Bill’s overarching objective to help people with a mental disorder to access effective treatment quickly and easily. The issues identified in the McManus Review regarding advance statements, named persons and multiple hearings at mental health tribunals are part of our clinical experience and therefore solutions to these issues are to be welcomed.

Members of the Board have been involved in discussions regarding the victim notification scheme and we have responded to a previous consultation on this. Similarly, we have been involved in discussions regarding appeals against excessive security using our considerable clinical experience and research into this provision.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care & Treatment) (Scotland) Act 2003 as set out in Part 1 of the Bill?

a) Application for a Compulsory Treatment Order
It will be helpful to patients, their carers and named persons to have 10, rather than 5, working days prior to a CTO hearing. It is noted that this will not increase the continuous period of detention as set out within the 2003 Act.

b) The new duties for the MHO to review CTO determinations in specific circumstances inserted under Section 87A fall within good practice.

c) Suspensions of orders on Emergency Detention
It is helpful that a patient subject to a community based CTO who requires an emergency detention certificate will remain subject to the giving of medical treatment in accordance with Part 16 of the 2003 Act.

d) It is helpful that patients subject to an assessment order, a treatment order, an interim compulsion order or a temporary compulsion order will no longer require the consent of Scottish Ministers for Suspension of Detention if this is to enable a patient to attend a hearing in criminal proceedings, or meet a medical or dental appointment.

e) The changes to the maximum period of suspension of detention are supported: up to 200 days in any 12 month period with the option of a 100 day extension if approved by the Tribunal following application. It is noted that the system should be simplified by not having to count any
period less than 12 hours and that does not include any time overnight (9.00pm-8.00am) for patients subject to orders under the Criminal Law (Section 224) or under a CTO (Section 127).

f) Excessive Security
The State Hospitals Board has significant experience in appeals against excessive security. See Appeals against detention in conditions of excessive security in Scotland, Journal of Forensic Psychiatry (Bennett, D.M., Skilling, G., Brown, K. & Thomson, L.D.G., (2013)). The repeal of Section 266 such that a Health Board now has a maximum period of 6 months to find a suitable alternative placement for a patient declared to be held in conditions of excessive security is supported. It is noted that appeals against excessive security are added to the list of applications in Schedule 2 to the 2003 Act which will be viewed as not having been made if withdrawn before determination. The State Hospitals Board supported the introduction of appeals against excessive security in the knowledge that there was a significant cohort of its patients unable to move on from high security. This provision has led to a significantly changed forensic estate with a much reduced State Hospital (from 240 to 140 beds) and the development of 2 new medium secure units in addition to an pre existing medium secure unit. This has considerably alleviated the problem of entrapped patients within the State Hospital.

Appeals against excessive security are however stressful to patients. We have found that Solicitors, in we suspect a well-intentioned attempt to give clients maximum “protection”, will at times appear to “automatically” lodge an appeal against excessive security. The concern would be that the apparently easy option of withdrawing such appeals at any time before determination may result in patients finding themselves in a prolonged stressful period of always having an ongoing appeal against excessive security.

The extension of appeals against excessive security from high security alone to the medium secure estate may result in the development of further low secure units within the forensic estate. However, there is no comparison between patients entrapped in an isolated high secure hospital in Lanarkshire unable to access the community, and those treated within medium secure units where independent access to the community is entirely possible and is indeed the clinical aim. The use of legislation to precipitate service development is not without its risks. As stated before, appeals are stressful proceedings for patients and divert clinical time and resources from the direct care and treatment of patients.
g) Detention Pending Medical Treatment – Nurses holding power
The extension of the Nurses holding power to detain a patient for a maximum of 3 hours for the purpose of enabling a medical examination to be carried out is supported.

h) The reduction in the time allowed for making an appeal to the Tribunal from 12 weeks to 28 days for those patients detained in a hospital subject to a Compulsion and Restriction Order, a Hospital Direction or a Transfer for Treatment Direction, who are transferred to the State Hospital is supported.

i) The referral of cases with patients subject to a Compulsion and Restriction Order to the Tribunal for review every 2 years, including those with an ongoing reference or application under Sections 185 or 191 which has not yet been determined by the Tribunal, is supported.

j) Opt out from having a named person
The ability to opt out from having a named person has been a major issue for our patients within the State Hospital. This has largely been due to the concern of patients that their named person may be distressed by receiving details of index offences and/or that they feel that their confidentiality is being breached by having this information shared if by default the patient’s primary carer becomes the named person. The amendment to Section 251 allowing a patient to make a declaration stating that their carer or relative may not become their named person is fully supported. Similarly, we have had experience of cases where a primary carer has found themselves in the role of named person and in receipt of information that they have found to be distressing without having consented formally to the role of named person. The introduction of this measure is also fully supported.

k) Registering of Advance Statements
We fully support the development of a register of advance statements to be maintained by the Commission. This will be most helpful in ensuring that we are fully aware of the stated wishes of our patients, particularly where the advance statements have been made in other health board areas.

l) The extension of regulations to include cross border transfer of patients to member states of the European Union is helpful. This is a clinical issue that has arisen.

m) Arrangements for dealing with absconding patients to include those on Interim Compulsion Orders and to cover the European Union are again sensible.

n) Agreement to transfer of prisoners
One of the major clinical issues that we deal with in forensic mental health services is the transfer of prisoners who need hospital care. This is difficult because it is often urgent, an appropriate bed may not
be easily found and the patient may be placed in a prison outwith their normal geographical area of residence. There is considerable concern within forensic mental health services that a requirement for a mental health officer to agree to the making of a transfer for treatment direction would involve considerable delay in the making of a TTD for no obvious gain to the clinical care of the patient.

In our view, it would be better to formalise the role of the MHO once transfer had occurred. At that stage, if the MHO was not in agreement with transfer, there should be an automatic appeal against hospital transfer to the Tribunal. Such a system would build in protection for the patient but without incurring delay.

Clinical experience has shown us that finding a designated MHO from the appropriate geographical service is time consuming and obtaining the services of the MHO system in the area where the prison is based is unlikely to be easy until the option of the designated geographical MHO service has been fully explored. Sadly, this will cause delays in the transfer of prisoners to hospital. The most recent audit of the transfer of prisoners in Scotland carried out by the Scottish Prison Service showed that the majority were transferred within days. These are individuals who are acutely unwell and at risk within the prison setting. It would be most unfortunate if a legislative change resulted in a deterioration in access to medical services. Further, it is not clear what ongoing responsibilities for the care and wellbeing of a prisoner are placed on a mental health officer who has refused to agree to a Transfer for Treatment Direction.

o) The extension to other legal members of the Tribunal as potential chair for proceedings relating to an application for a Compulsory Treatment Order in respect of patients subject to a TTD or an HD is sensible, as is giving notice of the application for a CTO on a patient subject to an HD or a TTD to Scottish Ministers.

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

a) The increase in the extension period for an Assessment Order from 7 to 14 days is helpful. The alignment of the calculation of the start of an assessment order to match criminal proceedings will hopefully prevent the confusion that has arisen to date. This likewise applies to treatment orders, interim compulsion orders, compulsion orders and hospital directions.

b) The power to vary the appropriate hospital or hospital unit specified within an order or direction is likewise clinically helpful in ensuring that the patient is cared for within the most suitable level of security.
c) The requirement on the MHO to prepare and submit a report to the Tribunal in cases where there is an extension of a compulsion order that requires a review of the determination of the tribunal is supported.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

a) Victims’ Rights
The State Hospitals Board supported the extension of victim notification scheme to include patients detained under a compulsion order and restriction order.

It is reasonable to inform victims if a mentally disordered offender subject to a hospital direction or a transfer for treatment direction is unlawfully at large. The information that can be given and the list of those that it can be given to are appropriate. The Board would support the right of victims to make representations in cases involving hospital directions, transfer for treatment directions or compulsion orders and restriction orders. It is noted that the means by which written and oral representations are to be made will be the subject of guidance. It would not be appropriate for victims and patients subject to these orders to be present at a Tribunal at the same time. Likewise, clinical consideration would need to be given to the appropriateness of a patient hearing a victim’s representation and a system created whereby this could be done, in appropriate cases, with clinical support.

It is noted that Section 18B provides the power to Scottish Ministers to extend the victim notification scheme to patients made subject to a compulsion order alone or where the restriction order has been revoked. We would agree that it may be appropriate in some cases to provide information to victims when a restriction order has been revoked. It remains our view, as stated in the consultation regarding the victim notification scheme, that compulsion orders alone should not be subject to this scheme. There is no time limit on compulsion orders as there is on sentences, and this would bring individuals into the victim notification scheme who would otherwise not be included had they received a sentence. Further, the Court has made a clear statement that the most appropriate place for these individuals is within the mental health system.

b) It is noted that Section 49 (4) of the Bill amends Section 224 of the 2003 Act and requires that a Responsible Medical Officer considers victims’ representations before deciding what conditions should be included in any certificates suspending detentions. The system will require to be developed that ensures that the RMO has access to such representations.
5. Other

a) The information contained within the financial memorandum is helpful in outlining the resources required to enact this Bill.

The State Hospitals Board for Scotland
August 2014
NHS Greater Glasgow and Clyde

Mental Health (Scotland) Bill

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<th>Question</th>
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<td>Do you agree with the general policy direction set by the Bill?</td>
<td>- Yes, the direction seems to be based on the reality and practicality of using the act whilst retaining the rights of patients who may be subject to it.</td>
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<td>- Yes, the bill strengthens current legislation which seeks to promote effective and timely treatment for those experiencing mental disorder and to safeguard their interests. The bill has given consideration to the experience of service users and clinicians who have now been working within, or have experience of, current legislation.</td>
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<td>- The overall response from our senior nurses in addictions has been that they welcome the paper and agree with the general policy direction.</td>
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<td>- Yes, the bill proposals do seek to amend several of the problems which have arisen in relation to the Act particularly around the named person provisions and the suspension of measures.</td>
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<td>Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?</td>
<td>- Yes - 1. Suspension of Orders. The ability for RMOs to apply a flexible approach to suspending orders which enable community access which aids recovery is welcomed; there is a slight concern that only overnight suspensions count towards the 200 days - there is an important question which arises when suspension is regular in terms of the persons 'need' to remain detained and it would be risky if this element were lost in the application of this new power. Typically people with Learning Disabilities can spend long periods of time in hospital, and it is this patient group which could be disadvantaged.</td>
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|                                                                           | - Increase from 2 to 3 hours Nurses Holding Power. This is welcomed by Learning
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<td>Disabilities nursing staff. It support both patients and nurses/medical staff in conducting an assessment which although is emergency in nature continues to be well planned.</td>
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<td>- Section 100 - Communication at Medical Examination. It is welcomed that existing provision for support for people with communication difficulties will be extended - however, there requires to be guidance in who can carry this out, for people with Learning Disabilities this would require someone with skill, prior knowledge of the patient, or some other demonstrable competence in supporting people with communication problems.</td>
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<td>- Concerns have been expressed by Mental Health Senior Nurses about the increase in nurses holding powers from 2-4 hours and any clinical evidence for making this change. Nurses feel it will have a detrimental effect on patients and staff. If there have been instances of medical staff not being available within the 2 hours, this should be addressed locally, and not in legislation.</td>
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<td>- There were further questions about the provision of beds for mothers with mental health disorders, other than postnatal depression. This needs further explanation and clarity.</td>
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<td>- Agree that service users under section 68 should have time already spent in hospital deducted from subsequent detention under this section.</td>
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<td>- Agree with the increase of the current extension mechanism that allows a STDC to be extended by 5 days to 10 days. Many cases brought before the MHTS, which are applications for a CTO, have not been fully prepared in terms of legal representation for the patient, or, the legal representative has not had sufficient time to instruct a second medical opinion. In these cases the MHTS has no option other than granting an interim order. This means another hearing for the patient.</td>
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<td>and potentially carers, which are often stressful. This change should minimise the number of interim orders being granted.</td>
<td>- No specific Learning Disabilities comments to make other than that we think the amendment to Section 127 - maximum suspension of detention measures - will make the administration of passes for longer stay patients very much less complicated.</td>
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<td>- The changes proposed in the previous consultation draft regarding medical examinations provided for the best position in obtaining evidence from initially the Approved medical practitioner (AMP) as an expert in his field and the General practitioner through the provision of among other things a commentary report on the AMPs mental health report. The inclusion of a GP report is not only recommended in the McManus review but was also part of the initial Millan committee report. While there would be cost and time implications for GPs there would be additional benefits to the patient from primary care input.</td>
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<td>- Section 14 provides for nurses to detain a patient pending medical examination. The preference in an emergency would be to seek a short term detention certificate; this amendment tends towards the making of an emergency detention certificate in the first instance and thus seems contradictory to the intent of the Act as a whole. The use of the power to continue to detain the patient where the medical practitioner has arrived but while awaiting Mental Health Officer attendance requires to be clarified either in the Act or amended code of practice.</td>
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<td>Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?</td>
<td>- The section 87 amendment is welcome. Any change in a patients diagnosis from that recorded in the original CTO should be notified to the MHTS, section 101 will help equip the MHTS with more relevant information which will help with decision making.</td>
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<td>Do you have any comments to make on</td>
<td>- Understand that this section is to bring victims rights to those victims who have had</td>
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| **Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?** | offences carried out against them by mentally disordered offenders. However these offenders are deemed to be mentally disordered at the time of the offence and many will be vulnerable themselves, The safeguard is that Scottish ministers will decide what information if any is released, but there remain potential risks to the person who is mentally disordered.  
- Comments were positive in regard to victim notification which would support and bring mental health policy in line with other criminal justice legislation. |
| **Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.** | - Medical examination as per response to Question 2 (copied below):  
  Section 14 provides for nurses to detain a patient pending medical examination. The preference in an emergency would be to seek a short term detention certificate, this amendment tends towards the making of an emergency detention certificate in the first instance and thus seems contradictory to the intent of the Act as a whole. The use of the power to continue to detain the patient where the medical practitioner has arrived but while awaiting Mental Health Officer attendance requires to be clarified either in the Act or amended code of practice. |
| **Do you have any other comment to make about the Bill not already covered in your answers to the questions above?** | - Yes, people with Learning Disabilities report to us that they do not support the term ‘Mental Disorder’ by virtue of having a diagnosis of LD, various advocacy groups would have a view on this generally and should be consulted with.  
- The overall response from our senior nurses in addictions has been that they welcome the paper and agree with the general policy direction.  
- Amendments to section 299 nurses holding power to allow an increase from 2 hours to 3 hours will allow additional time for considered medical examination where this has been used and is welcomed.  
- Amendments to the use of the named person are welcomed. Currently the MHTS |
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<td>can appoint a named person by default. This does not allow any consent by this person or full consideration of the role and responsibilities. This measure will mean only those consenting to the role after full information has been given to them will be able to take on this role.</td>
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<td>- The financial memorandum at paragraph 41 predicts only &quot;minimal costs to the NHS&quot; there is a potential increase in hearings relating to conditions of excess security that will involve staff costs other than RMO time. Managers, nurses from the ward as escort have input into existing hearings therefore costs to forensic services may be increased.</td>
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The Law Society of Scotland

Mental Health (Scotland) Bill

Introduction
The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interest of solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making process.

To help us do this, we use our various Society committees which are made up of solicitors and non-solicitors to ensure we benefit from knowledge and expertise from both within and outwith the solicitor profession.

The Mental Health and Disability Sub-Committee (the Committee) welcomes the opportunity to consider and respond to the Mental Health (Scotland) Bill (the “Bill”). The Committee has the following comments to put forward in response to the questions posed in the Call for Evidence.

Question 1:
Do you agree with the general policy direction set by the Bill?

The Committee welcomes steps taken by the Scottish Government to improve upon, and bring additional clarity to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the “2003 Act”). Whilst a number of the Bill’s provisions achieve this, we do have some concerns. In particular, many of the Bill’s provisions are based on recommendations made following the limited review of the 2003 Act by the McManus Committee, which was conducted in the main during 2008 and reported on in March 2009. With the delay in producing the Bill, the Society is of the view that some of the McManus recommendations no longer reflect current needs or practice. Our specific concerns follow below.

Question 2:
Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Section 1
The proposal to extend the short term detention pending determination of the application under section 68(2) of the 2003 Act from 5 to 10 working days did not appear in the Scottish Government’s consultation earlier this year on the draft proposals for a Mental Health Bill. Nevertheless, the Committee did note in its consultation response to the draft Bill that they were pleased that this McManus Report recommendation was not contained in the draft Bill. It is the Society’s view that such an extension of time is no longer necessary and an unmerited further encroachment on the patient’s rights. In particular, it affords less legal and procedural safeguards for the patient in terms of Articles 5
(right to liberty and security) and 6 (right to a fair trial) of the European Convention on Human Rights (“ECHR”).

We question how the proposal to deduct the period in which a patient has been detained in hospital, under a short term detention certificate or an extension certificate, from the 6 month period, in the case of section 64, or 56 day period, in the case of section 65 of the 2003 Act, will work in practice. It may be difficult for the Responsible Medical Officer (RMO) (or in practice, the medical records office) and the Tribunal to accurately calculate the maximum period of compulsion remaining. This is partly because there will be no uniform practice on when the patient will attend a hearing during the 10 working day period. We therefore believe that this amendment may result in unnecessary complications regarding the calculation of time and uncertainty.

Section 2
We welcome the move to place this information on a statutory footing.

Section 4
We have no particular concerns about this section and we particularly welcome section 4(4) which requires managers of the hospital, when giving notice under subsections (2) or (3), to send a copy of the certificate to each recipient of the notice.

Section 9
We recognise that calculating a “9 month” period of suspension has led to uncertainty and we therefore welcome the proposal to substitute this with a period of “200 days”. This amendment will lead to greater clarity.

However, we do not support the proposal at section 9(2) to insert a new section 127(2A) to the 2003 Act that will exclude any period of suspension authorised by the RMO that is less than 12 hours outwith the times of 9 pm and 8 am. It is regrettable that, to our knowledge, the Scottish Government did not consult on this proposal. We believe that this proposal is unnecessary and will likely add confusion when calculating the permitted suspension period.

We also do not support the proposal in section 9(10) to grant the Tribunal the authority to extend the period of suspension by a further 100 days in a given 12 month period. Again, it is regrettable that, to our knowledge, the Scottish Government did not consult on this proposal. We do not believe that there is a need to change the current law. The proposal will result in further tribunals for the patient and an increase in the overall volume of hearings for the Tribunal, which is already one of the busiest of the devolved jurisdictions. We suggest that where a patient is approaching the maximum period of suspension the more appropriate route towards extending this is for the RMO to make an application to have the order varied.

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1 See for example DC, Petitioner, 2011 GWD 39-805
Section 10
Repealing section 266 of the 2003 Act will remove the power of the Tribunal to grant the Health Board a further 28 day period (in addition to the 6 month period) to find an alternative place where a patient could be appropriately detained, where the patient has been detained in conditions of excessive security. We recognise that the effect of this repeal will be to reduce the number of Tribunal hearings.

Section 11
We acknowledge that the definitions of “qualifying patient” and “qualifying hospital” for the purposes of section 268 of the 2003 Act were to be provided in regulations but that no regulations have yet been enacted. The effect of this is that there is presently no provision for an appeal against levels of excessive security for patients other than those detained within the state hospital. The Supreme Court decision of *RM v Scottish Ministers*\(^2\) held that the Scottish Ministers had acted unlawfully in failing to bring forward regulations under section 268 of the 2003 Act. The Committee does not believe that the Bill’s proposals fully address the *RM* decision. In particular, we are concerned that the Bill does not provide a right to appeal to the Tribunal for an order declaring that the patient is being detained in conditions of excessive security in respect of patients held in low secure settings. The *RM* decision concerned a patient’s detention in a low secure hospital. Confining the right of appeal to patients in medium secure facilities is, in the Committee’s view, restrictive and discriminatory. Low security may extend beyond those patients who are detained within low secure (locked) hospital wards. For example, a patient who is detained within an intensive psychiatric care unit/ward (“IPCU”) may consider the conditions of security to be excessive, in comparison to being detained within an open psychiatric ward. We acknowledge that the IPCU is not ordinarily described as a “low secure ward” but it is nevertheless an environment where the patient’s liberty is subject to additional restriction. Whilst we accept that the Scottish Government may have concerns about unmeritorious claims, detained patients should nevertheless be able to make a free and unrestricted appeal.

It follows that we believe that the definition of “relevant patient” in section 11(5) is too narrow and unduly excludes the right to appeal from classes of patient. We suggest that a general definition of “relevant patient” is enacted to ensure that it includes patients subject to an order requiring them to be detained in conditions of medium and low security.

The Bill must be compatible with rights under the ECHR. There are significant implications in terms of an individual’s autonomy, liberty, dignity, due process and non-discrimination where a patient is detained in conditions of excessive security, whether high, medium or low security. For this reason, Articles 5 (right to liberty), 8 (right to private and family life - in other words, autonomy), 3 (freedom from torture and inhuman or degrading treatment or punishment) and 14 (non-discrimination) are relevant. Additionally, Article 6 (right to a fair trial) has application in relation to any appeal to the Tribunal. Nor must the Bill

\(^2\) [2012] UKSC 58
contravene the UK’s obligations under international human rights treaties that it has ratified. These may not be expressly incorporated into UK law but several such treaties have application to persons with mental disorders which impose obligations on the UK under international law. In the context of persons with mental disorders, the most relevant treaty is the UN Convention on the Rights of Persons with Disabilities (CRPD). Several CRPD rights correspond with those ECHR rights that are particularly relevant to the Bill. Moreover, in light of increasing references to the CRPD being made in European Court of Human Rights cases, and its superior status under international law, it is likely to ultimately influence the interpretation of ECHR rights.

As currently drafted, section 11(5) provides that “re relevant patient” means a patient whose detention is authorised in hospital by – (a) if the patient is also subject to a restriction order, a compulsion order…”. This is not grammatically correct and may lead to uncertainty.

Section 12
This section provides that a “qualifying hospital” is a hospital other than a state hospital, with the other requirements for qualification to be defined by regulations. Scotland has three medium secure units – Rowanbank Clinic, Glasgow; Orchard Clinic, Edinburgh and Rohallion clinic, in Perth. However, each of these units has different characteristics and security levels between them. Therefore simply using the same form of words as the section 264 test may be problematic. We suggest that direction is required to harmonise certain aspects of the three units, for example physical security, to ensure consistency with the Scottish Government’s guidelines for medium security. We believe that the Bill requires to provide further clarity on what is meant by “level of security”. The Society notes that not all regions within Scotland have all levels of secure facilities. For example, in Edinburgh there is no low secure hospital provision – only a general IPCU facility and a medium secure unit. In contrast, Glasgow has different levels of security units/wards within the same hospital (as there is for example within Leverndale Hospital in Glasgow, which provides, IPCU, separate locked and unlocked low secure wards). These inconsistencies and variations in the provision of different levels of secure environments within different regions could result in patients, who would be best suited to lesser levels of security, being admitted to the higher level of security within the region. Any patient detained in a more secure setting than they clinically require should be able to make a free and unrestricted appeal to the Tribunal.

Section 14
We generally support the amendments this section makes to section 299 of the 2003 Act as we believe that these will reduce the emphasis on the purpose of section 299 being only to obtain a medical opinion. The amendments will place an onus on nurses to detain the patient where they believe that the necessary criteria in section 299(3) have been fulfilled.

However, we are concerned that the Bill has not amended section 299(3) of the 2003 Act. The wording of this section - “the patient be immediately
restrained from leaving the hospital” – suggests that the patient requires to take active steps to leave the hospital before a nurse is able to exercise the holding power. Even where patients have no capacity, the wording suggests that the patient would be held unlawfully unless he or she was trying to leave the hospital. We understand that this causes particular problems in out-of-hours situations where nurses may not immediately call the doctor because the patient is not actively trying to leave. We understand that in such situations nurses traditionally rely on their skills to keep patients content, even though they may have recognised several hours earlier that the patient has no capacity and should not continue to be held as an informal patient. Accordingly, we suggest that section 299(3) is amended to remove any suggestion that patients must actively attempt to leave the hospital before nurses can exercise the holding power.

Section 15
We have no objection to the proposal to reduce the time limit for making an appeal from 12 weeks to 28 days.

Section 16
We recognise that this section seeks to tidy up the statutory language in the 2003 Act with respect to non-civil orders and we acknowledge that this may help provide additional clarity with respect to the application of sections 189 and 213 of the 2003 Act. However, there are no analogous provisions in the Bill with respect to civil orders. This will unnecessarily lead to two different procedures. We are unsure if this was the Scottish Government’s intention. We recommend that the position for civil and non-civil orders is the same for consistency and to reduce the likelihood of confusion.

Section 17
This section depends on the Scottish Government introducing statutory timescales, which do not appear in the Bill. Accordingly, this section does not make sense as things currently stand. The Society notes that the proposal to introduce statutory timescales appears in the first [draft] Bill.

Sections 18 - 20
The policy memorandum accompanying the Bill provides that “The Scottish Government considers that an individual should only have a named person if they chose to have one.” However, this does not coincide with the position in the Bill. The Bill retains the default provisions outlined in section 251 of the 2003 Act. This outlines the position where no named person is nominated or the nominated person declines to act. If the Scottish Government wishes to fulfil their policy intent then we suggest that section 251 should be repealed.

We do not support the requirement in section 18(3) that a declaration, in relation to a named person, requires to be made in writing. It is unusual for law to require a person to make a formal declaration that they do not want something. We have some doubt on whether the requirement for writing would be compatible with section 1 of the 2003 Act. We suggest that a patient should be able to make their views known by any means, in writing or
otherwise. For example, by telling their independent advocate, their representative or by making an oral statement at a Tribunal hearing.

These issues aside, we support this section of the Bill as it provides additional clarity by outlining, on a statutory footing, what is to happen where a person indicates that they do not want a named person.

**Section 21**

We suggest that the reference to “the thing” in section 276C(2)(a) should be substituted for more appropriate statutory language which will provide clarity.

**Sections 24 and 25**

We emphasise that the principles in section 1 of the 2003 Act (and corresponding ECHR and CRPD rights, including that of non-discrimination) must be adhered to and respected at all times in the implementation of these provisions.

When Scottish Ministers grant a warrant for transfer of a patient subject to detention out of Scotland, the patient has the right of appeal to the Tribunal. However, the named person has no right of appeal. The Committee suggests that the 2003 Act requires to be amended to grant the right of appeal to the named person. This will require to be achieved by primary legislation and not by regulations.

**Section 26**

We do not believe that the requirement for a Mental Health Officer (MHO) to agree in writing to the transfer before the transfer takes place will be workable. This is particularly so with respect to emergency transfers of patients from a hospital in mainland Scotland who have an ordinary place of residence in a Scottish island community. In this example, the MHO will be located in the area of the patient’s ordinary place of residence.

**Question 3:**

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

**Sections 28 and 29**

The Committee notes that no provision is made for cross-border transfers in the new section 52D of the Criminal Procedure (Scotland) Act 1995. We anticipate that problems may be encountered with respect to female and child patients on remand who should be detained in a high secure facility, given that Scotland’s state hospital does not have provision for female or child patients.

Section 29(4)(c) allows the court to extend the Assessment Order for a period of 14 days. We note that the consultation to the first [draft] Bill proposed extending the period to 21 days. Whilst we acknowledge that it is in the patient’s interests that as full an assessment as possible is made, we do not support the increase from 7 days to 14 days. Articles 5(4) and 6(1) ECHR require a timely hearing and we are not convinced that such an extension is necessary or proportionate.
Sections 41 and 42
We welcome these provisions and believe that they will help achieve a consistent approach with respect to both civil and criminal matters.

Section 44
We suggest that the statutory language adopted for the new section 16A(1)-(3) of the Criminal Justice (Scotland) Act 2003 is cumbersome. The following wording is proposed to provide greater clarity:-

“(1) Where—
(a) an offence has been perpetrated against a natural person,
(b) another person (“O”) has been made subject to a compulsion order and a restriction order in proceedings in respect of that offence,
(c) a person has asked to be given information about O under this section and that person is, or was at the time of asking, a person entitled to ask to be given the information (see section 16B),
(d) O has attained the age of 16 years, and
(e) there are no exceptional circumstances which, in the opinion of Scottish Ministers, make it inappropriate to do so,
the Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).”

We further suggest that the proposed section 16C(2)(c ) of the Criminal Justice (Scotland) Act 2003 should be amended to read “that O has died, and the date of O’s death”.

Question 4:
Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

Section 44
Generally, we would be concerned if the effect of the Bill was that mental health patients were subjected to more disclosure requirements than perpetrators of crime.

Section 44(3) provides that “Scottish Ministers need not give a person information under this section if they consider there to be exceptional circumstances”. We are unclear on what is meant by “exceptional circumstances”. Guidance on this will be necessary.

As drafted, the victim’s rights provisions in Part 3 of the Bill are restricted to patients that are subject to compulsion and restriction orders. Currently, the victim’s rights will not extend to situations where that patient’s restriction order is removed. We are unsure if this was the Scottish Government’s intention.
Question 5: Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

As stated at Question 1 above, we note that the Scottish Government did not consult in the first [draft] Bill on the McManus recommendation, now contained in section 1 of the Bill, to extend the period of short term detention possible under section 68(2)(a) from 5 working days to 10 working days. Despite the absence of draft provision, we noted in our consultation response to the first [draft] Bill that we were not in favour of this. We maintain that the proposed extension is unnecessary and an unmerited further encroachment on the individual’s rights. In particular, it affords less legal and procedural safeguards for the patient in terms of Articles 5 (right to liberty and security) and 6 (right to a fair trial) of the ECHR.

This aside, the McManus Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland. It should also be noted that mentally disordered offenders in prisons have inadequate access to independent advocacy. Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision is made in the Bill to strengthen and extend the duty to provide for such advocacy (for both civil patients and mentally disordered offenders) so that the right to independent advocacy can be fully realised by those who are entitled to it. It is recommended that this is addressed.

Separately, there are a number of matters, not arising directly from the McManus Report that the Committee believes merit inclusion in primary legislation. These include:-

1. The use of covert medication and restraint
   At present, there is little reference to the use of force, restraint or covert medication in the 2003 Act’s Code of Practice. Any non-consensual treatment must be considered and administered with the 2003 Act’s underlying principles and human rights standards firmly in mind. However, given the potential for Articles 2, 3, 5 and 8 of the ECHR to be engaged in such situations, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.

2. Deaths of psychiatric patients
   The State has an operational duty, under Article 2 ECHR, to protect the right to life for detained psychiatric patients and this may also extend to non-detained psychiatric patients. Moreover, Article 2 requires an effective national legal framework that will provide for an independent and impartial

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3 pp10-12.
5 Rabonne v Pennine Care NHS Foundation Trust [2012] UKSC 2.
investigation into the deaths of individuals in custody\(^6\) and following hospital care and treatment\(^7\). This was partially explored in the 2009 *Report of Findings of Review of Fatal Accident Inquiry Legislation*\(^8\) but remains to be addressed in terms of putting in place necessary legislative changes and any outstanding procedural measures. We recommend that this should be undertaken now in order to give full effect to the requirements of Article 2. The Mental Welfare Commission’s monitoring report *Death in detention monitoring* reinforces this need\(^9\).

3. Incompatibility between section 242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000

The opportunity should be taken to amend section 242 of the 2003 Act in order to address any areas of incompatibility between this and the Adults with Incapacity (Scotland) Act 2000 (the “2000 Act”). Section 50 of the 2000 Act permits welfare attorneys and guardians to consent to medical treatment on behalf of an adult with incapacity. However, where treatment of such an adult for mental disorder under the 2003 Act is being considered, it is unclear as to whether such consent is permitted. The particular problem concerns the inter-relationship of the 2000 Act and the 2003 Act as regards the status under the 2003 Act of decisions and consents on behalf of a patient by an appointee (guardian, attorney or appointee under an intervention order) under the 2000 Act. This requires to be addressed and we recommend that Scottish Government take this opportunity to do so.

4. Curators ad litem

At present, the 2003 Act contains no provision allowing curators *ad litem* the right of appeal from the Tribunal to the Sheriff Principal or to the Court of Session. This should be included in the Bill.

5. Recorded matters

At present, the 2003 Act contains no provision allowing recorded matters to be made by the Tribunal in a compulsion order. This should be included in the Bill.

6. Section 244 2003 Act – Scottish Ministers’ power to make provision in relation to treatment to certain informal patients

We also propose that regulations be introduced under section 244(a) of the 2003 Act to provide that when artificial nutrition is being provided, informally, to a child under the age of 16 years, this is supported by a second, specialist, opinion. This will introduce an additional safeguard. We understand that this proposal is supported by the Mental Welfare Commission.

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\(^6\) *Shumkova v Russia* (App no 9296/06) judgment of 14\(^{th}\) February 2012, para 109.


Question 6:
Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

Additional comments on the proposals were outlined in our consultation response to the draft Bill. A copy of this response is appended in the appendix for consideration.

The Law Society of Scotland
August 2014
APPENDIX

Consultation on draft proposals for a Mental Health (Scotland) Bill

The Law Society of Scotland's response
April 2014

Introduction
The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interest of solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making processes.

To help us do this, we use our various Society committees which are made up of solicitors and non-solicitors and ensure we benefit from knowledge and expertise from both within and outwith the solicitor profession.

The Mental Health and Disability Sub-Committee (the Committee) welcomes the opportunity to consider and respond to the Scottish Governments consultation on the proposed Mental Health (Scotland) Bill. The committee has the following comments to put forward:

Comments:
Mental Health (Care and Treatment)(Scotland) Act 2003.

The Committee notes that the 2003 Act is internationally regarded as an example of good practice in terms of patient-centred and human rights compatible legislation. However, it must, of course, be kept under review to take into account developments in international human rights standards and practice.

The Act’s provisions govern the compulsory care and treatment of persons with mental disorder. That being said, it is important to appreciate that the Act’s principles endeavour to ensure that it will operate as part of an environment in which the primary objectives are that the right to the highest attainable standard of health is recognised and individuals with mental disorder are supported towards effective living and, hopefully, recovery. For example, the Act’s underlying principles require anyone ‘exercising functions’ to consider a number of factors. These include having regard to the range of available options, patient participation, the least restrictive option, whether the intervention will be of maximum benefit to the individual and non-discrimination. The patient’s wishes, background and circumstances and the views of named persons, carers, guardians and attorneys must also be taken into account as well as the encouragement of patient participation. Additionally any functions involving children or young persons under 18 years of age must also be discharged in a “manner that best secures the welfare of the patient.”

10 ss1(3)(c)-(g) and 1(4).
11 ss1(3)(a),(b) and (h).
12 s.2(4).
Importantly, the presence of mental disorder alone is insufficient justification for compulsory treatment to be ordered or for short-term detention to occur. Issues of treatability, risk, the existence of significantly impaired decision making ability owing to mental disorder, and the necessity for such compulsory treatment, must also be considered\(^{13}\).

**European Convention Human Rights (ECHR) – compliance / compatibility**

Consideration and implementation of the 2003 Act, and any amendments to it, must be compatible with ECHR rights\(^{14}\). Compulsory care and treatment of individuals with mental disorder is without their consent. This accordingly has significant implications in terms of an individual’s autonomy, liberty, dignity, due process and non-discrimination. For this reason, Articles 5(right to liberty), 8 (right to private and family life (in other words, autonomy), 3(freedom from torture and inhuman or degrading treatment or punishment), and 14 (non-discrimination) are relevant. Additionally, Article 6 (right to a fair trial) clearly has application to proceedings before the Mental Health Tribunal for Scotland and the right to life in Article 2 may be engaged whilst a person is in the care and control of state institutions.

**International human rights standards**

Nor must the 2003 Act and any amendments to it contravene the UK’s obligations under international human rights treaties that it has ratified\(^{15}\). These may not be expressly incorporated into UK law but several such treaties have application to persons with mental disorder which impose obligations on the UK under international law. In the context of persons with mental disorder the most relevant treaty is the UN Convention on the Rights of Persons with Disabilities (CRPD). Several CRPD rights correspond with those ECHR rights that are particularly relevant to the draft Proposals\(^{16}\). Moreover, in light of increasingly references to the CRPD being made in European Court of Human Rights cases\(^{17}\), and its superior status under international law, it is likely to ultimately influence interpretation of ECHR rights.

At the time of submitting this response, the outcome of the recent consultation held by the UN Committee on the Rights of Persons with Disabilities on its

\(^{13}\) ss.64(5) and 44(3)-(4).

\(^{14}\) ss.29(2)(d) and s.57 Scotland Act 1988 and s.6 Human Rights Act 1998.

\(^{15}\) ss.29(2), s.35(1) and s.58 Scotland Act 1998.

\(^{16}\) Article 5 (equality and non-discrimination), Article 12 (equal treatment before the law), Article 14 (the right to liberty), Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), Article 17 (protecting personal integrity), Article 19 (independent and community living), Article 22 (respect for privacy) and Article 23 (respect for home and family).

\(^{17}\) For example, see *Glor v Switzerland* (13444/04) judgment 30 Apr 2009; *Kiss v Hungary* (38832/06) judgment of 20 May 2010; *Stanev v Bulgaria* (36760/06 ) judgment of 17 Jan 2012; *DD v Lithuania* (13469/06 ) judgment of 14 Feb 2012; *ZH v Hungary* (28973/11) judgment of 8 November 2012; *Sykora v Czech Republic* (23419/07) judgment of 22 November 2012; *Mihailovs v Latvia* (35919/10) judgment of 22 January 2013; *Lashin v Russia* (33117/10) judgment of 22 April 2013; *MS v Croatia* (36377/10) judgment of 25 April 2013; *MH v UK* (11577/06) judgment of 22 October 2013; *Koroviny v Russia* (31974/11) judgment of 27 February 2014.
Draft General Comment on Article 12 CRPD is unknown. As drafted, the comment proposes that legal capacity cannot be denied on the basis of disability (as this would constitute discrimination), that decision-making be supported not substituted (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder. However, whatever form the General Comment finally takes, what is clear is that genuine and demonstrable respect for the autonomy of all individuals with mental disorder, whether or not they are subject to compulsion, will be paramount.

Advance Statements

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions?

Advance statements are an important expression of individual autonomy and are of considerable importance even in compulsory treatment situations. The fact that advance statements also provide an indication of whether a patient would consent to a particular measure is integral in assessing whether a deprivation of liberty engaging Article 5 ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR)\textsuperscript{18}. They are also reflect supported decision making which is reinforced by the Committee on the Rights of Persons with Disabilities (see above). The proposed amendments are therefore to be welcomed. However, relatively few advance statements are actually made. For this reason, in addition to general information and awareness-raising, the Committee suggests the following:

1. That a statutory duty should be placed on the Responsible Medical Officer (RMO) to:
   a. Discuss the making of an advance statement, and to explain its effectiveness, as part of the patient’s after-care plan; and
   b. To periodically review the advance statement with the patient at no less than three yearly intervals starting with making of the original advance statement.

2. That the Act permits the RMO to delegate their aforesaid duty to another person such person to be specified in regulations.

3. That the Act’s Code of Practice provides guidance on the operation of the register to be maintained by the Mental Welfare Commission and that the Scottish Government has regard to the Commission’s recent guidance on advance statements\textsuperscript{19}.

Named Person

Question 2: Do you have any comments on the proposed amendments to the Named Person provisions?


\textsuperscript{19} Mental Welfare Commission for Scotland, Advance Statements Guidance, 2013, 
As with psychiatric advance statements, a patient’s nominating of a named person is an expression of individual autonomy and reflects supported decision-making model. However, the Draft Bill contains some areas of concern:

1. **Definition of “named person”**
   The 2003 Act currently contains no definition of “named person”. There is a lack of understanding by many service users, named persons and even by professionals about the precise role of named persons\(^ {20} \). It is therefore recommended that a definition of “named person” be included in the draft Bill.

2. **The retention of the default provisions\(^ {21} \)**
   A named person may assist in establishing an holistic picture of the patient’s preferences and circumstances which is valuable in the preparation of their care and treatment plan. Where a named person is nominated without the patient’s consent this is a restriction of their right to autonomy (Article 8(1) ECHR) which may be difficult to justify under Article 8(2) as always being in pursuit of a legitimate aim although the Committee acknowledges that there may be limited circumstances where the rights of an individual who is unable to nominate a named person are most effectively protected by the default provisions.

3. **The proposed removal of the current automatic right of a named person to be involved in Tribunal proceedings as a party and requirement to apply for leave to appeal.**
   Refusal to permit a named person to automatically be included as party in proceedings to represent the patient’s interests is contrary to the exercise of the patient’s right to autonomy and to s1 of the Act. It removes an important additional patient safeguard which, again, is difficult to justify under Article 8(2). The draft Bill should be amended to ensure that such safeguards remain.

In relation to appeals, the Bill does not specify how the “Tribunal’s prior leave” is to be addressed. It is therefore difficult to ascertain how this would work in practice and it could present a considerable challenge in time critical appeals, for example, a section 50 application under the 2003 Act, (to revoke a Short Term Detention Certificate) which is ordinarily fixed within 5 working days from receipt to hearing. If a “leave to appeal” process is to be introduced this will undoubtedly lead to delays and possibly multiple hearings. The Committee has previously expressed considerable concern to the Scottish Government over delays in the scheduling of section 50 applications during the period 2005 to 2008. Finally, the Committee recommends that section 290 (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) be amended to introduce a right of appeal to the named person, which is in

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\(^ {21} \) s257(1)
keeping with section 289 (Cross-border transfer: patients subject to requirement other than detention).

**Medical matters**

**Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions?**

**Medical examinations and Compulsory Treatment Orders (CTOs)**

The Scottish Government justifies a single medical report in CTO applications on the basis of concern about the involvement of GPs, a perceived lack of independence between the two reports and of conflicts of interest\(^ {22}\). It should be emphasised, however, that the McManus Report\(^ {23}\) stated that there was widespread support for the involvement of primary care in long term compulsory treatment\(^ {24}\) and little support for CTOs being accompanied by a single medical report. If the current proposed amendment is founded on resourcing issues – although, admittedly, the consultation paper does not state this - then it should also be recalled that the McManus Report did state that a lack of availability of GPs should not be justification for preventing them from providing such report\(^ {25}\).

We also emphasise how important it is that patients should regard the Tribunal as independent and impartial. This may not be the perception where the Tribunal requests the second medical report.

In light of the implications for a person who is subject to a CTO application, and requirements of Article 5 ECHR,\(^ {26}\) it is strongly recommended that the additional safeguard of a second medical report is retained.

**Suspension of detention**

**Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions?**

We acknowledge that the current provisions are lacking in clarity and that case law has not helped to significantly resolve the issue\(^ {27}\). We recommend that the time limit is not removed but clarified instead. The proposed amendment is compatible with respect for autonomy and the least restrictive treatment alternative but it leaves the possibility of the original order being left in place as a precautionary measure in circumstances when it is no longer required or appropriate. This could place the patient in the situation where he or she is subject to greater measures than is necessary, which is also contrary to the least restrictive alternative. Whilst a patient can seek revocation this is placing the onus on them to do so which is contrary to the procedural requirements of Article 5(4) ECHR.

**Information about extending a CTO**

\(^ {22}\) Para 14.


\(^ {24}\) Even though it also identified that GPs were requested to provide the second report in less than 50% of cases (op cit, p.28).

\(^ {25}\) Op cit, p28.

\(^ {26}\) That an individual is not deprived of their liberty except where they suffer from a genuine which has been “reliably shown” by “objective medical experts” and only where such deprivation of liberty is required for their effective treatment (Winterwerp v The Netherlands ((6301/73) (1979) 2 EHRR 387, para 39; Shukatarov v Russia (44009/05) (2008) 54 EHRR 27, para 114; Stanev v Bulgaria (36760/06 ) judgment of 17 Jan 2012, para 45).

\(^ {27}\) For example, DC, Petitioner [2011] CSOH 193
Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal?
This requirement is protective of the patient and appears to be a reasonable amendment.

**Emergency, short-term and temporary steps**

Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions?
The sharing of personal medical and other data falls within the ambit of the right to privacy in Article 8(1) ECHR\(^{28}\). Any interference with this right must be justified under Article 8(2)\(^{29}\). At the same time, however, an individual’s Article 8(1) right allows them to choose who they share information with unless this can, again, be justified under Article 8(2).
Any wishes of the individual that one of the specified persons or the Mental Welfare Commission is informed of their detention must therefore be respected unless it can be justified in terms of Article 8(2) ECHR. This should be reflected in the legislation.

**Suspension of certain orders etc**

Question 7: Do you have any comments on the proposed changes to the suspension of certain powers etc. provisions?
We have no comments regarding the proposed amendments to apply the same suspension provisions to Interim Compulsion Orders and Compulsion Orders that currently apply to CTOs in the case of an emergency or a short-term detention certificate being granted. However, we repeat the cautionary note made above regarding the use of emergency detention.

**Removal and detention of patients**

Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions?
The proposed amendment about MHO notification, is acceptable as it provides an additional safeguard for the individual affected at a time when his or her rights to autonomy and liberty are likely to be restricted.
However, the proposal to extend the maximum period for a nurse’s holding power from two to three hours is not justified in the consultation paper. Given the implications this has for a patient in terms of their liberty and autonomy, and the inability of a patient to challenge this, this proposal is therefore of concern to us..

**Timescales and referrals and disposals**

Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions?
The Mental Health Tribunal will be well aware of its obligations under Articles 5(4) and 6 ECHR. However, in light of the significance of the matters to be considered, it is submitted that the requirement on the Tribunal should be imperative.

**Support and services**

Question 10: Do you have any comments on the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why.

We welcome the proposed amendments to section 261 (extending the provision of assistance to patients with communications difficulties) and section 24 (extending provision of services for certain mothers with post-natal depression to mothers with mental disorder). They reflect the requirements of Articles 5, 6, 8 and 14 ECHR and also with Articles 5, 6 (women with disabilities),12,13(access to justice),14,17 and 23 CRPD.

Arrangements for treatment of prisoners and cross-border patients and absconding patients (paras 42-49)

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why.

a. Arrangements for treatment of prisoners

The proposed amendment seeks to rectify the fact that there is currently no legislative requirement that Scottish Ministers consult MHOs when considering a Transfer for Treatment Direction (TTD) for a prisoner. This is out of step with other applications under the 2003 Act. This is a reasonable amendment but the additional burden on MHOs must be considered and adequate resources allocated. Moreover, delays in receipt of the MHO report should not delay the transfer of prisoners for treatment and the legislation should reflect this.

b. Cross-border patients and absconding patients

We emphasise that the principles in section 1 of the 2003 Act (and corresponding ECHR and CRPD rights, including that of non-discrimination) must be adhered to and respected at all times in the implementation of these provisions.

We are concerned about the proposed amendments to sections 301-310 regarding treatment of absconding prisoners which seem to provide for the provision of care in an emergency or short term capacity during the period where the prisoner is waiting to be returned from to the place from where they absconded. Section 243 already provides for emergency treatment. We concerned that any extension of sections 301-310 may render patients from outside Scotland vulnerable to treatment (e.g. non-consensual invasive treatment) without safeguards that they would not be able to receive in the jurisdiction from which they came. This is at odds with the principles set out in section 1 of the Act.

There will also be inevitable resourcing issues to consider in regard reception of prisoners from out of the jurisdiction.

Criminal Cases

Making and effect of orders

Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?

It is in the patient’s interests that as full an assessment as possible is made. However, the extension of 7 to 21 days is considerable. Given the Articles 5(4) and 6(1) ECHR requirement for timely hearing, further clarification than
the need to take into account the “vagaries of situations that may be met within the criminal justice system”\textsuperscript{30} is required as to the necessity of such a time extension and why this is deemed a proportionate response in such situations.

**Variation of certain orders etc**

**Question 13:** Do you have any comments on the proposed amendments to the “variation of certain orders” provisions?

No comment.

**Question 14:** Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be.

**Question 15:** Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer.

**Question 16:** Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to Mentally Disordered Offenders? If not, please explain why not and please outline what your preferred approach would be.

In general, the extension of the victim notification and representation arrangements are reasonable. However, it would be discriminatory for mentally disordered offenders to be treated differently to other offenders in this respect under Article 14 ECHR in conjunction with Article 8 ECHR and taking into account of Articles 3(b), 4(1)(b) and 5 CRPD. The provisions must not, therefore, go beyond that which would apply to other offenders.

Related to this, reconsideration of the right to receive information relating to offenders subject to compulsion orders (proposed section 16A of the Criminal Justice (Scotland) Act 2003 is also necessary. Offenders subject to compulsion order have often committed only minor offences. To allow the proposed notification in such cases may therefore be an unnecessary and disproportionate limitation of their right to private and family life (see previous comments on Article 8 ECHR and privacy).

\textsuperscript{30} Para 57, Consultation Document.
Chapter 5 Assessing Impact

Equality

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics" listed above.

See response above.

Business and Regulation

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible.

The relevant authorities must be consulted on the actual costs involved. However, the following are likely to involve resourcing considerations:

(a) For local authorities as a result of the additional duties required of MHOs in connection with extending CTOs (Question 5) and being consulted in connection with proposed TTDs (Question 11).
(b) For local authorities and health boards as a result of the reception and treatment of patients from other jurisdictions.
(c) For the Mental Health Tribunal the additional costs that may arise from more interim hearings if more independent reports are ordered as a result of the proposals regarding medical examinations and CTOs (Question 3).
(d) The possible multiple hearings identified in relation to Question 2 may also incur costs for the Tribunal, patients and other parties involved.
(e) The proposed amendment to section 24 (extending provision of services for certain mothers with post-natal depression to mothers with mental disorder) will also incur costs for health boards.

It is important, however, that legislative changes must not be resource driven where individuals’ rights are at stake. The Scottish Government’s obligations in relation to recognition and protection of the rights in the ECHR and other international treaties identifying civil and political rights are therefore emphasised. This was also fully recognised in the Millan Report\(^{31}\) which shaped the form and content of the 2003 Act.

Additional Matters

The introduction of the Bill into the Scottish Parliament provides the opportunity to attend to the following additional matters:

1. **Section 268, 2003 Act – detention in conditions of excessive security in non-state hospitals**

For an individual to be detained in conditions of excessive security engages Article 8 ECHR and, potentially, even Article 3 (with corresponding Articles 17, 22 and 15 CRPD). Following its recent consultation\(^\text{32}\), the Scottish Government should make the necessary Regulations or legislative changes to ensure that this right to challenge detention in conditions of allegedly excessive security can be effectively exercised.

2. **The use of covert medication and restraint**

At present, there is little reference to the use of force, restraint or covert medication in the 2003 Act’s Code of Practice. Any non-consensual treatment must be considered and administered with the Act’s underlying principles and human rights standards firmly in mind. However, given the potential for Articles 2, 3, 5 and 8 ECHR to be engaged in such situations, and taking in account the aforementioned comments on Article 12 CRPD, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.

3. **Deaths of psychiatric patients**

The state has an operational duty, under Article 2 ECHR, to protect the right to life for detained psychiatric patients\(^\text{33}\) and this may also extend to non-detained psychiatric patients\(^\text{34}\). Moreover, Article 2 requires an effective national legal framework that will provide for an independent and impartial investigation into the deaths of individuals in custody\(^\text{35}\) and following hospital care and treatment\(^\text{36}\). This was partially explored in the 2009 *Report of Findings of Review of Fatal Accident Inquiry Legislation*\(^\text{37}\) but remains to be addressed in terms of putting in place necessary legislative changes and any outstanding procedural measures. This should be undertaken now in order to give full effect to the requirements of Article 2. The recent Mental Welfare Commission monitoring report *Death in detention monitoring* reinforces this need\(^\text{38}\).


\(^{34}\)Rabonne v Pennine Care NHS Foundation Trust [2012] UKSC 2.

\(^{35}\)Shumkova v Russia (App no 9296/06) judgment of 14\(^\text{th}\) February 2012, para 109.


4. **Incompatibility between section 242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000**

A full consideration of any areas of incompatibility between the two Acts may be more productive following the anticipated amendment of the 2000 Act in light of the forthcoming Scottish Law Commission report\(^{39}\). That being said, the opportunity should be taken now to amend section 242 of the 2003 Act in order to provide clarity.

Section 50 of the 2000 Act permits welfare attorneys and guardians to consent to medical treatment on behalf of an adult with incapacity. However, where treatment of such an adult for mental disorder under the 2003 Act is being considered, section 242 it is unclear as to whether such consent is permitted.

5. **Independent advocacy**

The McManus Review Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland\(^{40}\). It should also be noted that mentally disordered offenders in prisons have inadequate access to independent advocacy.

Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision is made in the draft Bill to strengthen and extent the duty to provide for such advocacy (for both civil patients and mentally disordered offenders) so that the right to independent advocacy can be fully realised by those who are entitled to it under the 2003 Act. It is therefore recommended that this be addressed in the final draft Bill.

6. **Curators ad litem**

At present, the 2003 Act contains no provision allowing curators *ad litem* the right of appeal from the Mental Health Tribunal to the Sheriff Principal or to the Court of Session. This should be included in the draft Bill.

7. **Multiple hearings**

The McManus Report recommended that the time limit of five working days for a extension of a short-term detention certificate when an application for a CTO has been made (section 68(2)(a)) be increased to ten working days as a means of reducing multiple hearings\(^{41}\). In its response to the McManus Review consultation, this was opposed by the Committee on the basis that it afforded less legal and procedural safeguards for the patient (Articles 5(4) and 6 ECHR). We are pleased to note that the McManus recommendation is not contained in the Draft Bill.

8. **Recorded matters**

At present, the 2003 Act contains no provision allowing Recorded Matters to be specified in Compulsion Order cases. This should be included in the draft Bill.

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\(^{39}\) Scottish Law Commission (2012) *Discussion Paper on Adults with Incapacity*, Discussion Paper No 156,

\(^{40}\) pp10-12.

\(^{41}\) Recommendation 6.1, p50.
9. Section 244 2003 Act – Scottish Ministers’ power to make provision in relation to treatment to certain informal patients

We also propose that regulations be introduced under section 244(a) of the 2003 Act to provide that when artificial nutrition is being provided, informally, to a child under the age of 16 years, this is supported by a second, specialist, opinion. This will introduce an additional safeguard when this form of medical treatment is being provided without compulsion. We understand that this proposal is supported by the Mental Welfare Commission.

The Law Society of Scotland
August 2014
Mental Health Network Greater Glasgow

Mental Health (Scotland) Bill

Mental Health Network Greater Glasgow is a service user led organisation that seeks to improve mental health support and treatment in the Greater Glasgow Area. We have over 600 members and have been in existence for fourteen years.

We have developed a number of projects relating to the peer-promotion of rights, self-management of mental wellness and Advance Statements. We currently have a contract to deliver ‘user-involvement’ within Mental Health Services with NHS Greater Glasgow and Clyde.

Advance Statements

We feel that the inclusion of the advance statement in medical records, and a copy being retained by the Mental Welfare Commission (MWC) was generally felt to be a positive and welcome move forward. A central register of advance statements also makes sense providing there are clear and explicit guidelines around access to potentially sensitive information. When promoting advance statements we recommend a ‘distribution list’ is made and retained with the statement, this could explicitly identify people with access to the statement and involvement in the care of the person making the statement.

We also note that the contents of an Advance Statement often duplicate information within assessments and contained within medical records, where the development of an advance statement more closely aligned to the development of care plans (assuming the patient is well enough to consent) then a statement could be built and reviewed much more ‘organically’ and frequently and the documentation would be more of a ‘living document’ that reflects current issues and views on treatment. We feel this approach would increase the number of statements made and greatly improve the workings of the mental health ‘system’ as well as treatment outcomes.

Promotion of Advance Statement

We feel that a well made Advance Statement has significant potential to improve treatment, strengthen the patient voice, promote greater involvement of carers as well protect a person’s rights. Therefore we feel that legislation should require health boards and local authorities to raise awareness and promote the use of advanced statements.

Many admissions are repeat admissions (and so a statement can be routinely developed on the basis of experience of treatment) and so organisationally there is a clear benefit in improving crisis response and treatment outcomes from having a well written and credible advance statement as well as benefits for the mental health tribunal process.

Advance Statements and Personal Statements

Advance Statements and Personal Statements offer the opportunity for people with mental health issues to ensure that the issues that they feel are important are
acknowledged within their treatment. The issues they feel are important are often out-with the immediate scope of the Advance Statement but impact qualitatively upon their treatment outcomes (e.g. security of home, family contact, religious support, finances, etc). Recognition of the personal statement would make the process of making an advance statement more attractive to people with a lived experience as well as creating the opportunity to identify and discuss issues such as looking after children and identifying carers/named persons. We feel that many issues that recur on a daily basis (e.g. carers unable to access information or be involved in the treatment process) can be circumvented by using the Advance/Personal Statement as a pro-active tool.

Named Persons

We feel that a person should have the right NOT to have a nominated named person as this may be better than a person who may be ineffective in this key advocacy role because they do not know them or what the role entails.

We feel this is a frequently occurring scenario because:
1. Many of our members are socially isolated and so lack an appropriate person who would be effective in the Named Person role.
2. The role demands both effective advocacy skills as well as knowledge of both a particular person and the mental health treatment/tribunal processes.

Due to the nature of the role within compulsory treatment process we feel that formal, written consent to undertake the Named Person role is essential. Relationships between the Named Person and the person receiving treatment can easily be damaged during the treatment/tribunal process. This is a significant concern and risk where the named person may be a spouse, partner or relative of the person receiving treatment.

We feel that explicit resource (training and information resources) should be developed to enable persons wishing to undertake the Named Person role to be effective in this role and realise their powers in relation to it. We feel that this would be beneficial to the treatment and tribunal processes.

There will be many occasions where a professional will have to undertake the role of Named Person (anecdotally often at short notice) and we would like to see the formalisation of standards around this in order for the professional to develop a relationship with the person to enable them to better advocate on the behalf of the person receiving treatment.

Amendments to the suspension of detention provisions

We echo the views of VoX in that suspension of detention is welcomed as a lessening on restrictions to freedom however the fact that the order is left in place could mean it is not reviewed when it should be and is left in place as a safeguard as opposed to through necessity.

Requirement of a MHO to submit a written report to the Mental Health Tribunal
We welcome the requirement for the MHO to submit a written report to the Tribunal. This is a critical opportunity for the MHO to review and collate information about the patient’s circumstances, the details of individuals who might be party to proceedings (like carers or named persons), and whether the patient has an advanced statement. Where circumstances have changed, this report may be a substantial tool for ensuring the Tribunal has up to date information to work with.

We appreciate that this reporting requirement places an additional burden on the MHO workforce, which is already very stretched.

**Amendments to the removal and detention of patients provisions**

We would query the reasoning behind the increase from two hours to three hours for nurses holding power and whether this is necessary for reasons related to ensuring the safety of a person or for reasons of local pragmatism.

**Amendments to the support and services provisions**

We welcome the extension of assistance to patients with communications difficulties and would highlight that Glasgow has areas with low levels of literacy and significant numbers of people for whom English is not their first language.

Extending provision of services for certain mothers with post-natal depression to mothers with mental disorder is also welcomed.

**Victims’ Rights**

We recognise and support victim’s rights but we are also guarded about media articles which may perpetuate stigmas around mental health, particularly in relation to criminal offences. We would like some system of monitoring to be put in place to examine the impact of this proposed amendment.

**Other issues**

**Advocacy Support**

We feel that access to both individual and collective advocacy is a right and that provision currently patchy at best needs. We feel that this needs to be improved and strongly recommend the inclusion of duties on Health Boards and Local Authorities to provide, monitor and quality check advocacy provision.

**Mental Health Network Greater Glasgow**

**August 2014**
Scottish Tribunals & Administrative Justice Advisory Committee (STAJAC)

Mental Health (Scotland) Bill

Introduction
The Scottish Tribunals and Administrative Justice Advisory Committee (STAJAC) welcome the opportunity to submit views to the Scottish Parliament on the Mental Health (Scotland) Bill.

STAJAC was established by Scottish Ministers in November 2013 (following the abolition of the Scottish Committee of the Administrative Justice and Tribunals Council) to provide external, expert scrutiny of the devolved administrative justice and tribunals system in Scotland. Its remit includes promoting the interests of system users and championing an administrative justice and tribunals system that is accessible, responsive and has users’ needs at the centre.

Comments on the Bill
Our comments are all in respect of Part 1 of the Bill.
Given our remit, STAJAC’s interest in the Bill is from the point of view of users of the administrative justice system, and therefore on those aspects of the Bill that affect how people assert their rights or are assisted to do so, and how they might complain or appeal against decisions that affect them.

We note the changes the Bill introduces to the Named Persons and Advance Statements arrangements, and although STAJAC does not have the expertise, nor the remit, to comment on the appropriateness of these changes, we do believe there is an overriding issue regarding the awareness amongst mental health service users, their next of kin and carers and the general public about these arrangements.

The Mental Health (Care & Treatment) (Scotland) Act 2003 introduced the safeguards of Advance Statements and Named Person, and supported this by a duty on local government on health boards to secure the availability of independent advocacy services.

We note the research carried out for the Mental Welfare Commission by Griesbach & Gordon1 (2013), highlighting the low levels of awareness amongst service users of Advance Statements, Named Person and independent advocacy. We are also aware that the McManus Review2 (2009) provided detailed information on the continued lack of access for certain groups to independent advocacy. The Scottish Independent Advocacy Alliance has published evidence highlighting the mixed implementation of the 2003 Act with reference to independent advocacy3.

We are concerned that the effectiveness of the safeguards put in place for mental health service users is compromised by a lack of awareness of these arrangements amongst those immediately affected by them (i.e. not only service users, but also potential Named Persons) and the general public, and by a lack of awareness and


The SIAA Advocacy Map is published every two years and tracks the annual national spend as well as who can access independent advocacy. The research covering 2013-14 is due to be published in September 2014.
comprehensive availability of independent advocacy services. In this context, we wonder if consideration was given to the possibility of keeping a register of Named Persons (as is envisaged for Advance Statements). This could give a route to provide Named Persons with information, support and training as recommended by the McManus Review.

Scottish Tribunals and Administrative Justice Advisory Committee
August 2014
The Forensic Mental Health Services Managed Care Network

Mental Health (Scotland) Bill

Introduction

The Forensic Mental Health Services Managed Care Network welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill.

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

We support the Bill’s overarching objective to help people with a mental disorder to access effective treatment quickly and easily. The issues identified in the McManus Review regarding advance statements, named persons and multiple hearings at mental health tribunals are part of our clinical experience and therefore solutions to these issues are to be welcomed. Members of the Forensic Network have been involved in discussions regarding the victim notification scheme and we have responded to a previous consultation on this. Similarly, we have been involved in discussions regarding appeals against excessive security using our considerable clinical experience and research into this provision.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care & Treatment) (Scotland) Act 2003 as set out in Part 1 of the Bill?

a) Application for a Compulsory Treatment Order
It will be helpful to patients, their carers and named persons to have 10, rather than 5, working days prior to a CTO hearing. It is noted that this will not increase the continuous period of detention as set out within the 2003 Act.

b) The new duties for the MHO to review CTO determinations in specific circumstances inserted under Section 87A fall within good practice.

c) Suspensions of orders on Emergency Detention
It is helpful that a patient subject to a community based CTO who requires an emergency detention certificate will remain subject to the giving of medical treatment in accordance with Part 16 of the 2003 Act.

d) It is helpful that patients subject to an assessment order, a treatment order, an interim compulsion order or a temporary compulsion order will no longer require the consent of Scottish Ministers for Suspension of Detention if this is to enable a patient to attend a hearing in criminal proceedings, or meet a medical or dental appointment.

e) The changes to the maximum period of suspension of detention are supported: up to 200 days in any 12 month period with the option of a 100 day extension if approved by the Tribunal following application. It is noted that the system should be simplified by not having to count any period less than 12 hours and that does not include any time overnight.
(9.00pm-8.00am) for patients subject to orders under the Criminal Law (Section 224) or under a CTO (Section 127).

f) Excessive Security
Staff within the Forensic Network have had significant experience of appeals against excessive security, both those working in high security and within local responsible NHS Board areas. See Appeals against detention in conditions of excessive security in Scotland, Journal of Forensic Psychiatry (Bennett, D.M., Skilling, G., Brown, K. & Thomson, L.D.G., (2013)). The repeal of Section 266 such that a Health Board now has a maximum period of 6 months to find a suitable alternative placement for a patient declared to be held in conditions of excessive security is supported. It is noted that appeals against excessive security are added to the list of applications in Schedule 2 to the 2003 Act which will be viewed as not having been made if withdrawn before determination. Appeals against excessive security were introduced in the knowledge that there was a significant cohort of patients unable to move on from high security. This provision has led to a significantly changed forensic estate with a much reduced State Hospital (from 240 to 140 beds) and the development of 2 new medium secure units in addition to a pre-existing medium secure unit. This has considerably alleviated the problem of entrapped patients within high security.

Appeals against excessive security are however stressful to patients. We have found that Solicitors, in we suspect a well-intentioned attempt to give clients maximum “protection”, will at times appear to “automatically” lodge an appeal against excessive security. The concern would be that the apparently easy option of withdrawing such appeals at any time before determination may result in patients finding themselves in a prolonged stressful period of always having an ongoing appeal against excessive security.

The extension of appeals against excessive security from high security alone to the medium secure estate may result in the development of further low secure units within the forensic estate. However, there is no comparison between patients entrapped in an isolated high secure hospital in Lanarkshire unable to access the community, and those treated within medium secure units where independent access to the community is entirely possible and is indeed the clinical aim. The use of legislation to precipitate service development is not without its risks. As stated before, appeals are stressful proceedings for patients and divert clinical time and resources from the direct care and treatment of patients.

g) Detention Pending Medical Treatment – Nurses holding power
The extension of the Nurses holding power to detain a patient for a maximum of 3 hours for the purpose of enabling a medical examination to be carried out is supported.
h) The reduction in the time allowed for making an appeal to the Tribunal from 12 weeks to 28 days for those patients detained in a hospital subject to a Compulsion and Restriction Order, a Hospital Direction or a Transfer for Treatment Direction, who are transferred to the State Hospital is supported.

i) The referral of cases with patients subject to a Compulsion and Restriction Order to the Tribunal for review every 2 years, including those with an ongoing reference or application under Sections 185 or 191 which has not yet been determined by the Tribunal, is supported.

j) Opt out from having a named person
The ability to opt out from having a named person has been an issue for patients across the Forensic Network. This has largely been due to the concern of patients that their named person may be distressed by receiving details of index offences and / or that they feel that their confidentiality is being breached by having this information shared if by default the patient’s primary carer becomes the named person. The amendment to Section 251 allowing a patient to make a declaration stating that their carer or relative may not become their named person is fully supported. Similarly, we have had experience of cases where a primary carer has found themselves in the role of named person and in receipt of information that they have found to be distressing without having consented formally to the role of named person. The introduction of this measure is also fully supported.

k) Registering of Advance Statements
We fully support the development of a register of advance statements to be maintained by the Commission. This is particularly useful in forensic psychiatric services where patients frequently move to units and hospitals of differing levels of security, and indeed to other health board areas.

l) The extension of regulations to include cross border transfer of patients to member states of the European Union is helpful. This is a clinical issue that has arisen.

m) Arrangements for dealing with absconding patients to include those on Interim Compulsion Orders and to cover the European Union are again sensible.

n) Agreement to transfer of prisoners
One of the major clinical issues that we deal with in forensic mental health services is the transfer of prisoners who need hospital care. This is difficult because it is often urgent, an appropriate bed may not be easily found and the patient may be placed in a prison outwith their normal geographical area of residence. There is considerable concern within forensic mental health services that a requirement for a mental health officer to agree to the making of a transfer for treatment direction
would involve considerable delay in the making of a TTD for no obvious gain to the clinical care of the patient.

In our view, it would be better to formalise the role of the MHO once transfer had occurred. At that stage, if the MHO was not in agreement with transfer, there should be an automatic appeal against hospital transfer to the Tribunal. Such a system would build in protection for the patient but without incurring delay.

Clinical experience has shown us that finding a designated MHO from the appropriate geographical service is time consuming and obtaining the services of the MHO system in the area where the prison is based is unlikely to be easy until the option of the designated geographical MHO service has been fully explored. Sadly, this will cause delays in the transfer of prisoners to hospital. The most recent audit of the transfer of prisoners in Scotland carried out by the Scottish Prison Service showed that the majority were transferred within days. These are individuals who are acutely unwell and at risk within the prison setting. It would be most unfortunate if a legislative change resulted in a deterioration in access to medical services. Further, it is not clear what ongoing responsibilities for the care and wellbeing of a prisoner are placed on a mental health officer who has refused to agree to a Transfer for Treatment Direction.

The extension to other legal members of the Tribunal as potential chair for proceedings relating to an application for a Compulsory Treatment Order in respect of patients subject to a TTD or an HD is sensible, as is giving notice of the application for a CTO on a patient subject to an HD or a TTD to Scottish Ministers.

3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
   a) The increase in the extension period for an Assessment Order from 7 to 14 days is helpful. The alignment of the calculation of the start of an assessment order to match criminal proceedings will hopefully prevent the confusion that has arisen to date. This likewise applies to treatment orders, interim compulsion orders, compulsion orders and hospital directions.

   b) The power to vary the appropriate hospital or hospital unit specified within an order or direction is likewise clinically helpful in ensuring that the patient is cared for within the most suitable level of security.

   c) The requirement on the MHO to prepare and submit a report to the Tribunal in cases where there is an extension of a compulsion order that requires a review of the determination of the tribunal is supported.
4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
   a) Victims’ Rights
   There is support within the Forensic Network to extend victim notification scheme to include patients detained under a compulsion order and restriction order.

   It is reasonable to inform victims if a mentally disordered offender subject to a hospital direction or a transfer for treatment direction is unlawfully at large. The information that can be given and the list of those that it can be given to are appropriate. The Network would support the right of victims to make representations in cases involving hospital directions, transfer for treatment directions or compulsion orders and restriction orders. It is noted that the means by which written and oral representations are to be made will be the subject of guidance. It would not be appropriate for victims and patients subject to these orders to be present at a Tribunal at the same time. Likewise, clinical consideration would need to be given to the appropriateness of a patient hearing a victim’s representation and a system created whereby this could be done, in appropriate cases, with clinical support.

   It is noted that Section 18B provides the power to Scottish Ministers to extend the victim notification scheme to patients made subject to a compulsion order alone or where the restriction order has been revoked. We would agree that it may be appropriate in some cases to provide information to victims when a restriction order has been revoked. It remains our view, as stated in the consultation regarding the victim notification scheme, that compulsion orders alone should not be subject to this scheme. There is no time limit on compulsion orders as there is on sentences, and this would bring individuals into the victim notification scheme who would otherwise not be included had they received a sentence. Further, the Court has made a clear statement that the most appropriate place for these individuals is within the mental health system.

   b) It is noted that Section 49 (4) of the Bill amends Section 224 of the 2003 Act and requires that a Responsible Medical Officer considers victims’ representations before deciding what conditions should be included in any certificates suspending detentions. The system will require to be developed that ensures that the RMO has access to such representations.

5. Other
   a) The information contained within the financial memorandum is helpful in outlining the resources required to enact this Bill

The Forensic Mental Health Services Managed Care Network
August 2014
Maurice Frank (Individual)

Mental Health (Scotland) Bill

Responding only on part 1.

* 2 (2) (3) "At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others." This places the bill's thrust contrary to natural justice. A criminal case handled in the same way would be corrupted in process, withholding from the defendant their means of defence. Likewise, a person contending for their personal liberty in the mental health system has the process biased against them if it is entrusted to any party's discretion to withhold evidence from them.

Where are any provisions for them to access all the doctors' medical files unhindered? and to prepare their own case without practical hindrance by the fact of being in hospital? and to obtain a representative who by automatic right will argue exactly the case which their client actually wants argued and will never act unilaterally over their client's head in making compromises with doctor opinion?

Without this, the patient's liberty is not protected even at the level of being enabled to make their own case. Patients including supporters of Psychiatric Rights Scotland have experienced the procedure weighted against them in those ways. This paragraph provides for a kangaroo situation akin to secret courts - where the tribunal could judge against a person's liberty armed with information which they keep secret from the defendant.

The United Nations Committee on Rights of Persons With Disabilities has adopted a position against all compulsory treatment, for too often producing effects which are distressingly inappropriate to the patient's condition and even physically harmful. The providers of treatment have a long history of the human flaws of easy certainty in their own theories, arrogant belief that their judgment must always be superior to the patient's, and controllingness over outcomes. Then theories often change over time. The publicised Hamilton and Claire Muir cases, and the concerns in petition 1494, have publicised this very clearly. Nobody in the country has security of person if law continues to entrust powers so capable of being misused selectively against liberty, into the personal judgment of doctors.

Other criminal law exists for removing physically dangerous people from society.

* The Scottish section of the Royal College of Psychiatrists wrote to parliament on Jan 20, on petition 1494, claiming that compulsory treatment is adequately regulated against these dangers. They wrote "Psychiatrists are regulated by the General Medical Council and abide by the standards laid out in Good Medical Practice." Neither they nor the Welsh section have replied to me, since I wrote to them on May 30 giving a test experience with GMC that points otherwise.

Yet even when no mental illness at all is ever claimed to exist, it is possible for powers of forced treatment, and for just the threat of their use, to devastate lives long term when child maltreatment situations which are obviously not the child's fault come to involve the so-called services of child psychiatry. That happened to me,
though I am not a person who has ever been labelled to have any mental illness. I have Asperger syndrome, but I belong to the generation who have only been recognised as adults, the delay in the condition's awareness itself being a consequence of diagnostic conservatism in psychiatry which was inhumanly slow to consider and absorb the evidence for AS's existence in place of traditional hopes of interventionist cure of every social problem. So as a teenager in the 1980s I was not diagnosed with any condition at all.

What were obviously autism caused islands of ability had caused a wishful belief that I was a high ability child, and reckless predictions by school teachers with high achiever authoritarian views. At age 13-14 this led to overwork trapped in a modern slavery situation where nobody was safe to confide in or willing to believe in rational limits to my ability, and this resulted in a stress collapse expressed in sleeplike catatonic unresponsive states.

The timing of RCP's letter to parliament was fortuitous. when I had been through the contacts with the NHS and Wales's child protection system that followed the threat's ending, and a PhD thesis referring to my case had been completed. At this appropriate stage for me to go to GMC, was RCP's confidence borne out by GMC's ability to respond to an actual case, made very late in bringing to them by a long period of intimidation into silence by fear of arbitrary sectioning? The outcome clearly bears out PRS's and UNCRPD's position against all sectioning powers. It evidences that psychiatrists evade regulation by the GMC, and by any other authority e.g. child protection, whenever they can intimidate a patient into silence by these powers. I was thus silenced for 28 years, far exceeding the GMC's 5 year rule for complaints. In its reply to my case, the GMC significantly acknowledged that this is "understandable" as a reason for delay with the case, which gives it a validity. Yet without giving any detailed grounds for why, GMC considers this not an "exceptional circumstance" overturning the 5 year rule.

Also that the treatment should not be classed as ending when the threat ended, which would be under 5 years ago - I put to them that the treatment was still happening to me, by putting an active constraint upon my actions, for as long as the threat existed. Hence, from bringing the case to GMC, I have evidenced that psychiatrists can evade regulation for any action which they can use treatment powers to frighten a patient into silence about for longer than GMC's time limit for cases. This endangerment of all patients would cease to exist along with forced treatment powers.

For obtaining a response at all it was lucky that some of the doctors who I had to mention are still on GMC's register. Another one I know is dead. GMC acknowledged that an aspect of the treatment I described was a serious occurrence in which "patient abuse" and "misconduct" are at stake, so was not a casually acceptable power for medical staff to exercise over patients including adolescent patients. This correlates with this event previously being referred to the All Wales Child Protection Procedure. This is both at once, a success in recording medical recognition that this part of my treatment was a serious wrong, and a demonstration that when intimidation by fear of treatment powers causes a long delay before the ex-patient feels safe to raise the case, this results in no accountability for it.
I was made safe for all these actions, taken out of threat, at a conference of the Autism Network Scotland. They arranged for an autism aware psychiatrist attending to meet me and discuss what to do about the threat, and he ended it, approved my present health and pledged that the past doctors no longer have any power. Immediately on being made safe and after checking up on remaining records, I sent the story and an enquiry into present treatment practices to the health boards in the region served by the adolescent service that I suffered from. But the outcome from the All Wales Child Protection Procedure was 2 agencies in contradiction. I raised with the Welsh government the problem that their procedure's "multi-agency strategy meetings" serves to give each agency an appearance of significant response, but it enables an evaded outcome where each of 2 agencies attributes to the other the reason for no answer, and in 2 contradictory ways. X referred issues back to Y, to "further the issues raised", while Y said that the reason why they could not take it any further was exactly because X had found it necessary to do this. X's position is that it is for Y to take further, while Y's position is that Y can not take it any further except by X taking it up.

Subsequently, Autism Network Scotland's autumn 2013 newsletter, themed on writers, published an item by me mentioning that a psychiatrist who is a published author was part of destroying my chance to be a child author. To see him continue in literary success while while my destroyed chance was unknown and his role in it was unsafe to talk about freely, matched exactly the described experience of Jimmy Savile's victims seeing his success continue. This also strengthened the public interest case to then make to GMC, but GMC's response now has not mentioned child authors at all.

I asked GMC: "What is your position generally on late cases where the delay was caused by being left under open ended threat of sectioning? It is bound to show that sectioning should no longer ever be subject to trusting doctors' arbitrarily expressed opinion to be expert?" This not being directly answered by GMC, they have not tried to refute it so it stands as a factual conclusion from my case brought to them. Involuntary treatment should never be subject to trusting any doctor's opinion to be expert. GMC did not answer at all 2 questions:

"In what other ways are you ensuring that children in treatment are safe from having this happen to them?"

"What is your position generally on late cases where the delay was caused by being left under open ended threat of sectioning? It is bound to show that sectioning should no longer ever be subject to trusting doctors' arbitrarily expressed opinion to be expert?"

That confirms of the problem, and that psychiatric services are not effectively regulated against maltreatment of patients who either are intimidated by, or actually suffer, forced treatments.

* As mentioned this adolescent experience happened in Wales. I am a Scot who was born and raised in exile with a background of parental migration. To relocate your life is one of the ways commonly found commonly beneficial for repairing life after damage by misguided attitudes likely to persist in the locality where the damage happened. Overpowerful adults applying delusional theories to a child is perfectly such a situation. My return to Scotland in adulthood has been the best beneficial
practical healing move in my life, removing totally from it the scene of an abuse and all the background circumstances that let it happen. So I am presently being traumatised further by this history, by the referendum.

I am in the population group, that if I had not already succeeded in returning here in time to get citizenship by being resident at the moment of independence, could now find residence here made refusable, if Yes wins and if the common travel zones breaks down. Further, the likelihood of such refusals is directly linked to being a victim of life misfortunes that are not a person's fault, punishing victims further for being victims, with rejection by their country and division from family. I have seen an important leading Yes speaker express openly his idea that the exile-born wishing to return here should be filtered for desirable skills exactly like is planned for migrants with no connections here at all, and tell an audience "We must not be afraid of this." This results in me having a petition to the EU not to accept the referendum as fair or a new state as validly mandated if this prospect of dividing families, against ECHR article 8 on family life, was not publicly known: "It is an unfair distortion of national self-determination for voters to be unaware and uninformed that they are voting to remove the absolute unrefusable entitlement to residence here and citizenship, from their own or other families and a part of their society. Voters led to assume that no such prospect can exist, because their media select to be oblivious to it and the campaigns on both sides select not to address it, have not mandated it. They have not mandated the whole choice on statehood that includes it."

For survivors of all forms of ill-treatment by any mental health service, including institutional abuses, whether by the formal treatment practices applied or by by the type of hidden abuses in the Jimmy Savile scandal, and relatedly by bad education systems and by non-recognition of conditions such as autism or dyslexia, these life damages are obvious practical reasons for not having high value skills. This makes it an addition to the abuse to class such a person as unvalued and purge them out of being allowed to live in their own country. In my case the adolescent service failed to save me from a modern slavery situation and forced me, only for the purpose of extrication from these doctors’ control, to return to the same damaging frightening provenly unsuitable school as had caused my stress collapse in the first place, and to spend another 2 years there, under conditions of containment of fear that carried no possibility of a successful outcome, before I could use the resulting failiure to get away from the school too.

With the doctors left not satisfied, because I had not been changed in all the ways they wanted to force, they left in place open endedly a threat of keenness to take me back after a failed outcome. So the outcome had to be kept from coming to their formal notice again, and that gagged me from raising child protection concerns about either them or the school, and made it impossible to present a school history to any further education institutions that would require it. So the long term effect on life, of experiencing power threats from psychiatrists at age 14, was to be forced into a school failure outcome and left totally without all the normal life opportunities related to acquiring high value skills. The outcome would not have been so totally bad, including I would never have had to return to the bad school, if there were no forced treatment powers in the system. The powers’ effects on life are now being made to extend even into citizenship and these ugly prospects of sick minded bigoted rejection by their own country, for life reasons not their fault, for institutional victims
who have already had the emotional misfortune to grow up in unwanted exile in the first place. If this situation happens, mitigation of its humanitarian effects is one of the measurable impacts of having no forcing powers, whose necessary measuring on the persons it has already affected will in turn establish a responsibility not to allow these citizenship exclusions to happen.

So I have made this point about Yes's citizenship plans, in the submission to the UN concerning UNCRPD's position, made by a group connected with PRS and in support of PRS's own submission. When people in life coping emergencies inflicted by bad institutions, that are not their fault, suffer further institutional injustices from psychiatry at any level, bolstered by long term threat around treatment powers, then the life injustices thus created now even include racist injustices of citizenship, with preexisting abuse victims as their victims too, which now stand as submitted to the UN formally against the legitimacy and status of any new Scottish state that carries out those plans instead of making citizenship by descent committally unrefusable.

* In the time when the threat still existed, I took an interest in the Advance Statements system to use for putting in place defences against the threat, focussed on what was wrong about the adolescent intervention. An insight into the low take-up of advance statements:

The principle that they are supposed to reflect the unpressured genuine wishes of the person making the statement is not always abided by in practice. An instance of an advocacy worker, not even asked to write a statement but consulted only on one item which his service had been involved in, who was arrogant enough to order the client to delete 80% of his statement and warned that otherwise he would never get it signed, in fact he got it signed by a GP without any trouble at all. A solicitor who refused to sign a statement because it contained one online criticising psychiatric nurses who smoke, and he said this would anger a doctor and work against getting the statement maker's wishes complied with. These were malpractices. They put a question over the system's genuineness. There needs to be a central point in each NHS region for statement makers to report any problems encountered in registering unvetoesd exactly the statement they wish, and to actually register it.

Maurice Frank (Individual)
August 2014
1. Do you agree with the general policy direction set by the Bill?

When it was introduced, the Mental Health Act put human rights and guiding principles for the treatment and care of people with mental health problems on the statute book. It was a substantial improvement on what had gone before and it was based on thoughtful research and consideration by the Millan Committee. The Millan principles upon which the Act is based are a reflection of this Committee’s firm belief in rights and liberty. We feel it is worth re-stating those principles:

- non-discrimination
- equality
- respect for diversity
- reciprocity: where society places an obligation on a person to comply with compulsory treatment, there should be an equal obligation for them to receive appropriate services
- informal care: compulsion must be used only when and to the extent that it is necessary
- participation
- respect for carers
- all treatment must be delivered in the least restrictive manner and environment compatible with the delivery of safe and effective care
- benefit: any treatment must benefit the individual in a way which cannot reasonably be achieved by any other means
- child welfare: this is paramount in any interventions imposed on a child under the Act.

SAMH was proud to be heavily involved in the creation of the 2003 Act, which we continue to believe is one of the most humane and recovery-focused pieces of mental health legislation in existence.

It has been six years since the McManus review made recommendations to improve the Mental Health (Care and Treatment) (Scotland) Act 2003. This thorough review sought the views of people with lived experience of mental ill-health, their families and carers as well as professionals from many backgrounds. It made 114 recommendations, most of which SAMH supported, and we have been anxious to see them implemented.

We appreciate that not all of the recommendations required primary legislation but note that the Scottish Government did publish a response\(^1\) to McManus. It would be very helpful for the Scottish Government to publish an update to that report, setting out which of the recommendations that did not require primary legislation have now been implemented.

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\(^1\) Scottish Government, [Response](#) to the Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003, 2010
We note that there have been several positive changes to the Bill since the consultation period ended earlier this year, and in particular we welcome changes to proposals on suspension of detention and medical reports. We also recognise that there are elements of the current Bill which seek to extend the rights of people with mental health problems, and we welcome those. However, there are a number of proposals which appear to restrict those rights in the interests of making the overall system run more smoothly, and we do not feel that these are in the spirit of the Millan principles.

Throughout our evidence, we express concern about people’s awareness of their rights under the Act. Evidence suggests that there is a low level of awareness of these rights and indeed considerable variation in the extent to which people feel their rights are respected by statutory services. This is supported by research with service users which we have carried out as part of preparing our evidence to the Committee. We have included some quotes from participants in this research throughout our evidence.

Research carried out for the Mental Welfare Commission reported that few participants had any recollection of their rights relating to advocacy, named persons and advance statements being explained to them. This is a serious issue, since the Act is dealing with people being deprived of their liberty. We therefore want to see meaningful discussion of rights taking place at every opportunity when the Act is applied to someone. We are aware that work is ongoing under Commitment five of the current Mental Health Strategy, which aims to increase the focus on rights in mental health, and we hope that this work will address the low awareness of rights under the Act.

The remainder of our response focuses on those sections of the Bill where we have concerns. For brevity, we offer no comment on the sections with which we are content.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Measures until application determined (Sections 1-5)
At present, the Tribunal has five working days in which to organise a hearing when an application for a Compulsory Treatment Order (CTO) is made. It is not unusual for the Tribunal to have to make an interim CTO and reconvene later, due to paperwork or essential personnel not being available within the five days. The Bill therefore proposes to increase this to ten working days. This was suggested by McManus in order to reduce multiple hearings and, at the time, supported by SAMH, but did not appear in the version of the Bill that was recently consulted on.


3 Griesbach and Gordon, Individual’s Rights in Mental Health Care, 2013
We understand that this would not lead to an overall increase in the maximum amount of time that a person can be detained, since the additional five days would be matched by a reduction of five days in the maximum length of a CTO or Short Term Detention Certificate (STDC). We also appreciate that having to go through multiple hearings is distressing for the person concerned. However, this measure would lead to an increase in the length of time for which people are held without any external scrutiny: up to 45 days in some cases. We also note that the number of interim orders is already falling, from almost 40% in 2008 down to 28% in 2013. We remain willing to support this measure if it is still needed. But we wish to be sure that this is the case, that it will address the issue and that it will include protection from unnecessary detention.

We would like to understand what estimates the Scottish Government has made of the reduction in multiple hearings which could be expected as a result of this change, and what the average number of days detained is likely to be following its introduction. We would also suggest that the Scottish Government should consider whether measures should be introduced to allow external scrutiny of a person’s detention before a full Tribunal hearing.

If the extension is introduced, we would strongly suggest that it is done as a sunset clause effective for a short period, perhaps 18 months, with regular reviews of its effect, to ensure that it can be revoked if it does not achieve its aims.

Information where order extended (Section 2 (2)).
This section introduces a requirement for Mental Health Officers (MHOs) to notify the Tribunal whether he/she agrees with a Responsible Medical Officer (RMO)’s proposal to extend an order, if the Tribunal will need to review the determination. The MHO must also inform the Tribunal whether he/she has interviewed the patient, notified them of their rights, helped to secure advocacy and sent a copy of their report to the patient. We welcome the introduction of this measure. However, we regret that the MHO must only notify the individual of their rights and helped them secure advocacy if it is “practicable”, particularly given that no definition of practicable is provided. Given that we know people who are detained under the Act often have a low awareness of their rights, and that there is a specific right to access advocacy for people with mental health problems, it seems to us essential that the MHO should conduct this interview.

Emergency Detention in Hospital (Section 3 (3))
This section provides that hospital managers must inform the Mental Welfare Commission when a person is detained on an Emergency Detention Certificate but removes the requirement to notify carers of the detention. Instead hospital managers “may” notify the nearest relative or named person that the person has been detained. There is no requirement for hospital managers to record the reason if they choose not to do so. We are concerned about this: if a person has been detained on an EDC, they may be in hospital for up to 72 hours, and if their carer or nearest relative is not informed, this could cause substantial distress.

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4 Mental Health Tribunal, Annual Report, 2013
Orders relating to non-state hospitals and Qualifying non-state hospitals and units (Sections 11-12)
This section responds to the Supreme Court\textsuperscript{5} case in 2012 which found that the Scottish Government had failed to make regulations to allow patients in secure hospitals other than the state hospital to appeal, if they consider that they are being held in conditions of excessive security. The original Mental Health Act had introduced the right to make such an appeal, which was to be implemented by regulation.

We do not consider that the proposals in the Bill are an improvement on the current situation: in essence, they simply repeat that the right to appeal against excessive security for people in medium-secure settings will be introduced by regulation. Given the Supreme Court’s findings, we request detail on when these regulations will be made and seek assurances that it will happen quickly.

We are concerned that there is no intention to introduce a right for people to appeal against excessive security in low secure facilities.

Paragraph 62 of the Bill’s Policy Memorandum states that the Scottish Government does not consider there to be a problem with patients being held in excessive security in low secure settings. We understand that the Government’s view is that an appeal against low security is essentially an appeal against detention, since the next step is a community setting. However, we note that the patient who brought the Supreme Court case (RM) was himself being held in a low secure setting, and that, given the existence of community-based CTOs, it is possible to achieve a reduction in security while still remaining on an order. We therefore believe that the Scottish Government should reconsider this position.

We note that paragraph 62 of the Policy Memorandum states that the right to appeal will apply only to patients who are subject to a compulsion and restriction order, a hospital direction or a transfer for treatment direction. However we do not think that is the effect of the Bill as it is currently drafted and would welcome clarification on this matter. Our view is that the right to appeal should apply as broadly as possible, as this appears to have been the policy intention when the original Act was passed.

More generally, we have concerns about whether sufficient low secure facilities are available, particularly for female patients. We would like to understand what analysis has been undertaken of the forensic estate to ensure that there is sufficient low security provision for both men and women, and what improvements are planned.

Detention pending medical examination (Section 14)
The Bill proposes to extend the power of a registered mental nurse to detain a person for the purposes of examination, from two to three hours, and to allow this to happen even when a doctor is immediately available.

We oppose this on two grounds. Firstly, no justification for the extension has been provided. Secondly, section 299 (4) of the Act already provides that the holding period can be extended by one hour if the examiner does not arrive within the first hour. Therefore a three-hour period is already available if it is required.

\textsuperscript{5} RM vs the Scottish Ministers, 2012, UKSC 58
Appeal on hospital transfer (Section 15)
Currently, a person has 12 weeks to appeal against an order to transfer them to the state hospital. The Bill proposes to reduce this to 28 days on the grounds that a lengthy appeal process can delay treatment.

However, section 220 (4) (b) of the Act states that the Tribunal can order the transfer of a patient pending an appeal. Therefore this appears to be a substantial reduction in rights without proper justification, to which we are opposed.

Named persons (Sections 18-20)
At present, if a person has not appointed a named person, their primary carer or nearest relative is appointed by default. They will receive substantial information about the person and have full rights to participate in Tribunal hearings. Due to the privacy and human rights implications of this, McManus recommended that default named persons be abolished. While this Bill does make positive changes to named persons, it retains the default role, proposing that people must opt out from having a Named Person. If they do not, and they have not specifically chosen a Named Person, then the provisions in Section 251 of the Act will still apply and a default named person – the primary carer or nearest relative – will be appointed.

Paragraph 90 of the Policy Memorandum states that

“The Scottish Government considers than an individual should only have a named person if they chose to have one”.

SAMH agrees but this is not the effect of the Bill as it is currently drafted. We would like to see McManus’ recommendations implemented in full and believe that the role of default named person should be entirely abolished. In order to ensure this does not diminish the support provided to service users, it will be vital to implement McManus’ wider recommendations on this area, including the widespread promotion of the role of named persons, the introduction of limited automatic rights for carers and the provision of support to them.

“I think that should be made very clear … that there is that choice [regarding appointment of a named person], that opportunity, if you didn’t want the next of kin to be the people to be supporting you mainly, and you’d like somebody else to be your named person, I think that should be made very clear. It never ever was made clear to me, ever, ever, never in our discussion, never”.

SAMH research participant

We would also like to see the implementation of McManus’ recommendation 4.15, that a Mental Health Officer (MHO) should have a duty to consult with the Named Person on the proposed care plan. McManus further recommended that Named Persons should be notified when a person is taken to a place of safety – again, we would like to see this enacted.

Advance statements (Section 21)
Anyone can make an advance statement, setting out what treatments they do or do not want in the event of being treated under the Act. If the advance statement is overruled, the Commission must be notified. The Bill introduces a register of
advance statements, to be held by the Commission, and sets out who can view the register.

We welcome the introduction of such a register but we are aware that some service users have concerns about privacy. Advance statements can contain highly personal information, often rooted in deeply traumatic experiences. We propose that the Commission’s register should simply note that a specific person has made an advance statement, the date it was last updated and where it is kept. We feel that this would be sufficient for the Commission to take an overview of the use of Advance Statements and, where required, to ensure they are acted on, but would not require the disclosure of highly personal information to people not directly involved in a person’s care.

If our proposal is not accepted, we would strongly urge that the definitions of who can access the register be tightened up. The Bill proposes that the power to inspect an advance statement be held by the person who made it, anyone acting on the person’s behalf, the person’s MHO and Responsible Medical Officer (RMO), and the responsible Health Board. Clearly the MHO, RMO and person who made the statement should have such access, but we are concerned that the remaining two categories are too broad.

We are aware that awareness of advance statements generally is low and consider that this should be addressed: advance statements are an excellent tool, allowing the service user to make their voice heard even when they are deeply unwell.

“I think they [clinical staff] were thinking about using xxxxx (name of drug) on me, and they looked at my statement and they saw I’d written it down and I wasn’t given it, so it was really good”.  

“This is the first time I’m hearing about this [advance statements], and I’ve been for the past 19 years in and out of hospital. Why is the mental health team not telling you about this? How can I ask if I don’t know it’s there?”  

SAMH research participants

We note that, in its response to the McManus review, the Scottish Government undertook to place a statutory duty on NHS Boards and local authorities to promote advance statements, and we would welcome the introduction of such a duty.

We further propose that the forms required to nominate a named person and make an advance statement should be simplified and combined.

Dealing with absconding patients (Section 25)
The Bill proposes to allow patients who have absconded from detention elsewhere in the UK to receive medical treatment in Scotland as if on a Scottish order, until they are returned.

As we outlined in our response to the initial consultation, we are opposed to this proposal. Section 243 of the current Act already allows for emergency treatment to be provided and the Scottish Government has not provided any justification for an extension to this. The consequences of these powers being extended could be the
approval of quite invasive treatment without the individual’s consent, something which may be required in their home jurisdiction. The additional treatment could have an impact on the individual’s treatment programme; the individual may not be well enough to have the rights to advocacy and other support explained and provided to them, which would be discriminatory; and this could have a long term impact on how the individual responds to acute mental health care and treatment, regardless of which jurisdiction they are in. Any treatment beyond emergency care requires a proper assessment of whether the individual meets the criteria for compulsory treatment in Scotland: it cannot be assumed that they would do so, simply because they meet the criteria elsewhere.

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

**Periods for assessment orders (Section 29)**
Currently, an Assessment Order made in respect of someone in the criminal justice system can be extended once, for seven days. The Bill proposes that to extend this to fourteen days. We are opposed to this on the grounds that no justification has been provided. We are aware of concerns within the judiciary regarding the quality and timely arrival of reports on the mental health of offenders. We speculate that it is these concerns that have driven the introduction of this extension. However, the arguments for such an extension need to be explicitly stated in order that they can be debated. Furthermore, if there are problems with the quality of reports being provided, it does not follow that these will be solved by having more time to produce them, on top of the existing 35 days that are available. If there are issues relating to staff capacity, training or ability, then these should be addressed.

**Variation of interim compulsion orders (Section 34)**
We note that paragraph 124 of the Policy Memorandum explains that this section of the Bill is intended to give an RMO the power to recommend to a court that a person being held on an interim compulsion order be moved to a different hospital in order to ensure that they receive the correct treatment. We support this change but suggest that the Bill should make clear that the court should only do so on the basis of an RMO’s recommendation, to ensure that such transfers only take place when it is clinically required.

**Transfer of patient to suitable hospital (Section 35)**
This section allows an RMO to transfer a person on an Assessment Order, Treatment Order or Interim Compulsion Order to a different hospital within the first seven days of the order, if it becomes apparent that the hospital is not suitable. We suggest that the person’s named person, if there is one, should be added to the list of people whom the RMO must notify of such a transfer.

**Information on extension of compulsion order (Section 41)**
This section introduces a duty on MHOs when an RMO intends to extend a Compulsion Order, in a similar manner to that introduced by section 2 in relation to civil orders. Our comments on section 2 also apply here: we wish to ensure that, wherever possible, the MHO interviews the person and advises them of their rights.
4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

This section introduces new rights for victims of Mentally Disordered Offenders (MDO) to make representations about an MDO’s release or temporary release and to be told about their likely date of release. It is our understanding that this is intended to ensure all victims have the same rights, and that it will only apply to people who are detained for eighteen months or longer. We support the principle of equality for victims but have two areas of concern.

Firstly, we are conscious that, while the length of a prisoner’s sentence can be taken as an indication of the severity of their offence, the length and type of an MDO’s detention is reflective of the severity and duration of their illness and not reflective of their offence. We would welcome some clarification on whether this scheme will ensure that those who have committed only minor offences, which would not lead to the victim having a right of representation if committed by a non-MDO, will not be affected by these provisions. We hope that the Scottish Government can provide some analysis of the offences committed by existing MDOs on the relevant orders, to allow this comparison to take place. We note that most MDOs have Multi-Agency Public Protection Arrangements (MAPPA) involvement in their case who already take into account the concerns of victims.

Secondly, we are concerned about the level of Ministerial power to vary this section contained within the Bill. Section 48 of the Bill gives Ministers the ability to vary the circumstances under which victims can make representations and the types of MDOs affected. We seek an explanation of the need for these powers.

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

Medical reports
We note that proposals to change the system of medical reports have been removed. While we were strongly opposed to the proposals made in the consultation to allow detention on the basis of one medical report, we have seen no evidence to suggest that the problems identified by McManus about medical reports have been addressed and we remain supportive of his recommendation to introduce a holistic GP’s second report. We note that a number of respondents during the recent consultation period expressed the view that where GPs have strong links with an individual, they could provide important information. We request that the Committee explores with the Scottish Government the reasons for making no proposals in this area.

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6 Scottish Government analysis of responses to proposals for a Mental Health (Scotland) Bill, July 2014
Certificates granted under Part 16 of the Act
We note that McManus recommended that expiry dates should be introduced for certificates granted under Part 16 of the Act, authorising specific treatments. It is our understanding that this has not yet happened and we believe that it should.

Mental health law
McManus made a number of recommendations intended to address the lack of appropriately qualified and experienced solicitors available to represent people who are the subject of applications to the Tribunal. In particular he recommended that new undergraduate or short postgraduate courses in mental health law should be set up, and that further in-service training should be offered. We recognise that these are not matters for primary legislation but strongly believe that this issue is affecting the quality of legal representation available and should be addressed.

Advocacy
The McManus Review of aspects of the 2003 Act reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland. Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. We note that the existing Act contains a right to advocacy for everyone with a mental health problem, but would suggest that the problems outlined by McManus have not been resolved. We understand that the Scottish Independent Advocacy Alliance intends to propose solutions in its evidence to Committee and we believe these should be carefully considered.

‘I’ve been offered nothing! Absolutely nothing. But maybe because my husband’s been my carer, maybe they’ve not felt there’s a need for any kind of advocacy, you know ... There’s a lot of lack of communication and it needs to be sorted out.’
SAMH research participant

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

Sections 25-27
Sections 25-27 of the current Act place obligations on local authorities in relation to people who have a mental disorder and are not currently in hospital, requiring them to provide care and support services, and services which promote wellbeing and social development. For some time, SAMH has been raising the issue that no-one has responsibility for monitoring local authority compliance with sections 25-27. As the largest mental health social care provider in Scotland, SAMH has had direct experience of the impact of substantial funding cuts on the provision of such services. We would suggest that now, more than at any other time since the introduction of the Act, it is particularly important that local authorities’

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implementation of these duties is monitored. We suggest that such a responsibility be built into existing care inspection regimes such as those operated by the Care Inspectorate.

**Mental Health Officers**

The Bill introduces new duties on MHOs: for example they will be required to give consent for prison to hospital transfers and to send a report to the Tribunal when a orders are to be extended. We welcome these new duties but are concerned about the capacity of MHOs to deal with them and believe that action is needed to increase the number of MHOs. In his review, McManus noted the shortage of qualified MHOs willing to practice as a matter of concern and reminded local authorities of their statutory duty (Section 32 (1) of the Act) in this regard.

Alarmingly, the number of trainee MHOs has decreased from 59 in March 2012 to 33 in December 2012: the lowest number since the survey began, and a substantial decrease from the 105 trainee MHOs recorded in 2008. The high proportion of current MHOs who are above the age of 50 completes this extremely worrying picture.

We need action to recruit, train and retain MHOs, in order to reduce the evident pressure on the current workforce. This is particularly the case since MHOs often act as Care Managers and as service leads on areas such as drug and alcohol addictions or learning disabilities, in addition to their duties under the Act. We suggest that the Scottish Government should, as part of its workforce planning, reviewing the duties, conditions and incentives of MHOs.

**Conclusion**

We thank the Committee for the opportunity to put forward our evidence and hope to have the chance to discuss it with members.

**SAMH**

**August 2014**
Scottish Human Rights Commission

Mental Health (Scotland) Bill

The Scottish Human Rights Commission (the Commission) welcomes the opportunity to comment on the Mental Health (Scotland) Bill. The Commission is pleased that some of the areas of concern highlighted in our response to the consultation on draft proposals for the Bill have been addressed.

The Commission notes that some of the recommendations of the McManus review are considered by the Bill, but there is no clear justification as to why some others have been excluded. The McManus review identified a broader package of changes which were required to achieve a more efficient system which delivered on the principles of the Act. The Commission’s own research has highlighted gaps between Scotland’s often strong human rights based legislation and policy and the delivery of rights in practice. These findings were particularly identified in the area of mental health care and treatment. The current Bill presents an opportunity to assure and not assume the realisation of human rights in practice. In light of that, the Commission believes that the Bill could go further to implement a number of the recommendations of the McManus review. We have made specific suggestions in this regard in this paper.

The Bill also presents an opportunity to begin to address the challenges presented by the UNCRPD, particularly the recent General Comment (authoritative interpretation) developed by the UNCRPD Committee regarding legal capacity, by taking steps towards strengthening opportunities for supported decision-making. In order to do so, further action should be taken

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1 The Commission acknowledges the contributions from Dr Jill Stavert in informing this submission.
2 http://www.scottishhumanrights.com/publications/consultationresponses/article/submissiondraftmentalhealthbill [Link No Longer Active]
4 Committee on the Rights of Persons with Disabilities, General comment No. 1 (2014) Article 12: Equal recognition before the law
in the areas of Advance Statements, Named Persons and advocacy in particular.

With regard to the proposed amendments, the Bill makes a number of apparently administrative changes, however, it is important that changes made with the aim of increasing efficiency are assessed to ensure they continue to uphold human rights.

**Human Rights Framework - Relevant law**

- Human Rights Act 1998 which brings into domestic law the majority of rights in the European Convention on Human Rights and Fundamental Freedoms (ECHR) and includes a series of measures which seek to make those rights effective.

- ECHR rights applicable to mental health care and treatment include:
  - Article 2 - right to life
  - Article 3 - freedom from torture and inhuman or degrading treatment or punishment
  - Article 5 - right to liberty
  - Article 6 - right to a fair trial
  - Article 8 - right to respect for private and family life
  - Article 14 - non-discrimination in the realisation of rights

- Scotland Act 1998 which requires that all legislation of the Scottish Parliament must be compatible with ECHR rights.\(^5\) It also requires that Scottish Ministers must observe and implement the UK’s other international obligations, which includes obligations under international human rights treaties the UK has ratified.\(^6\) There are several international human rights treaties that have application to mental health and mental disorder.\(^7\) This submission focusses on the UN Convention on the Rights of Persons with Disabilities (CRPD). Several Articles in the CRPD correspond with those ECHR rights that are particularly relevant to the Bill. Among the Articles of the CRPD which are of most relevance are:

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\(^5\) ss29(2)(d) and s.57 Scotland Act 1988 and s.6 Human Rights Act 1998.

\(^6\) ss.29(2), s.35(1) and s.58 Scotland Act 1998.

\(^7\) For example, in this context, the UN Convention on the Rights of Persons with Disabilities, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Rights of the Child, European Convention for the Protection of Human Rights and Fundamental Freedoms and European Social Charter and European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, all of which impose binding obligations on the UK under international law. The Council of Europe Recommendation Rec (2004)10 concerning the protection of the human rights and dignity of persons with mental disorder and UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (“MI Principles”) are also influential though not binding under international law.
PART 1: THE 2003 ACT

Section 1: Measures until application determined

**Human Rights Standards**

**Article 5 ECHR (right to liberty and security)**

For any deprivation of liberty to be lawful:

1. It must have a legal basis and be “in accordance with a procedure prescribed by law” (Article 5(1)).

2. Where compulsory psychiatric treatment is concerned the individual must suffer from “unsound mind” (Article 5(1)(e)) which has been “reliably shown” by “objective medical experts”.  

3. Any measures adopted must be a proportionate. The mental disorder must thus (a) be of a nature to justify detention (in other words, treatment is necessary to alleviate the condition and/or the person needs control and supervision to prevent them causing harm to themselves or to others); and (b) persist throughout the period of detention.

4. Detention must be in an appropriate place so that the individual can receive the treatment they require. Indeed, detention in a place that is inappropriate to the needs of an individual with mental disorder may even engage and violate Article 3 ECHR.

5. Certain procedural safeguards must be present such as (a) the ability to challenge the deprivation of liberty through the courts; (b) [to allow

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8 Winterwerp v the Netherlands (6301/73) (1979) 2 EHRR 387, para 39.
9 Winterwerp, para 39; Stanev, para 146.
10 Winterwerp, para 39; Shtukaturov, para 114; Stanev, para 45.
12 MS v UK (24527/08) judgment of 3 May 2012; Claes v Belgium (43418/09) judgment of 10 January 2013.
13 Winterwerp, para 55; Stanev, paras 168-171; DD, paras 163-167.
the patient to take] regular reviews of the detention where the detention is lengthy or indefinite; and (c) timely release of a person where their detention is found to be unlawful.

Article 5(4) ECHR provides that:

“Everyone who is deprived of his liberty by arrest or detention 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”.

The essential purpose of the requirement is to protect the individual from arbitrariness. In light of this, there is a requirement for both “speedy review” of the lawfulness of detention and continuing review “at regular intervals”, particularly in circumstances where the grounds for detention are susceptible to change over time, such as mental health. Imposing a time limit on the period of detention before automatic review is one way of achieving these requirements.

In addition, human rights standards require that treatment and detention for mental disorder accord with the least restrictive treatment principle, also reflected in the principles of the Mental Health (Care and Treatment)(Scotland) Act 2003.

Comments on Bill

The Bill proposes adding a further week to the duration of a Short Term Detention Certificate where an application for a Compulsory Treatment Order has been made. The total period of detention before any automatic review by a judicial body takes place would therefore extend to between 45 and 48 days. The Commission is concerned that extending the existing period of detention increases the risk that people may be subject to arbitrary detention and does not meet the requirement for speedy review. The Commission is also concerned that the restriction is not adequately justified.

The Commission is aware of the difficulties arising from multiple hearings, which this amendment seeks to address, for both patients and the burden on the system as a whole. However, any steps taken to address this issue must not result in a disproportionate restriction on patients’ rights.

As identified in the McManus review, delays in the system arise at a number of levels (the service of papers and issuing of invites by the tribunal service,

14 Stanev, paras 168-171; DD, paras 163-167.
16 Herczegfalvy v Austria (1992) A 244, 15 EHRR 437
17 See, for example, Reid v United Kingdom (50272/99)(2003) 37 EHRR 9, paras 48-52. See also Articles 8, 18-20 and 27-28 Council of Europe Recommendation Rec(2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder (adopted by the Committee of Ministers on 22 September 2004). The principle is also reflected, in general terms, in Article 14 CRPD (right to liberty).
the appointment of curators ad litem, the availability of suitable solicitors, the availability of independent psychiatrists to prepare reports within short timescales etc). A number of these problems are administrative and logistical, however, the proposed amendment opts for a solution which places restrictions on patient liberty. Such a restriction can only be justified if it does, in fact, result in shorter overall detention periods by achieving the objective of reducing multiple hearings. The Commission queries whether the proposed extension will achieve this objective. Preparation for a hearing will remain dependent on swift administration and action at all of the levels identified. For example, if papers are not provided to the patient and their solicitor until towards the end of the extension period, as is often the case at present, the additional time will not result in parties being prepared at a first hearing.

The Commission recommends that less restrictive alternatives be explored before extending the deprivation of patients’ liberty. The Commission believes that the least restrictive alternative is to address administrative problems in the first instance. However, at the very least, these problems must be addressed in addition to the extension of the period of detention. The Commission would support the implementation of the McManus recommendation for the Mental Health Officer to provide a copy of the application for a Compulsory Treatment Order to the patient and/or patient’s solicitor at the same time as it being sent to the tribunal office. If the proposal is to be implemented, the Commission recommends that the impact on multiple hearings is closely monitored.

**Section 11 & 12: Orders relating to non-state hospitals & Qualifying hospitals**

For an individual to be detained in conditions of excessive security engages Article 8 of the ECHR and, potentially, even Article 3 (with corresponding Articles 17, 22 and 15 CRPD). The scope of Article 8 is broad, including the right to personal autonomy and “the right to live privately, away from unwanted attention” securing to the individual “a sphere within which he or she can freely pursue the development and fulfilment of his or her personality”. Restrictions imposed by conditions of excessive security would therefore fall within the scope of Article 8 and must consequently be justified. Restrictions must have a legal basis, pursue a legitimate aim, and be a proportionate means of achieving that aim.

It must therefore be considered whether the choice of individuals who will be entitled to make such appeals is accompanied by sufficient justification. For example, evidence shows that patients are more likely to be successful in an appeal if they are on a civil order, however, the policy memorandum explains that the intention is to extend the right only to those on criminal orders (COROs, TTDs, Hospital Directions). The Bill does not, however, actually appear to define which patients will be eligible but rather makes

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18 Pretty v United Kingdom (2002), 35 EHRR 1
19 Smirnova v Russia (2003), 39 EHRR 2 at para 95
20 Excessive Security, Report to Scottish Government, April 2013
provision for Ministers to make regulations to determine “qualifying hospitals”. If this is the case, the provisions will not resolve the issue identified by *RM v Scottish Ministers*\(^2\), until such regulations are made. If, however, the right to make an application is to be restricted to certain categories of patients, the provisions do not appear to provide adequate justification for restricting the rights of those on civil orders. In addition, *RM* concerned a patient in a low security ward seeking transfer to an open ward. Such a patient would remain excluded from the provisions and it is difficult to see why that should be the case.

The Commission recommends that the definition of “qualifying hospitals” and patients entitled to bring proceedings should be construed more widely. At a minimum, patients on both civil and criminal orders in medium secure facilities should be brought within the provisions. However, in order to accord more closely with the principles of the Act (reciprocity, maximum benefit, least restrictive alternative) and the Article 5 requirements they derive from (outlined above) the Commission suggests that the impact of the conditions of security should be the essential factor. The provisions should be extended to anyone detained in conditions of excessive security for a significant period of time. The qualifying factor would therefore be the length of detention, rather than the category of patient, which may be a somewhat arbitrary way of determining the impact on patients.

**Section 14: Detention pending medical examination**

The intention to extend the maximum period for the nurses’ holding power from two to three hours is not accompanied by any justification. Given the implications this has for a patient in terms of ECHR rights i.e. their liberty and autonomy, and the inability of a patient to challenge this, any proposal of this nature should be specifically explained and justified before it can be deemed acceptable. A more proportionate response would be to retain the present provision of Section 299(4), whereby if there is no medical practitioner available within the first hour, it is then extended for an hour from the attendance of a medical practitioner. While not as immediately straightforward, the provision allows for a three hour period where circumstances require it, rather than a blanket extension in all circumstances.

Discussions with partners also suggest that the use of the existing powers is not well understood by nursing staff. The Commission recommends that efforts are made to support nursing staff within the existing powers before introducing a standard three-hour holding period which impinges on patients’ rights.

**Section 15: Appeal on hospital transfer**

The reduction of the period of appeal from 12 weeks to 28 days is a significant curtailment and requires to be justified. It is noted that the change is intended to bring the timeframe in line with other appeals, however, a move to the

\(^2^\) [2012] UKSC 58
conditions of security within the State Hospital is a significant restriction on a patient’s Article 8 rights and should accordingly be given particularly careful consideration. It is also noted that the reduced time period is intended to address difficulties with transferring patients pending appeal, allowing access to appropriate treatment. Section 220(4) of the Act, however, already makes provision for such a situation. The Commission queries why such a significant reduction in the right of appeal is necessary in the circumstances.

Section 18: Opt-out from having named person

A patient’s nominating of a named person is an expression of individual autonomy and fits well within a supported decision-making model (discussed later with regard to Advance Statements). The McManus Review recommended that “A service user should have a named person only if he or she has appointed one… The form appointing the named person should require the written consent of the named person.” The Bill makes provision for a person to opt out of having a named person, meaning that individuals will continue to have a default named person. The Commission believes that changing this opt-out, into an opt-in would more appropriately reflect the principle of autonomy and the recommendations in the McManus Review.

This is particularly important in light of the changes proposed to the information which will be provided to named persons on detention. In terms of Section 4 of the Bill, a copy of a Short Term Detention Certificate, rather than simply notification of its granting, will be sent to the named person (among others). The provision of such information without the patient’s explicit consent raises concerns in terms of the Article 8 right to privacy. This will happen at a time when people are likely to be most unwell and may not be able to engage with the process of making a decision about who they wish their named person to be or even have the capacity to make a valid nomination. The McManus Review identified issues with the amount of confidential information a named person receives as a matter of course. This will now also be the case at the stage of the granting of an STDC. It is important that a person’s wishes regarding their named person be ascertained before they are entitled to receive such information.

The McManus Review suggested a range of additional provisions to ensure that the interests of those who were unable to appoint a named person were safeguarded, for example, the primary carer or nearest relative having a right to appeal against orders and the appointment of a safeguarder as well as a curator ad litem. These should be considered together with the opt-in alternative to ensure that the interests of both those who can and those who cannot nominate a named person are protected. This option should be accompanied by a programme of awareness-raising and support regarding the role of the named person.

22 Recommendation 4.1 and 4.10.
Section 21: Registering of Advance Statements

**Human Rights Standards**

European Court of Human Rights (the Court) jurisprudence has recognized that autonomy and decision making are an integral part of the right to respect for private and family life as protected by Article 8 of the ECHR. There has been found to exist a positive obligation on the State to protect individuals from interference with their legal capacity from others, and to take reasonable steps to uncover previously stated wishes. The Court has also considered that Council of Europe Recommendation No R (99) 4 “Principles concerning the legal protection of incapable adults”, “may define a common European standard in this area”. Principle 9 of which includes:

1. In establishing or implementing a measure of protection for an incapable adult the past and present wishes and feelings of the adult should be ascertained so far as possible, and should be taken into account and given due respect.

Incapacity – or significantly impaired decision-making ability resulting from mental disorder as required by the 2003 Act - should not lead to a complete disregard for autonomy even in involuntary treatment situations where patients must be involved in all aspects of their care and treatment insofar as it is possible.

The Court has held that a restriction of a person’s legal capacity amounts to an interference with that right which must have a legal basis, pursue a legitimate aim, and be a proportionate means of achieving that aim. This accordingly permits non-consensual treatment but only where national law provides for such intervention, the intervention is in pursuit of a legitimate aim, appropriate safeguards exist and, where there is a degree of discretion in its implementation, the scope of such discretion is defined. That being said, although the Court also accepts that medical intervention affecting a person’s moral or physical integrity will not necessarily violate Article 8 it does not have to amount to inhuman or degrading treatment before Article 8 is violated.

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23 See for example *Evans v UK*, Grand Chamber (application 6339/05) judgment of 10 April 2007; *Pretty v UK*, supra at note 18.
24 *Storck v Germany*, (Application no. 61603/00), judgment of 16 June 2005.
26 *Shtukaturov v Russia*, (Application no. 44009/05), judgment of 27 March 2008.
27 See s36(4)(b) (emergency detention), s44(4)(b) (short term detention) and s64(5)(d) (compulsory treatment orders).
28 *Glass v UK* (61827/00) (2004) 39 EHRR 15, para 84; *Storck*, paras 143-44.
30 *Shtukaturov v Russia*, (Application no. 44009/05), judgment of 27 March 2008.
31 *Silver v United Kingdom* (5947/72) (1983) 5 EHRR 347, paras 88 and 90.
33 *Ibid.* See also *Costello-Roberts*, para 36.
In addition, it appears that the unqualified right to respect for physical and mental integrity in Article 17 CRPD was intended to apply in situations of involuntary detention and treatment.\textsuperscript{34} This may arguably strengthen the Article 8(1) ECHR right and thereby provide an additional constraint on unwarranted and excessive treatment\textsuperscript{35} that may otherwise be justified under Article 8(2).\textsuperscript{36}

The recent radical interpretation of Article 12(4) CRPD by several human rights experts\textsuperscript{37} advocates that legal capacity cannot be denied on the basis of disability (as this would constitute discrimination), that decision-making be supported not substituted (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder. The UN Committee on the Rights of Persons with Disabilities has recently published a General Comment to this effect.\textsuperscript{38} The Commission, together with other members of the UK’s Independent Mechanism under the UN CRPD, has raised concerns at the apparent dissonance between the General Comment and ECHR jurisprudence.\textsuperscript{39} However, it is clear that the requirement for genuine and demonstrable respect for the autonomy of all individuals with mental disorder, whether or not they are subject to compulsion, is paramount. This view is also supported by the UN Committee on Economic, Social and Cultural Rights that has advocated that coercive treatment is used for the treatment of mental illness “only on an exceptional basis”\textsuperscript{40}. The UN Principles for the Protection of Persons with Mental Illness

\textsuperscript{34} See, for example, United Nations, \textit{Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its Seventh Session} (UN Doc A/AC265/2006/2, 13 Feb 2006).


\textsuperscript{36} However, the Court has admittedly not arrived at this conclusion yet and missed such an opportunity in \textit{DD v Lithuania}.

\textsuperscript{37} For example, see European Union Agency for Fundamental Rights, \textit{Legal Capacity of Persons with Intellectual Disabilities and Persons with Mental Health Problems}, Report, 2013, pp15-18; UN General Assembly, \textit{Report of the Special Rapporteur on Torture}, op cit, paras 57-70

\textsuperscript{38} Committee on the Rights of Persons with Disabilities, \textit{General comment No. 1 (2014) Article 12: Equal recognition before the law}

\textsuperscript{39} Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, \textit{UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12}, 28 February 2014, \url{http://www.scottishhumanrights.com/application/resources/documents/UKIMjointresponsetodraftGeneralCommentonArt%2012FINAL.doc}

\textsuperscript{40} UN Committee on Economic, Social and Cultural Rights, “The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)” (Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No 14, 2000) para 34.
similarly warn against inappropriate, disproportionate and degrading treatments.\textsuperscript{41}

The Court has recognised the heightened vulnerability of patients in psychiatric institutions\textsuperscript{42} pointing out that whilst treatment without consent, if therapeutically necessary, may not \textit{per se} be illegitimate in the case of incapacitated persons, it must not exceed the “minimum level of severity” as prohibited by Article 3 of the ECHR.\textsuperscript{43} Whether or not a treatment reaches the minimum level of severity threshold necessary to engage Article 3 depends on the circumstances of each case. It will not include the suffering and humiliation which inevitably forms part of legitimate non-consensual treatment.\textsuperscript{44} However, treatment that is premeditated, applied for a long period of time, humiliates or debases, shows a lack of respect for human dignity, arouses feelings of fear, anguish or inferiority may do so.\textsuperscript{45} Unlawful deprivation of liberty and/or restriction or denial of patient autonomy may also contribute to a finding of inhuman or degrading treatment.\textsuperscript{46}

\textbf{Comments on Bill}

Psychiatric advance statements are an important expression of individual autonomy and their importance, even in compulsory treatment situations, is undeniable, viewed in light of the above human rights comments. Even in compulsory treatment situations a patient’s autonomy must be respected insofar as it is possible. Advance statements also provide an indication of whether a patient would consent to a particular measure which is integral in assessing whether a deprivation of liberty engaging Article 5 of the ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR).\textsuperscript{47} Moreover, they are an important element of supported decision-making which is reinforced by the UN Committee on the Rights of Persons with Disabilities. This is an area where there is an opportunity to address the challenges of the UNCRPD Committee’s General Comment on Article 12 and make further strides towards a supported decision-making model.

Notwithstanding their importance, relatively few advance statements are actually made. This is often owing to a lack of awareness or patient belief that they are ineffective.\textsuperscript{48} The proposed amendments are to be welcomed as a step towards increasing the effectiveness of advance statements, however,

\textsuperscript{41} Principles 1(3), 10 and 11(11)-(15).
\textsuperscript{42} Herczegfalvy v Austria (10533/83) (1993) 15 EHRR 437, para 82; Dybeku v Albania (41153/06) judgment of 18 Dec 2007, para 47; Rivière v France (33834/03) judgment of 11 Jul 2006, paras 72 and 63.
\textsuperscript{43} Herczegfalvy, para 82.
\textsuperscript{44} Kudla v Poland (30210/96) (2002) 35 EHRR 11, para 92.
\textsuperscript{45} Pretty v UK (2346/02) (2002) 35 EHRR 1, para 52; Kudla, para 92; Stanev, paras 202-204.
\textsuperscript{46} Pretty, para 52; Kudla, para 92. See also Tyrer v United Kingdom (5856/72) (1979-1980) 2 EHRR 1, para 30; Soering v United Kingdom (14038/88) (1989) 11 EHRR 439.
further efforts need to be made to encourage people to make use of advance statements.

The Commission recommends that consideration be given, in addition to general information and awareness-raising, to a statutory duty on appropriate medical staff to discuss the making of an advance statement and explain their effectiveness as part of their after-care plan.

The Commission also recommends that accountability for overriding advance statements be strengthened and supports the recommendation of the McManus Review to require Responsible Medical Officers to review regularly any treatment in conflict with an advance statement and provide a written record of efforts made to address the person’s stated wishes.

Discussions with partners have indicated that some patients may be discouraged from making Advance Statements by the fact that the information within them will be shared with the Mental Welfare Commission. In order to avoid this unintended consequence, the Commission recommends that individuals are able to choose that the information held by the Mental Welfare Commission be restricted to the fact that an Advance Statement exists and a record of where it can be accessed.

The Commission would also recommend that the definition of who may access Advance Statements be clarified. At present, allowing access to “any individual acting on the person’s behalf” appears widely drawn and could raise issues in terms of the right to privacy.

PART 2: CRIMINAL CASES

Section 29: Periods for assessment orders

The Commission welcomes that the proposed extension period is 14 days, rather the 21 days proposed in the draft Bill. However, the Commission considers that any extension of times or variations of the present conditions needs to be justified, taking into account the requirements for a speedy determination and trial within a reasonable time in Articles 5(4) and 6(1) of the ECHR. That justification is still lacking. The Commission recommends that, if such an extension is introduced, the use of the provision be monitored to ensure that a 28 day order does not become a 42 day order as a matter of course.

PART 3: VICTIMS’ RIGHTS

Whilst the extension of the victim notification and representation arrangements are welcomed as an important step towards implementing the EU Directive\textsuperscript{49}, the right to receive information and make representations relating to mentally disordered offenders subject to certain orders must be given careful consideration.

\textsuperscript{49} 2012/29/EU
Human rights principles allow for “the views and concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system.” However, any move to amend the current practice to allow representations to be made by victims should also allow for proper opportunity for those representations to be challenged by the offender in order to avoid the potential for non-compliance with the ECHR (Articles 5 and 6). Similarly, consideration needs to be given to data protection, confidentiality and privacy rights as a consequence of disclosure of sensitive information.

In response to the draft Bill, we commented that offenders subject to Compulsion Order have often committed only minor offences. To allow the proposed notification in such cases may be an unnecessary and disproportionate limitation of their right to private and family life (Article 8 of the ECHR). We therefore welcome the restriction of the provisions to offenders subject only to Compulsion Order and Restriction Orders (COROs). We note, however, that in terms of Section 48, the Scottish Ministers will have the power to amend the provisions so that it may apply to persons who are not subject to Restriction Orders. This re-opens the possibility of persons who are subject to Compulsion Orders for minor offences being included within the scheme and the Commission queries why such a power is required.

Additional Matters

The introduction of the Bill into the Scottish Parliament also provides the opportunity to attend to the following additional matters:

1. **Independent advocacy**

   The McManus Review Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland.\(^{51}\) It made several recommendations to reinforce the right to independent advocacy in s.259 of the 2003 Act, particularly in terms of adequacy of provision of such advocacy by local authorities and health boards.\(^{52}\)

   Independent advocacy is integral to the enjoyment of human rights, particularly in terms of promoting autonomy and supported decision-making (see earlier comments). It is therefore disappointing that no provision is made in the Bill to strengthen the duty to provide for such advocacy so that the right to independent advocacy can be fully realised by those who are entitled to it under the 2003 Act. It is therefore recommended that the Bill include provisions to implement the McManus recommendations regarding advocacy.

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\(^{50}\) UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985), para. 6(b).

\(^{51}\) pp10-11.

\(^{52}\) Paras 3.1-3.6, p.12
2. The use of force, restraint and covert medication

At present, there is little reference to the use of force, restraint or covert medication in the 2003 Act’s Code of Practice. The manner in which any non-consensual treatment is administered must be considered with the Act’s underlying principles and human rights standards firmly in mind. The Mental Welfare Commission highlighted specific issues in relation to the wording of s.242 regarding the use of force in the community\(^{53}\). They also highlighted that there remain situations where the use of force may be necessary to administer care, rather than medication. The authority required for the use of force in various settings is an area where widespread confusion exists in practice. It would be beneficial for both patients and staff to have a clearer understanding of the boundaries and legal requirements to protect patient’s rights. Given the potential for Articles 2, 3, 5 and 8 of the ECHR to be engaged in such situations, and taking in account the aforementioned comments on Article 12 CRPD, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.

3. Incompatibility between s.242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000

A full consideration of any areas of incompatibility between the two Acts may be more productive following the anticipated amendment of the 2000 Act in light of the forthcoming Scottish Law Commission report on adults with incapacity and deprivation of liberty. However, at this stage, the opportunity should be taken to amend s.242 of the 2003 Act in order to provide clarity. This raises issues under Article 8 ECHR and Article 12 CRPD\(^ {54}\) and the role of substituted decision makers in compulsory treatment situations.

Essentially, s.50 of the 2000 Act permits substituted decision-makers to consent to medical treatment on behalf of an adult with incapacity. However, where such an adult falls to be treated for mental disorder under the 2003 Acts, s.242, which relates to treatment for mental disorder other than that requiring special safeguards, it is unclear as to whether such consent is permitted.

Scottish Human Rights Commission
August 2014

\(^ {53}\) [http://www.mwcscot.org.uk/media/189940/mha_consultation_further_doc_t.pdf](http://www.mwcscot.org.uk/media/189940/mha_consultation_further_doc_t.pdf)

Fife Council Social Work Service

Mental Health (Scotland) Bill

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

Yes, including the overriding objective of the Bill to help people with a mental disorder to access effective treatment quickly and easily.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Yes, see below-

Section 13 (2)(2). This is an additional responsibility for a mental health officer. It is suggested that a requirement could be made for the Clerk of the Court to send a copy of any application for a removal order whether granted or not.

Section 19. We welcome the explicit need for consent to operate as Named Person. This receives disproportionate attention at times during a hearing and would allow focus on the individual (patient), the tests and the individual’s care and treatment.

Section 21.(2) The MHO must comment on and include the advance statement during a CTO application. We believe that the Health Board should also be required to send the MHO/local authority a copy of the advance statement.

Section 23. We welcome the inclusion of all mental disorder for the provision of services and accommodation for mothers.

Section 41 (2)- We welcome the inclusion of a report by the Mental Health Officer in terms of accountability to record their duties arising from extensions and evidence opinion. We suggest wording change at (c) to replace “the things done by”.

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

No additional comments to the ones previously submitted as part of the original consultation.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

No additional comments to the ones previously submitted
5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

None noted.

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

No additional comments to the ones previously submitted.

Fife Council Social Work Service
August 2014
Barnardo’s Scotland and NSPCC Scotland

Mental Health (Scotland) Bill

Key Points

- The proposed Mental Health (Scotland) Bill does little to specifically address the biggest issues currently affecting children and young people in Scotland who are in need of the support provided by mental health services.
- Waiting times for Child and Adolescent Mental Health Services (CAMHS) vary widely across Scotland. Several NHS Boards are not meeting the current HEAT (Health, Efficiency, Access, Treatment) targets for CAMHS waiting times, and a stricter target is due for delivery from December 2014.
- All elements of The Mental Health of Children & Young People: A Framework for Promotion, Prevention, and Care (published in 2005 by the then Scottish Executive) are expected to be in place by 2015, as previously stated by the Scottish Government. There should be scrutiny of this.
- The specialist NHS CAMHS workforce has grown significantly over the last decade. However, it still falls short of the level of need predicted in 2005 by a Scottish Executive workforce review.
- Early identification and support for perinatal mental health and infant mental health requires a universal services workforce knowledgeable and informed in these issues. Further progress is needed to achieve this.

Introduction

In the main, the proposed Mental Health (Scotland) Bill does not specifically address some of the biggest issues currently affecting children and young people in Scotland who are in need of the support provided by mental health services. Whilst we understand that this Bill has arrived out of the specific process of reviewing the Mental Health (Care and Treatment) (Scotland) Act 2003, we nevertheless see it as a missed opportunity to address some of the most significant issues affecting children and young people. Therefore, in this briefing we present evidence relating to a number of significant issues which currently affect children and young people who are experiencing mental ill health or illness, and suggests ways in which the Committee could either address them through the Bill or highlight them in other ways.

CAMHS waiting times

Barnardo’s Scotland and NSPCC Scotland would like to highlight to the Committee a long-standing concern that we have with the lengthy waiting periods faced by vulnerable children needing mental health services. Child and Adolescent Mental Health Services (CAMHS) are a crucial part of the mix of mental health services that exist across Scotland, and, as a particularly important
form of early intervention it is crucial that they can be accessed in a timely fashion by those needing their support. However, waiting times across Scotland are extremely inconsistent, and a number of health boards have not met the existing HEAT target for CAMHS waiting times, even though a stricter target is due for delivery from December 2014\(^1\).

In 2009, the following target was approved by the Scottish Government for inclusion in HEAT from April 2010. ‘By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMH services’. Since then, the Scottish Government has established a stricter target of 18 weeks, in line with waiting times for adult services. NHS Boards are expected to be meeting this target from December 2014 onwards. These targets were given further force in the Scottish Government’s Mental Health Strategy for Scotland: 2012-2015\(^2\),

“They will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets”

Since August 2012 ISD Scotland has published quarterly waiting times statistics for CAMHS, including a breakdown for each of the Scottish NHS Board areas. The statistics highlight the waiting time for a young person between referral and receiving treatment.

The most recent waiting times statistics for CAMHS were published by ISD Scotland on the 27th of May\(^3\). These figures raised a number of things that may be of interest to the Committee:

- In the three months between January and March 2014, 310 children and young people had waited more than 26 weeks (the existing target) to be seen by specialist mental health services.
- In that same quarter, 580 children and young people had waited more than 18 weeks (the target due to be introduced by the Scottish Government in December 2014)
- 4 out of 14 NHS Boards in Scotland were not meeting the Scottish Government’s current target of a maximum wait of 26 weeks. All of these NHS Boards were also below the target when the previous batch of figures were published on the 25th of February.

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\(^1\) Detail on the relevant HEAT target is available here - http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/CAMHS18weeks [Link No Longer Active]
• A further 4 NHS Board areas, making a total of 8, are not currently meeting the stricter target of 18 weeks, due to be met by December 2014.
• There is a great deal of variation in the average (median) waiting times between different NHS Boards. At one extreme, NHS Orkney, NHS Western Isles and NHS Borders were all achieving median waiting times of just 3 or 4 weeks. However, at the other end of the scale, NHS Grampian and NHS Ayrshire & Arran are only achieving waiting times of 15 and 14 weeks, respectively.

On the basis of these statistics, both organisations are concerned that there is still a great deal of work for the Scottish Government and several NHS Boards to do, in order to achieve the stricter CAMHS waiting targets being introduced in December. Equally, it is concerning, given the long-standing focus on CAMHS, dating back to the publishing of the Scottish Needs Assessment Plan (SNAP) Report on Child and Adolescent Mental Health in 2003⁴, and the fact that there has been a 26 week waiting time target since March 2013, that there are still a number of NHS Boards missing the current target by a significant amount.

We know from our own services that it is vital for children and young people who have suffered trauma and abuse to get timely support. The earlier that intervention takes place, the more likely it is that they will make as full a recovery as possible.

It is not possible from the statistics to ascertain the extent to which more vulnerable children, with a more significant clinical need, are getting earlier support. NHS Boards have the flexibility to allocate all appointments on the basis of clinical need, and the figures only show averages.

We welcome the Scottish Government’s current target, as well as the introduction of a new, stricter target from December this year. However, we hope this is part of a continuous journey of improvement, towards a situation where all of Scotland’s NHS Boards are performing as well as the best performing NHS Boards.

It would be possible to put the CAMHS waiting time targets onto a stronger statutory footing through the proposed Mental Health (Scotland) Bill. It would also be possible to require regular reporting by Ministers on the target, and to require the establishment of an action plan. At the very least, we suggest that the Committee establishes a process to seek information and evidence from the highest and lowest performing Health Boards to better understand what the successes and failures can be attributed to, where learning can be shared and where progress can be made. We also suggest that the Committee should seek evidence from the relevant Minister to understand what actions the Scottish Government has taken to support Health Boards to meet the target and what

actions Ministers are taking to ensure that the goal of reaching the lower waiting time target, as set out in the Scottish Government’s Mental Health Strategy, is achieved.

**Implementation of ‘The Mental Health of Children & Young People: A Framework for Promotion, Prevention, and Care’**

In 2000 the then Scottish Executive commissioned a strategic review of the state of children and young people’s mental health and the supports available to them. This lead to the publishing of the SNAP needs assessment report in 2003, a comprehensive review with 10 major areas of recommendation. The Scottish Executive then translated this into the development of a delivery framework, the Framework for Promotion, Prevention and Care. This was published in 2005 as a 10-year master plan for how children and young people’s mental health services should be developed and delivered in Scotland. The framework sets out comprehensive service elements and activities plans, across five areas: the Early Years (Universal services), School Years (Universal services), Community-based activity, Additional and Specific Supports, and Specialist Child and Adolescent Mental Health Services. The framework set out that,

> `'All of the elements outlined in the framework are expected to exist within local services by 2015. This will be a challenging timescale, in some areas more than others. However, with effective planning and appropriate prioritisation, much can be achieved over the next 10 years.' (paragraph 1.19, page 5)`

Furthermore, the framework survived the transition from the Labour-Liberal Democrat Coalition to the SNP Scottish Government. In 2010 Shona Robison MSP, who was then the Minister for Public Health and Sport said,

> "I am pleased that the [Health and Sport] Committee recognises the priority that we place on the implementation of the Mental Health of Children and Young People’s Framework, which we are working towards full delivery of by 2015."

With the life of the framework now almost complete, and the expectation that virtually all of the actions of the framework should now have been put in place by the Scottish Government, Local Authorities and Health Boards, we suggest that now would be an appropriate time for the Health and Sport Committee to revisit

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7 Health and Sport Committee Debate on Child and Adolescent Mental Health and Wellbeing, **Wednesday 6th January 2010, Col 22426**
Child and Adolescent Mental Health and Wellbeing, in much the same way that they did in 2008-09\(^8\), when the framework was three years into its lifetime.

**Maternal and Infant mental health**

The Framework mentioned above looks at the action needed to improve the mental health of children from birth onwards.

The mental health of infants is indivisible with that of their mothers, and maternal and infant mental health need to be viewed holistically.

A healthy secure parent-child attachment is the most important protective factor for infants and a strong predictor of good outcomes. Mental health issues experienced by women in the perinatal period – during pregnancy and the year after childbirth – can affect this, by inhibiting a mother’s ability to provide the sensitive, responsive care a baby needs. To reduce the impact on babies, it is important that mothers receive timely support for their own mental health needs, and that this support specifically addresses their interaction with their babies, for this intimate interaction performs a vital role in the cognitive, emotional and social development of infants.

Early identification and support by universal services is essential for both perinatal and infant mental health. For this to happen all occupations in contact with women in the perinatal period, and with infants, need to be equipped with the appropriate knowledge.

As part of the Early Years Framework, both the Scottish Government and COSLA signed up to actions to improve infant mental health. These included:

- moving to a parenting model of ante-natal and post-natal support to promote parenting skills and attachment;
- building the capacity of universal services through mental health training for front line professionals, and CPD for early years workers.

Early identification and support is essential and our universal early years professionals - midwives, health visitors and GPs – play a crucial role in this. Infant mental health care, comprising primary, secondary and tertiary interventions, should be an essential part of our universal service provision.

We would like to see an audit of progress in terms of instating infant mental health as a core compulsory topic within the curriculum and post qualification training of all children’s services occupations in contact with children under three years of age including midwives, general practitioners, health visitors, community mental health nurses, paediatricians, and other professionals. It remains a

\(^8\) In 2009-10 the Health and Sport Committee undertook an inquiry into Child and Adolescent Mental Health and Wellbeing, and published a report on the matter: [http://archive.scottish.parliament.uk/i3/committees/his/inquiries/mentalhealthservices/index.htm](http://archive.scottish.parliament.uk/i3/committees/his/inquiries/mentalhealthservices/index.htm)
concern that those health professionals who have contact with all children under three, are still generally not trained in infant mental health.9

The same issues apply to perinatal mental health. The SIGN Guidelines on the management of perinatal mood disorders indicate that competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness should be established.10

At the moment knowledge of perinatal mood disorders is not a core compulsory topic within the curriculum of the health occupations that come into contact with women during pregnancy, birth and the post natal period. There should be a further audit of progress made in instating this topic in the curriculum and post qualification training offered in Scotland to these occupations and a time-bound plan made with targets set for achieving this.

**Young children in the care system**

While the focus of early intervention work is on the universal workforce, an equally important issue which demands attention is the ongoing skills development of those in contact with infants and very young children either at the threshold or within the child protection system. Recent research found, for example, that decision-making by child protection social workers is still insufficiently informed by current knowledge of attachment, early childhood development, and the long term impact of maltreatment on life chances.11

As highlighted by Furnivall, training and support in attachment is required by all those caring for young looked after children, including foster and kinship carers and adoptive parents, residential and early years staff.12 This type of training and support is not routinely available in Scotland to those who provide care to our most vulnerable children. We need a coordinated national strategy to address this and improve practice by sharing knowledge about effective interventions.

**CAMHS workforce**

A parallel strategic review of the CAMHS workforce, in 2005, addressed the capacity issues around implementation of the new framework. It identified the education, training and skills development needed to deliver an appropriate pattern of services. However, it also undertook an estimate of the size of the NHS

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10 http://www.sign.ac.uk/guidelines/fulltext/127/
specialist CAMHS workforce at the time, concluding that a total of 615wte (whole time equivalents) was “the best available estimate of actual current workforce in NHS specialist CAMHS” (Paragraph 6.1.1). On that basis, it made a recommendation to increase the size of the CAMHS specialist workforce based within the NHS:

“Recommendation 44: A plan for phased investment in workforce should be developed in conjunction with plans for implementation of the Framework for Promotion, Prevention and Care, with the aim of doubling the size of the NHS based CAMHS workforce within ten years.”

However, although the most recent statistics from ISD Scotland show that there has been a very significant increase in the size of the specialist NHS CAMHS workforce, by 20% (measured in wte) between September 2009 and the end of March 2014, they showed that the workforce size, at 917.5wte, was still well short of the estimated workforce need, of 1200-1450wte, established by the 2005 workforce review.

The Mental Health (Scotland) Bill could establish a duty on each Health Board or Health and Social Care Integration Scheme (where there has been an agreement with the relevant local authority (ies) to integrate CAMHS services) to develop, publish and report on a CAMHS workforce development strategy, perhaps as part of the local children’s services plans required by the Children and Young People (Scotland) Act 2014. However, as a minimum we suggest that any work by the Committee to consider progress on the implementation of the framework should also consider workforce issues. We suggest that the Committee should write to the Scottish Government to ascertain whether Ministers still consider the 2005 workforce need estimate to be up-to-date, and either how they intend to reach it or how they intend to update it.

Barnardo’s Scotland
NSPCC Scotland

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13 Scottish Executive Health Department National Workforce Unit, Getting the Right Workforce, Getting the Workforce Right: A Strategic Review of the Child and Adolescent Mental Health Workforce, 2005
The Scottish Independent Advocacy Alliance

Mental Health (Scotland) Bill

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

The Mental Health (Care & Treatment) (Scotland) Act 2003 is based on the Millan Principles which give it a clear rights based framework. We would like to see the Bill reiterate a commitment to these Principles. We are aware that low levels of awareness around the Millan Principles remain and steps should be taken to raise awareness about them amongst services users, carers and practitioners. As well as a lack of awareness of these Principles we understand that service users are not always aware of their rights such as Advance Statements, Named Person and Independent Advocacy. This is of major concern and is clearly highlighted in research published by the Mental Welfare Commission\(^1\) which showed that few participants knew about these important safeguards.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care & Treatment) (Scotland) Act 2003 as set out in Part 1 of the Bill?

Tribunal timescales - We would find it useful to have more information about the proposal to extend the time that the Tribunal has to organise a hearing from 5 to 10 days. We are concerned that the impact of such a change could lead to individuals being detained without external scrutiny for extensive periods of time.

MHO duty to inform about independent advocacy - We believe that the requirement as described in section 2 an MHO extending an order to tell the individual about advocacy where practicable should be changed. It is important that the Bill gives a consistent message about the duty placed on practitioners to tell service users about independent advocacy. Early findings from our own research due to be published in the autumn show that service users are not always routinely told about their right to access independent advocacy timeously. Different groups repeatedly stated that if they had been told about advocacy earlier it would have helped them better understand their rights and what was happening to them.

Section 3.- We believe that if a person is detained for up to 72 hours and hospital managers have a duty to inform the Mental Welfare Commission then they should also have a duty to inform that person’s carers or nearest relative.

Section 11 -12 - We would like to see mention of when the regulations regarding appeals against excessive security will be introduced. In addition we believe that people in low secure facilities should have the right to such an appeal.

Section 14 - We note that the Bill proposes the extension of nurses holding power from 2 to 3 hours. We feel that reasons for this extension should be made clear.

Section 15 - We further note that the Bill proposes a substantial reduction of the time limit for making an appeal against transfer to a state hospital to the Tribunal from 12 weeks to 28 days. We believe that reasons and evidence for this change should be included in the Explanatory notes.

Named Person - We believe that an ‘opt in’ system for appointing a Named Person is better and ensures that the individual has full control in the situation and we are concerned that the default Named Person has not been completely removed as per the McManus recommendation. We believe that when an individual appoints a Named Person their MHO or RMO should have a duty to also discuss the benefits of an Advance Statement and Independent Advocacy. We believe that there should be effective support and training available for a person appointed as a Named Person.

Although the Named Person has a right to access legal representation we believe that they should also have a right to access independent advocacy. In addition we feel that consideration needs to be given to children over the age of 12 being able to appoint a Named Person. The other recommendations made by McManus regarding consulting the Named Person on the care plan and being notified about an individual being taken to a place of safety should be included in the Bill.

Advance Statements - We believe it should be as easy as possible for a person to make an Advance Statement. We know that many individuals find out about Advance Statements and receive help from their independent advocate when considering whether they wish to make one and when drawing one up.
We believe that a person should have the option not to submit their Advance Statement with the MWC if they so choose. We are concerned about who will have access to Advance Statements held by the MWC. There needs to be clarity about whether the MWC will hold a register of everyone who has an Advance Statement or will hold the full Advance Statement. If they have the full Advance Statement then there needs to be careful consideration given to who has access to the details.

When an Advance Statement is overridden there should be a duty on the RMO to meet with the individual to explain the reasons for such an override. This would help the individual to better understand how the Advance Statement can be strengthened in the future.

In the instance of an individual not having an Advance Statement and being in the process of being discharged from hospital there should be a duty on the RMO to discuss the importance of having an Advance Statement. The value of an Advance Statement should be raised with the individual as part of the aftercare discussions. This would fit with the McManus recommendation regarding the promotion of Advance Statements.

Section 25 - We do not support this proposal and are concerned about the treatment of a patient who has absconded especially if they do not have access to independent advocacy if they are in other parts of the UK.

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

Section 29 - We do not support the extension of the assessment order from 7 to 14 days without clear evidence.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

We would like to see a clear statement regarding minor offences committed by individuals with a mental disorder not being included in the victim notification scheme. Also we are concerned about the Power of Ministers to vary section 48 and would like to see clarification around this.
5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation?

The SIAA is concerned that the MacManus Report highlighted a number of issues regarding access to independent advocacy including appropriate levels of provision, adherence to the SIAA good practice guidance, collective advocacy and advocacy for carers. It is disappointing to see that almost a decade after the legislation was introduced we still have people with a statutory right unable to access independent advocacy for one reason or another. We call for the Bill to make provision for more scrutiny of the implementation of section 259 regarding independent advocacy.

We are in the process of finalising our biennial research into the national funding and provision of advocacy in Scotland. Early findings indicate that overall funding for the 2013-2014 year may be, in real terms, 5% lower than for the 2011-2012 year, most organisations report a standstill or reduced budget. Meanwhile demand for advocacy has increased by over 5% in the same period.

Role of advocacy commissioners
We believe that consideration needs to be given to the strengthening of the duty placed on NHS Boards and partner Local Authorities to ensure availability of independent advocacy in their areas.

We have concerns about some commissioners not following the Independent Advocacy: A Guide for Commissioners (2013) regarding all aspects of strategic planning including;

- Clarity about the definition of independent advocacy – we are still encountering different definitions of independent advocacy that don’t fit with the legislation. As a consequence there are still some areas that don’t meet the statutory requirements regarding access to independent advocacy.

- Commissioning – there are still many variances in commissioning practice that don’t always consider the strength of small user led organisations.

- Planning – in some areas there is very little evidence of effective planning for the development of advocacy.

- Consultation with service users – in some areas there is very little evidence of meaningful and effective consultation with users about advocacy provision.

- User involvement – we are still to see effective and meaningful user involvement in some areas.
- Realistic levels of funding for the population – advocacy organisations report levels of funding that do not effectively cover the populations they serve.
- Sustainable funding levels – from both statutory and non-statutory sources. We know that independent funders and trusts are reluctant to fund organisations that do not have guaranteed core funding for a reasonable amount of time.
- Monitoring – we know that in some areas there is little or no effective, meaningful, qualitative outcome focussed monitoring of the advocacy delivered.
- Evaluation – organisations report that funding for external evaluation is often not included in their funding.
- Ongoing support – some organisations report that there is little ongoing support from commissioners and funders.

We are concerned about quality assurance at the strategic level of planning; there isn’t any monitoring of strategic plans which should be produced every 3 years. Some commissioners do produce them some don’t.

Some organisations report that monitoring is either non-existent or purely quantitative and does not consider impact or advocacy outcomes.

We believe that the Mental Welfare Commission should have a role in monitoring the planning and commissioning of independent advocacy to ensure that this is done in a manner compliant with the Independent Advocacy: A Guide for Commissioners (2013).

**Access to advocacy**

Currently the legislation is not being followed in some areas. For example many organisations have reported that their Service Level Agreement requires that they prioritise people subject to compulsory measures under the Mental Health Act. As a result of this, along with the reduced budgets and increased demand, they have been forced to introduce waiting lists which can involve lengthy waits, sometimes for as long as several weeks for people with mental disorder not facing compulsion.

There are also reports about misunderstanding of the right of access to advocacy amongst some commissioners who appear to believe that only people who are detained have a right of access.
We are increasingly receiving calls from parents with mental disorder facing child protection issues who need advocacy support but are unable to access it. This can be due either to the requirement placed on their local advocacy organisation to prioritise those facing compulsory measures or, because of waiting lists and high demand their local advocacy provider cannot respond in what can often be a fairly short time span to support them through the process.

While independent advocacy is available to some degree for all adults with a mental disorder in almost all areas of Scotland the situation is very different for children with a mental disorder. Many areas of Scotland do not have independent advocacy provision for children with either learning disability or mental health problems. Even children, who are detained, in some areas, do not have access to independent advocacy.

There is only limited access to collective advocacy across Scotland. In some areas advocacy organisations providing one to one advocacy have gone on to develop collective advocacy in addition but gaps in provision remain.

There is still a great deal of confusion regarding the definition of independent advocacy. The definition in the Act is clear, the accompanying Code of Practice states ‘Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy. If the independent advocacy service or advocate has a conflict of interest, they should inform all relevant parties of this, and should withdraw from acting for the patient.’

We believe that the MWC should have a role in monitoring availability of and access to independent advocacy.

Quality assurance
We are concerned about a situation arising in response to the Social Care (Self-directed Support) (Scotland) Act 2013. Reports are coming from a number of areas about organisations and individuals who are advertising or wish to advertise that they provide independent advocacy which can be purchased by service users by means of Direct Payments. We are concerned that some of the most vulnerable people who need advocacy are also going to be the least likely to be able to afford it.

We believe that independent advocacy should be free at the point of access therefore this development could leave vulnerable individuals open to exploitation. The Social Care (Self-directed Support) (Scotland) Act 2013 refers
to independent advocacy as defined in the Mental Health (Care & Treatment) (Scotland) Act 2003. The SIAA Principles & Standards for Independent Advocacy clearly state the importance of being ‘accountable’ and ‘free from conflicts of interests’ as key components of high quality advocacy. We believe that the robust systems in place for the procurement of independent advocacy need to be strengthened in this context in order to safeguard vulnerable groups.

We feel that the proposed Mental Health Bill is an important opportunity to reinforce the duties on Local Authorities and NHS Boards and to ensure that everyone is clear on the definition of independent advocacy and the structures within which it can be provided. Ultimately we want to see the right of access to high quality independent advocacy for everyone covered by legislation become a reality. We believe that the role of ensuring access to good quality independent advocacy for all with a mental disorder should be covered within the remit of the MWC.

We hope to have an opportunity to discuss our response and further evidence with the Committee.

The Scottish Independent Advocacy Alliance
Mental Health (Scotland) Bill
August 2014

The Scottish Independent Advocacy Alliance (SIAA) is Scotland’s national membership body for advocacy organisations. The SIAA promotes, supports and defends independent advocacy in Scotland. It aims to ensure that independent advocacy is available to any person who needs it in Scotland.

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Together (Scottish Alliance for Children’s Rights)

Mental Health (Scotland) Bill

Together (Scottish Alliance for Children’s Rights) is an alliance of children’s charities that works to improve the awareness, understanding and implementation of the UN Convention on the Rights of the Child (UNCRC) in Scotland. We have over 260 members ranging from international and national non-governmental organisations through to small volunteer-led after school clubs. Our activities include collating an annual State of Children’s Rights report to set out the progress made to implement the UNCRC in Scotland. The views expressed in this submission are based on the general principles of the UNCRC and don’t necessarily reflect the specific views of each member organisation.

Introduction
Together welcomes the opportunity to respond to the call for evidence to inform the Health and Sport Committee’s consideration of the Mental Health (Scotland) Bill. Some of the most vulnerable children in Scotland are affected by mental health issues – both personally and through having parents or siblings affected by mental health issues. This Bill provides an opportunity to ensure that these children are able to enjoy the highest attainable standard of health, in line with Article 24 of the UNCRC\(^1\). The Bill could further children’s rights and progress the duty placed on Scottish Ministers through the Children and Young People (Scotland) Act 2014.

However, the Bill as introduced is currently a missed opportunity and fails to take account of many concerns raised by children’s organisations through the Scottish Government’s consultation. Together urges the Health and Sport Committee to take a number of steps to ensure that the Bill fulfils its potential:

1. A Child Rights Impact Assessment should be carried out on the draft Mental Health (Scotland) Bill, to systematically and fully consider its impact on children and young people.

2. The Bill should take account of the rights of all children, including those with mental health needs as well as those affected by the mental health needs of their parents, carers or siblings.

3. The Bill should include preventative measures to avoid children from developing more serious mental health problems later in life. It should be used as an opportunity to address the difficulties many children and young people face in accessing CAMHS.

1. Child Rights Impact Assessment
A Child Rights Impact Assessment (CRIA) would help to ensure that opportunities to promote children’s rights through the Bill are identified and taken forward, and that any negative impact of the proposals can be

predicted, and if necessary, avoided or mitigated. It would help to fulfil a commitment made by the Minister for Children and Young People during Stage 3 of Parliamentary scrutiny of the *Children and Young People (Scotland) Bill.* The Scottish Government is currently developing a CRIA model which could be trialled on this Bill.

- **The Health and Sports Committee should encourage the Scottish Government to undertake a Child Rights Impact Assessment (CRIA) on the Bill.**

2. **Taking account of the rights of all children**

The Mental Health Strategy 2012 recognises that more could be done to provide mental health support to those who are most vulnerable. The Strategy particularly focuses on the needs of looked after children and children with learning disabilities. Together’s members have highlighted that more needs to be done to support children from other vulnerable groups, including children of prisoners, asylum seeking children, children from ethnic minority communities, young carers, young offenders, looked after children, those who have suffered abuse or neglect and those with hearing loss.

- **The Mental Health (Scotland) Bill should include provisions to ensure equal access and consistent, timely provision of mental health services for all children. Attention needs to be paid to ensure that the needs of children from particularly vulnerable groups are met.**

The Bill as introduced does not take account of the impact that a parents’, carers’ or siblings’ mental health needs can have on a child. Children affected by a close relative’s mental health needs can become withdrawn and isolated, particularly as a result of adult-focused agencies overlooking the rights of children.

- **The Health and Sport Committee should ensure that the impact of the Bill on children and young people who are affected by a parent, carer or sibling’s mental health needs is fully taken into account and that the best interests of the child are the primary consideration throughout further scrutiny of the draft Bill.**

3. **A preventative approach to mental health in Scotland**

The importance of supporting a preventative approach whilst taking forward mental health policy in Scotland is recognised in the Mental Health Strategy 2012 and outlined in consultation responses by a number of children’s organisations. Despite this, there is no explicit statutory foundation for preventing mental health problems in the proposals cited. The importance of including preventative provisions in the Bill are outlined in the consultation response by the WAVE Trust and should be fully taken into account throughout the scrutiny process.

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• The Health and Sport Committee should ensure that the Bill promotes sufficient preventative measures for children to help avoid mental health problems from escalating.⁴ There should be a holistic approach to mental health and support and services that are not seen in isolation from other strategies and policies (including the Children and Young People (Scotland) Act⁵ and the National Parenting Strategy⁶).

Members of Together have raised concerns that the vast majority of children are not able to access specialised Child and Adolescent Mental Health Services (CAMHS) because they are not diagnosed or not seen as needing that level of intervention.⁷ Together’s members report that although the quality of CAMHS is generally thought to be good, it is hugely under-resourced, leading to long waiting lists that can cause more damage to the child as well as longer, and ultimately more expensive, treatment.⁸

• The Mental Health (Scotland) Bill should be used as an opportunity to address the difficulties many children and young people face in accessing CAMHS.

Together (Scottish Alliance for Children’s Rights)
August 2014

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⁵ Scottish Government (2014). Children and Young People (Scotland) Act
Do you agree with the general policy direction set by the Bill?

1. The Society welcomes the proposals contained in this Bill which will strengthen the rights of those who are subject to compulsory mental health treatment. However, we would welcome greater efforts to promote the principle of reciprocity, and in particular the provision of psychological interventions in the treatment of mental disorder.

Psychological interventions are not simply an adjunct to medication. They are an essential component of the treatment of serious mental illnesses such as schizophrenia, depression and bipolar disorder, and in the management of dementia, and are the mainstay of treatment for learning disabilities, autistic spectrum disorders and personality disorders (see NICE and SIGN guidelines).

This is recognised in Scottish Government mental health policy (see Mental Health Strategy for Scotland: 2012-2015; [www.scotland.gov.uk/Publications/2012/08/9714](http://www.scotland.gov.uk/Publications/2012/08/9714)) and the current HEAT target for psychological therapies has undoubtedly had a huge impact in improving the availability of psychological therapies. However, although the target applies to inpatient as well as community settings, the data submitted by Health Boards does not allow comparisons between these to be made. Moreover, in any place where patients’ needs are not properly assessed, the demand for psychological therapies remains hidden. It is of note that our national care standards for mental health services (Integrated Care Pathways for Mental Health, NHS Quality Improvement Scotland, December 2007), which include a standard to assess the suitability for psychological and/or psychosocial intervention (Care Standard 15) have never been enforced.

However, there are strong indications that access to psychological interventions for those in psychiatric hospitals remains poor:

- Members of the Society who are employed in health services in Scotland report a substantial disparity between the provision to patients in hospital and those in the community, with the former losing out, despite generally being the more vulnerable group.
- A study of Intensive Psychiatric Care Units (IPCUs) by Quality Improvement Scotland revealed that only one of the IPCUs in Scotland had dedicated input from a clinical psychologist and that many people in IPCUs did not have access to psychological therapies ([Intensive Psychiatric Care Units Overview Report, June 2010, NHS Quality Improvement Scotland](http://www.scotland.gov.uk/Publications/2012/08/9714)).
- A report by the Scottish Intercollegiate Guidelines Network (SIGN) on the management of schizophrenia (SIGN publication no. 131, March 2013) states that “Despite increasing evidence of the efficacy of discrete psychological interventions and therapies such as family intervention and cognitive behavioural therapy (CBT), delivery of such interventions has been difficult to realise in practice.”
The Mental Welfare Commission visit report, ‘Dignity and Respect: Dementia Continuing Care Visits’ (2. June 2014) describes how 19% of units for dementia sufferers have no access to psychology services.

The Scottish Government needs to do more to address this problem in order to up-hold the principle of reciprocity. Mental health legislation should be strengthened and scrutiny increased and examples of how this could be done are provided in this response. In summary, the key recommendations are:

- Application of the Integrated Care Pathway for mental health (NHS Quality Improvement Scotland, December 2007) should be enforced by stronger monitoring procedures, to ensure that all those in mental health services have their needs for psychological interventions assessed.
- For all those who are to be detained beyond the short-term, a holistic care plan, which includes a description of proposed psychological interventions, should be prepared. Progress with these interventions should be reported on for the consideration of any proposed extension to a compulsory care order. Medical practitioners and MHOs presenting to the Tribunal should be directed to consult with those undertaking psychological assessment or intervention in the preparation of their reports.
- Statutory roles regarding the assessment and management of patients in the application of mental health legislation should be extended to include practitioner psychologists, in cases where the primary treatment for the relevant mental disorder is psychological in nature.

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

2. 1. Relating to Section 87, the Society would recommend that the legislation should specify that, in cases where an order is to be extended, Responsible Medical Officer’s (RMO) reports contain details relating to all aspects of medical treatment which have been offered to the person. This will help to emphasise the importance of providing a range of social and psychological interventions in the treatment of mental disorder, which is line with the principle of reciprocity.

2. Under the proposed New Section 87, where there is a difference of opinion or a change in diagnosis, the Mental Health Organisation (MHO) is required to prepare and submit a report to the Tribunal. Again in support of the reciprocity principle, it is the view of the Society that this report should include a summary of the full range of medical treatment (as currently defined in the Act) that has been considered and tried, with explanations of progress. Associated guidance to MHOs should emphasise the importance of seeking information about a person’s care from the range of professionals who may be involved. Amongst others, this would include those who have delivered psychological interventions or have assessed a person’s psychological needs.
3. The Society welcomes the fact that under the proposals, the right to excessive security tribunals will be extended to patients in medium secure services, as this is likely to lead to a greater focus on psychological interventions to help patients progress to conditions of lower security.

4. In relation to Named Persons, we have concerns that no consideration appears to have been given to the wishes of some patients to limit the extent of information provided to a Named Person, for example, private details contained in documents submitted to the Tribunal which are shared with the Named Person.

5. The Society welcomes the attempts to make better use of Advance Statements but is concerned that no mention is made of a person’s wishes being likely to change and the need for Advance Statements to be regularly up-dated to take account of this.

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

3. In relation to New Section 153A, the Society believes that the legislation to require RMOs to provide information about the full range of interventions which have been tried and progress made with these, thereby raising the profile of psychological interventions. This view also extends to the reports to be provided by MHOs to the Tribunal when a case is reviewed under Section 165 (2).

- Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

4. The Society welcomes these proposals, which respects victims without compromising the treatment of mentally disordered offenders.

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

5. **Advocacy**
The McManus report recognised that provisions in respect of independent advocacy needed to be strengthened and the Society has concerns regarding the lack of attention to this in the proposed Bill. The provision of advocacy services is patchy, with some of those most in need of help to overcome their difficulties understanding procedures or in representing themselves, such as people with dementia and children and young people seeming to have particularly poor access. An example of good practice is cited by practitioner psychologists working in forensic services in NHS Greater Glasgow and Clyde, where an independent advocacy service is fully funded by the Health Board. The Advocacy team is given office-space alongside clinicians and managers, which allows them to integrate well-enough with the healthcare staff to be familiar with how the service operates and kept informed of any developments which are likely to impact on patients, without compromising its independence.
Although some patients make more use of the service than others, the advocates have links to every single inpatient and some community-based patients. They are able to develop trusting relationships with individual patients, which is likely to make their involvement more meaningful. They also have time to work with groups of patients and encourage the growth of self-advocacy. The Society would like to see examples like this in all parts of the country and for all care groups and is of the opinion that additional measures may be required to ensure that all Health Boards and Local Authorities adhere to their responsibilities to provide advocacy services.

**Care Plans**
The McManus report highlighted the short-comings of care plans and recommended that a care plan template be provided to improve this. The Society welcomes this recommendation and, therefore, disappointed that the proposed legislation view overlooks it, as it would help to ensure that due consideration is given to psychological interventions in the treatment of mental disorder.

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

**6. Detention**
The Society notes that the majority of respondents to the earlier consultation on this Bill were not in favour of people being detained on the basis of only one medical report. However, it is the Society’s view that the purpose of a second report should be defined, as it considers that reports from two medical professionals are likely to present similar views. There would be merit in conducting research to examine this. An alternative perspective is more likely to be obtained by seeking the views of a professional with a different background, such as a psychologist. This is particularly relevant to people with learning disabilities, autistic spectrum disorders and personality disorders, where the principal treatments are psychological rather than medical.

**Role of psychologist**
The Society recommends that the role of psychologist is made more explicit in mental health legislation to recognise the profession’s role in addressing mental health problems and to increase the prominence of psychological interventions in the treatment of mental disorder. The use of the term ‘medical treatment’ rather than ‘treatment’ in the existing Act presupposes a traditional medical approach to mental health and in turn overlooks the importance of psychological interventions. Moreover, the Society recommends future legislation to include a broader range of practitioners in the assessment and management of people subject to mental health legislation, as is the case with the clinical supervisor role in England and Wales. Not only would this afford the opportunity to better match patient needs to clinician expertise in certain cases, it would also help to increase resources, which are currently limited by a shortage of psychiatrists and other medical professionals in Scotland.
Local Authorities
The Society believes that the Bill should revisit sections 25 to 31 of the 2003 Act, which deal with the obligations on local authorities to promote recovery and access to other services, including employability and education, all of which are bound up in issues around welfare reform. This would also help to underpin an assets-based approach to mental health and wellbeing, which is strongly supported by the Society.

Impact Assessment
A mental health impact assessment of Government legislation – both policy and practice – could be carried out to promote psychological well-being in the general population and support assets based approaches. It would demonstrate, and the evidence supports the fact, that most public policy decisions have a mental health dimension and recognise that mental health and well being are important factors in personal resilience.

Young people
The Society has concerns that the current proposals fail to mention children and young people who are subject to compulsory care. Policy is required to address the specific needs of this population, taking into account the interface between mental health care and education.

British Psychological Society
August 2014

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.
Midlothian Council

Mental Health (Scotland) Bill

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

Midlothian Council welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill and would support the general policy direction set by the Bill.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

We would refer you to the consultation response submitted by Social Work Scotland.

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

No comment.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

The proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders is welcomed although will require clear guidance on definitions, entry and exit points, roles, responsibilities, boundaries, accountabilities and any inconsistencies in applicability addressed.

Since Restricted Patients are already managed under MAPPA it would make sense for victims to have the right to receive information via the Victim Notification Scheme, as victims of offenders not in the mental health system can do. It is crucial as part of risk management planning to take previous victims’ safety into account as well as potential future victims. Unfortunately many victims do not sign up to the VNS and this makes it difficult to contact them when release plans are being made. It would be useful to look at ways of increasing the number of victims signing up to the scheme.

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

No comment.

6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
We agree that the proposals are positive in most areas although there is concern that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.

The Bill proposes further increases to the existing duties and responsibilities of our MHO Services. Whilst many of the proposed duties and responsibilities are welcome we need to ensure that our Mental Health Officer (MHO) workforce and workload capacity are sufficiently resourced to enable us to meet increased statutory functions.

Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder we have concerns that the amendments do not always provide clarification of already complex areas. We would ask if the Codes of Practice would be reviewed to take account of any changes.

Consideration also needs to be given to the potential consequences of the integration of Health and Social Care. We need a common understanding of what the defined MHO role is and how it fits in with integrated services.

Midlothian Council
August 2014
ADSW Mental Health Sub Group

Mental Health (Scotland) Bill

Introduction
The ADSW Mental Health Sub Group welcomes the opportunity to respond to the consultation on draft proposals for a Mental Health (Scotland) Bill following on from the limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Scottish Governments response to the limited review report in October 2010.

Whilst elements of the bill positively address a few existing gaps within our Mental Health Act, in some instances reflecting current good practice, it cannot be viewed in isolation from the shifting sands of an already complex legal and policy landscape in the midst of reshaping our health and social welfare agenda.

The Adult Support and Protection Act, the Mental Health Act and the Adults with Incapacity Act have all greatly extended the protective, monitoring and investigative functions of local authorities in respect of people who may be vulnerable as a result of mental disorder. All three Acts are inter-related but equally must be viewed within the context of the broader policy framework of health and social care integration, self directed support and the review of our criminal justice services to name but a few.

The Bill proposes further increases to the duties and responsibilities of our Mental Health Officer Services which equally need to be viewed in the broader context of our national MHO workforce and workload capacity. Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Question 1: Do you have any comments on the proposed amendments to the Advance Statement provisions? Comment.

The proposed amendments to the Advance Statement are welcomed. Consideration should be given to the potential to introduce a recommended proforma which incorporates an advisory note to the effect that it requires to be submitted within a specified timeframe following completion to be effective, will require to be reviewed annually or where there are a change of circumstances and that it revokes any preceding statement. The proforma should be signed, dated and include reference to the fact that the Health Board must forward the proforma to the Mental Welfare Commission to be added to the register.
Clarity is required on the central point within Health Boards to which the proforma should be submitted.

There remain questions around the potential need for 24 hour accessibility to the Advance Statement for those parties who require access and a few data protection considerations that will require to be addressed in the operationalisation of the register

**Question 2: Do you have any comments on the proposed amendments to the Named Person provisions?**

**Comment**
The introduction of an opt out system is welcomed as is the named person’s consent to undertaking the role. There is an assumption that issues around capacity in this area will be addressed within the Code of Practice.

The existing Named Person system works well with the above amendments and there appears to be no practical benefit to the service user from the other measures proposed which would be operationally impracticable unless consistently pre-planned which is unlikely to be achievable. Mental Welfare Commission statistical data suggests that there are approximately 3,500 Named Persons currently, the proposals contained within section 257 to involve the MHO in seeking signatures etc are not best use of the limited MHO resource.

Consideration should be given to the expansion of the proposed Advance Statement register to incorporate a Named Person Register.

The proposed Tribunal rules which will be subject to a separate consultation are welcomed in relation to mentally disordered offenders or where there may be victim considerations. There are however concerns that the proposal erodes the rights of the Named Person and this will require to be addressed within the regulations.

**Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions?**

**Comment**
There was strong rejection of these proposed amendments which undermine existing good practice across disciplines and organisations including attempts to engage General Practitioners in the process in all instances.

The proposals transfer responsibilities and costs from Health Boards and RMO’s to Local Authorities and MHO’s, facilitate the disengagement and detachment of General Practitioners from the process with no obvious benefits to the service user.

The transferring of responsibility for securing second medical recommendations from RMOs to MHOs on all CTO applications, (over1100 in the period 2012/2013. Mental Welfare Commission figures) would entail a significant workload increase on an already stretched service.
The retention of the existing medical examination and compulsory treatment order provisions was overwhelmingly supported.

**Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions? Comment**

Whilst acknowledging the difficulties experienced to date with suspension of detention measures, particularly immediately following the Acts inception, the proposal to remove the 9 month restriction in any 12 month period was rejected. It was the consensus that this was a retrograde step which would replicate the issues identified with Section 18 Leave of Absence under the 1984 Act.

It was suggested that an upper limit of 6 months in any 12 month period be considered with a disregard for short periods such as one day, one overnight, one weekend in the cumulative period.

There were also a few concerns that RMOs can add more restrictive conditions during periods of Suspension of Detention than those originally approved by the Tribunal.

The Part 13 proposals were supported but would require clarification on the thresholds and it was suggested that the upper time limit of 6 months suspension of detention be equally applicable under section 224.

**Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal? Comment**

Whilst elements of the proposal are unquestionably good practice, there are however major workload concerns for the MHO service.

The proposed changes to section 87 would require an additional 1789 reports by MHO’s each year (1789 over the period 2012/2013, Mental Welfare Commission figures). There may be considerations around whether the requirement for an MHO report is limited to extensions but not variations of the order or alternatively limited to those orders where there is likely to be a hearing (issue related to diagnosis, MHO disagrees with the proposed action, or, where there is a revocation of the application).

The introduction of a recommended form would be of benefit in this area together with clarification around the role of the SCR, section 57c and section 59.

Within the current Act, MHOs should complete an SCR following any relevant event or a letter to advise that the completion of an SCR would serve no practical purpose.

Good practice would also suggest that an SCR is completed at least annually for individuals on long term orders and that an SCR should be completed at each renewal of order for individuals who are parents. The Mental Welfare
Commission annual report notes a sizeable deficit in the report submissions nationally.

There are concerns around the proposal to place further administrative duties around notification on MHOs which may sit better within the MHTS. Concerns were also expressed around thresholds for significant harm and the need to limit the information in the MHO report given the proposed circulation.

Timeous notification to MHOs from RMOs of plans to extend a CTO also require to be addressed.

Questions were raised around whether these proposals would also apply to Compulsion Orders.

**Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions?**

**Comment**

Whilst these proposals were viewed as a positive development, it was felt that hospital managers would require a statement from the RMO / GP to advise of sensitivities in order to facilitate the exercising of their discretion.

Whilst there were no concerns with the notification of the granting of the order to the various parties, concern was noted around the circulation of the full papers, particularly if the default Named Person role is retained.

**Question 7: Do you have comments on the proposed changes to the suspension of certain orders etc. provision?**

**Comment**

The proposed changes in this area were viewed positively.

**Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions?**

**Comment**

The proposal to place a duty on the MHO to notify the Mental Welfare Commission when making an application for a removal order to enable the Mental Welfare Commission to consider whether it should make a section 295 recall or variation of the removal order was viewed positively.

The proposal to extend Nurses holding power from 2 to 3 hours to enable an informal patient to be detained for the purposes of enabling medical practitioner examinations irrespective of whether a doctor is immediately available or not was viewed positively.

It was noted however that Nurses should notify both the RMO and the MHO at the start of the holding power to facilitate attendance at the earliest opportunity.

**Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions?**

**Comment**

These proposals were viewed positively although it was felt that further guidance would be required on the definition of specified circumstances
Question 10: Do you agree with the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why. Comment
These proposals were welcomed although it was noted that there is a lack of relevant Mental Health Act materials in other languages.

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why. Comment
The removal of the restriction for the convener of the tribunal panel to be either the tribunal president or to be selected from the Shrieval panel was viewed positively in relation to cost efficiencies and increased flexibility of scheduling hearings.

Whilst this was viewed as good practice, concern was noted around the notification to Scottish Ministers of the making of a CTO application to follow a TTD, although it was generally conceded that this was more related to any potential intervention in the hearing process which could be dealt with within the Code of Practice.

The proposal to involve the MHO in the process for making a decision under section 136, TTD was viewed positively. Mental Welfare Commission figures suggest that there were 45 of these orders in the last financial year.

Operationally local authorities would require to put in place arrangements for the responsible authority to respond to the request in relation to prisoners whose ordinary residence was in their area with the hosting local authority providing a backup MHO service for those instances where the relevant local authority MHO is unable to respond within the specified timeframes.

The proposal to extend cross border transfer to include patients from outwith the UK from other EU member states was welcomed but would require further guidance.

Question 12: Do you have any comments on any of the proposed amendments relating to the "making and effect of orders" provisions? Comment
The proposal to add the word ‘remanded’ before custody to ensure references to ‘custody’ do not include police custody was welcomed.

The proposal to bring in line the calculation of the period of detentions from day of relevant event (MH) to the day after the relevant event in line with courts for AOs, TOs, ICOs and HDs will no doubt cause confusion for both RMOs and MHOs in its early implementation but may assist in court processes.

The proposal to extend an AO for up to 21 days following the initial 28 day period to enable better flexibility for assessment purposes rather than the
current 7 days was welcomed although due to the impact on an individual's freedom should require due justification.

Question 13: Do you have any comments on the proposed amendments to the "variation of certain orders" provisions? Comment
The proposed amendments were welcomed.

Question 14: Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be. Comment
The proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders is welcomed although will require clear guidance on definitions, entry and exit points, roles, responsibilities, boundaries, accountabilities and any inconsistencies in applicability addressed.

There are questions around whether this should be restricted to CORO patients only and particular offences of a serious nature which will require further clarity and guidance.

There are also questions around transition points from the criminal procedures elements of the Mental Health Act to the civil elements such as TTDs to CTOs and how this is dealt with for both patient and victim or their relatives.

Question 15: Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer. Comment
The proposal that victims should be prevented from making representation under the existing Mental Health legislation once they have the right to do so under the proposed Victim Notification Scheme is problematic and inconsistent for example, the RMO would notify victims when orders are being suspended but not when being revoked.

From the limited proposals noted in the bill it is difficult to fully ascertain the potential ramifications of extending the scheme but it was agreed in principle that the extension of the scheme was welcomed.

Question 16: Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to Mentally Disordered Offenders? If not, please explain why not and please outline what your preferred approach would be. Comment
There was general consensus that this is both a complicated and complex area involving the balancing of the rights of the patient and the rights of the victim. It was noted that the proposal may result in those with a learning disability or lacking in capacity being treated less favourably which was of concern.

More detailed proposals and notional guidance on how the VNS may operate in practice is required to facilitate discussion in the first instance.
Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics". Comments:
It was generally agreed that the proposals were positive in most areas although there was concern that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible. Comments:
Please refer to the introduction section of this report.

The Bill proposes further increases to the duties and responsibilities of our Mental Health Officer Services which equally need to be viewed in the broader context of our national MHO workforce and workload capacity.

Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Not withstanding the year on year increase in MHO workload demand, which is not matched by any increase in the existing MHO infrastructure, the additional roles and responsibilities for MHOs contained within the proposals will incur further significant costs to local authorities which needs to be considered by the Scottish Government

ADSW Mental Health Sub Group
August 2014
East Renfrewshire Community Health and Care Partnership

Mental Health (Scotland) Bill

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

East Renfrewshire CHCP has welcomed the opportunity to discuss and comment on the proposed changes to the Mental Health Act as introduced in the Mental Health (Scotland) Bill. We have recognised the need for a review and changes to the Act since its implementation on October 2005, whilst also acknowledging that the Mental Health (Care and Treatment) (Scotland) Act 2003 has greatly changed the way in which law and practice in mental health has been delivered to the benefit of the service users.

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

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

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) (Scotland) Act 2003 as set out in Part 1 of the Bill.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
We would agree in principle with extending the Criminal Justice victim notification scheme to include victims or the relatives of mentally disordered offenders. There would be concern if this were to include those service users subject to a compulsion order, who may have committed only a minor offence and this should be discussed on a case to case basis.

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

5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
No other pressing issues identified.

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

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

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

East Renfrewshire Community Health and Care Partnership
August 2014
North Ayrshire Health and Social Care Partnership

**Mental Health (Scotland) Bill**

**General Points**
North Ayrshire Health and Social Care Partnership welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill and we support the general policy direction set by the Bill.

The Bill proposes further increases to the existing duties and responsibilities of our local Mental Health Officer service which needs to be viewed in the broader context of the national MHO workforce and workload capacity. Whilst many of the proposed duties and responsibilities further promote good practice by strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder, there is an increasingly critical requirement to review national and local MHO workforces and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas. Without such a review, delivery of the proposals will be threatened.

**Comments on Part 1**

**Advance Statements**
We welcome the proposed amendments to the Advance Statement. We believe that there are some practical issues that would be worthwhile addressing at this point. We would ask that you consider developing a standard format for the Advance Statement and clarify exactly where within NHS Boards the form should be submitted and stored. The form could usefully include advice that it needs to be submitted within a specified timeframe to be effective and will require to be reviewed annually or where there are a change of circumstances. We would ask that you address the need (potentially) for 24 hour accessibility to the Advance Statement for those parties who might require to view it (RMOs, nursing staff and MHOs for example). We support the introduction of an opt-out system. We also support the introduction of the named person’s consent to undertaking the role of supporting someone to complete an Advance Statement. We would also suggest that issues around the person’s capacity to complete an Advance Statement are addressed within the Code of Practice.

**Suspension of Detention Section 127**
Whilst we acknowledge the difficulties experienced to date with suspension of detention measures, particularly immediately following the Act’s inception, we do not agree with the proposal in Section 9 to remove the 9 month restriction in any 12 month period. We believe that this is not a positive step in relation to the principles of the Act and it may in fact replicate the issues identified with Section 18 Leave of Absence under the 1984 Act. We would suggest that you consider an upper limit of 6 months in any 12 month period, incorporating instead a disregard for short periods (for example, one overnight, one weekend etc.) in the total period. We have a concern that RMOs are
potentially able to add more restrictive conditions during periods of Suspension of Detention than those originally approved by the Tribunal.

Proposed Section 87A
We acknowledge that the proposals to amend section 87 are good practice, however, we have major concerns about the impact of the additional workload for our MHO service. The proposed changes to section 87 would require a large number of additional MHO reports in North Ayrshire which we would currently find prohibitive for our small service. We would suggest that you consider whether the requirement for an MHO report is limited to extensions but not variations of the order or alternatively limited to those orders where there is likely to be a hearing (for example, where any issue related to diagnosis is raised or the MHO disagrees with the proposed action etc.). The need for the MHO report needs to be proportionate to the issues surrounding the order. We believe that the introduction of a recommended form for the MHO report would be of benefit in this area together with clarification around the role of the SCR, Section 57c and Section 59. We have concerns around the proposal to place further administrative duties around notification on MHOs which may sit better within the MHTS. We would seek clarification from you as to whether these proposals would also apply to Compulsion Orders.

Notifications
We support the notification of the granting of a CTO to the various parties, but have concerns around the circulation of the full papers, particularly if the default Named Person role is retained. We fully support the proposal to place a duty on the MHO to notify the Mental Welfare Commission when making an application for a Removal Order to enable the Mental Welfare Commission to consider whether it should make a Section 295 recall or variation of the Removal Order.

Nurses Holding Powers
We support the proposal to extend nurses holding power from 2 to 3 hours to enable an informal patient to be detained for the purposes of enabling medical practitioner examinations irrespective of whether a doctor is immediately available or not. We would note that nurses should notify both the RMO and the MHO at the start of the holding power to facilitate attendance at the earliest opportunity and request that this is built into the Bill or statutory code of practice.

Transfer for Treatment Direction
We support the proposal to involve the MHO in the process for making a decision under Section 136, TTD. Operationally we will need to put arrangements in place to respond to these requests in relation to prisoners whose ordinary residence is in North Ayrshire with the hosting local authority providing a backup MHO service for those instances where our MHO service is unable to respond within the specified timeframes. Further guidance on this would be welcome. We also support the proposal to extend cross border transfer to include patients from outwith the UK from other EU member states but again we would request further guidance.
Comments on Part 2
We have no additional comments on the provisions in Part 2 of the Bill on criminal cases.

Comments on Part 3
We welcome the proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders although would request clear guidance on how to consistently apply the scheme. In particular, we have remaining questions about whether notification should be restricted to CORO patients only and particular offences of a serious nature and request further clarity and guidance. We would highlight that the proposal that victims should be prevented from making representation under the existing Mental Health legislation once they have the right to do so under the proposed Victim Notification Scheme is problematic and inconsistent for example, the RMO would notify victims when orders are being suspended but not when being revoked. We acknowledge that this is both a complicated and complex area involving the balancing of the rights of the patient and the rights of the victim. We would note that the proposal may result in those with a learning disability or lacking in capacity being treated less favourably and would be concerned about this – we would recommend close monitoring and evaluation of the scheme in order to address this potential source of discrimination. Overall we would request more detailed proposals and draft guidance on how the scheme could operate in practice in order to facilitate national and local discussion in the first instance. This guidance should also cross reference the management of this requirement under MAPPA when relevant.

General Comments on the Bill
Whilst we welcome many of the proposed new duties and responsibilities in the interests of good practice (and being consistent within the principles of the Act) we would highlight that there is an increasingly urgent requirement to review the national and local MHO workforce. The Bill proposes further increases to the duties and responsibilities of our MHO service which needs to be viewed in the broader context of the MHO workforce and workload capacity. Notwithstanding the year on year increase in MHO workload demand, which is not matched by any increase in the existing MHO infrastructure, the additional roles and responsibilities for MHOs/RMO’s contained within the proposals will incur further costs to the North Ayrshire Health and Social Care Partnership and requires to be further considered and addressed by the Scottish Government.

North Ayrshire Health and Social Care Partnership
Legal Services Agency Mental Health Representation Project

Mental Health (Scotland) Bill

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

We agree with the general policy direction set by the Bill which on the whole seeks to promote the approach adopted by the 2003 Act to ensure that law and practice relating to mental health is underpinned by a set of principles, particularly minimum restriction of an individual’s liberty, maximum benefit and involvement of service users in their care and treatment.

We also agree with the policy objectives of the Bill to improve the efficiency and effectiveness of the mental health system in Scotland, to ensure that patients have sufficient time to prepare for hearings, even those requiring to be held at short notice, and that the Tribunal has all the required information to make its decision.

We are concerned, however, that the proposed changes contained in the Bill, whilst in theory may appear to promote the policy objectives, will not achieve the policy objectives in practice. Furthermore, we are concerned that some of the changes proposed may be an unnecessary infringement of individuals’ rights and freedoms.

We welcome the policy objective to extend the system of review of conditions of excessive security with proposals to provide an effective right of appeal against detention in conditions of excessive security for patients outwith the State Hospital, to promote the principle of least restriction. We do however look forward to being consulted in relation to relevant draft Regulations.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Procedure for Compulsory Treatment
S1: Measures until Application is Determined
We are very concerned about the proposal to increase the five working day period to ten working days in s1 of the Bill.

We are also concerned that this proposal did not feature in the draft Bill consultation and in our view there has not been a full, considered consultation on this point. We have significant concerns regarding this proposal and believe that it may not be ECHR compliant. We note that there are provisions for an individual to challenge a Short Term Detention Certificate under s50 of 2003 Act however in practice where an individual lacks capacity or lacks the motivation, to do so, the proposal could essentially result in individuals being detained in excess of 40 days without any form of independent review by a judicial body.
We noted that a number of respondents, in particular the Mental Welfare Commission for Scotland, commented in their responses to the draft Bill consultation that they were pleased to see that this aspect of the McManus review had not been included in the draft Bill consultation and we are therefore surprised that it has been included at this stage.

In our view not only are the proposals potentially not ECHR compliant but they are also unnecessary. Whilst the McManus Report indicated that during their consultations there were concerns about the large number of cases which required multiple hearings, it has not been evidenced that this remains an issue. The Mental Health Tribunal for Scotland has reported a decrease in multiple hearings. A number of factors have occurred since the McManus Report which may have contributed to this decrease.

Firstly, it is expected that the Code of Conduct for Mental Health Tribunal work produced by the Law Society of Scotland will have assisted in reducing the number of multiple hearings. Secondly, there has been an increase in solicitors practicing mental health law throughout Scotland since the McManus report was produced which has assisted in accessing solicitors in areas outside the Central Belt within the tight timescales for Mental Health Tribunals and it is reasonable to expect that this too will have reduced the number of multiple hearings required. Thirdly, since the McManus report there has been a greater use of technology with individuals, particularly medical professionals giving evidence by phone which will have reduced the number of multiple hearings. The Mental Health Tribunal is also now piloting video conferencing that may further help reduce the need for multiple hearings particularly in rural locations. Fourthly, many Mental Health Officers will now also include details of the solicitor acting in the CTO application where this is known which has also assisted as this gives the solicitor acting more advance notice of the hearing.

Furthermore, in our view, extending the five day to ten days would not necessarily resolve the issue of multiple hearings. We would submit that in many cases it may be difficult to fully prepare for a Tribunal hearing where a patient is opposed to a Compulsory Treatment Order in 10 working days. The steps that require to be taken include meeting with the patient, obtaining papers from the Tribunal, considering these and discussing them with the patient, thereafter carrying out enquiries that can include obtaining an independent psychiatric report. This requires the solicitor to identify an available expert, have the expert examine the patient and prepare a written report which thereafter requires to be fully considered and discussed with the patient. This does not account for inevitable delays that will still exist outwith the solicitors control such as late service of papers, patients not seeking legal representation until close to the hearing (which in our experience is not uncommon), and availability of suitably qualified experts.
We would submit that if the issue of multiple hearings still exists to the same extent as it did when the McManus Report was produced, (which we do not consider to be the case), other areas could be addressed which would potentially improve the experience of the Tribunal process without further infringement on the patient’s rights. For instance, one of the main issues expressed during the consultation for the McManus Report was panels at continued hearings having different panel members from those at the first hearing which then requires evidence previously heard by the Tribunal to be repeated. This could be addressed by other means through the Tribunal administration.

The proposal to ensure that the proposed extension to ten working days will not increase the continuous period of detention of 56 days provided by s65(3) or the six month period in s64 although well meaning would result in considerable confusion, and would not be sufficient to offset the infringement of human rights caused by the extension of the five day period. We believe that the proposal would lead to confusion and lack of certainty in establishing the start date and end date of the Compulsory Treatment Order. There is also in our view a real risk that this in itself could lead to unnecessary delays in the Tribunal process and hearings have to be adjourned which is clearly not the policy objective of the Bill.

Orders Regarding Level of Security
Section 11 and 12: Orders relating to non-state hospitals
We welcome the proposal to amend legislation to allow movement of an individual within the same hospital as we agree that this more accurately reflects the current forensic estate.

S12 Qualifying Non-State Hospitals and Units
We note that s272A provides that ‘qualifying hospitals’ should be provided for by Regulations but note that the Policy Memorandum indicates that there will be no provision for patients detained in low secure setting and yet the Supreme Court judgement in RM v Scottish Ministers relates to exactly this. In our response to the draft Bill consultation we agreed that it was appropriate for ‘qualifying hospitals’ to be medium secure facilities given the current landscape of the secure estate.

Time for appeal referral or disposal
S15: Appeal on Hospital Transfer
We note the proposed change to bring the appeal period down from 12 weeks to 28 days. We do not support this change and do not agree with the policy objective to bring the Act into line with similar appeals in other parts of the Act in this regard. Our view is that there are specific transfer provisions for transfer to the State Hospital and these serve a very distinct purpose from other transfer provisions found in s125 or s219 of the Act. Section 126 and section 220 relate to the State Hospital alone. There are other instances of special provisions throughout the 2003 Act in respect of the State Hospital, for example
the excessive security provisions, and we would submit that it is appropriate that State Hospital cases are treated differently.

The first consideration is that generally individuals are admitted to the State Hospital when they are very unwell, particularly so where they have been transferred from another hospital or prison. Such individuals may at the time of transfer lack capacity to instruct a solicitor in relation to a potential appeal against their transfer, or may not realise initially the implications of their transfer to the State Hospital. In these circumstances, it would disadvantage individuals transferred to the State Hospital to reduce the 12 week period to 28 days.

Secondly, the comments in the Policy document that all that is required to initiate an appeal under both s219 and 220 is to submit an appeal in writing with a brief statement of reasons does not have regard to good professional practice. It is appropriate before advising a client to appeal against their transfer to make enquiries and provide them with advice regarding prospects of success. In the context of the State Hospital this is not always possible within the timescale of 28 days given the location of the hospital and the difficulty in identifying appropriately qualified doctors to complete independent psychiatric reports for patients at the State Hospital. Often appropriately qualified psychiatrists who are willing and able to do such reports have other heavy work commitments. There are also special security measures at the State Hospital which further impinge on their ability to complete reports in limited time scales. We would therefore submit that 28 days from the date of transfer is not sufficient time to allow patients to appeal to the Tribunal against the transfer.

Finally, in practice we do not agree that the current 12 week period should cause any significant problems in people receiving appropriate treatment. We would point out that there are already provisions contained in the 2003 Act to allow transfers to go ahead before the determination of an appeal in urgent situations.

**S19: Consent to being a Named Person**
We continue to have concerns regarding the provisions of requiring consent to be given to being appointed as a Named Person contained within s19. Whilst we understand the rationale behind the need for an individual to consent to acting as a Named Person we are concerned that the focus should be on the individual making a nomination or declaration. We would suggest that the onus should be on the individual nominated to make a declaration where they do not wish to accept the nomination of Named Person. To have a situation where someone is not a Named Person until they provide written consent to acting as Named Person is fraught with difficulties, could potentially delay the Tribunal process and result in an individual being deprived of the additional safeguard of a Named Person.
3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

4. We do not have any further comments to make on Part 2 of the Bill beyond those we made in our response to the draft Bill consultation.

5. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

We do not have any further comments to make on Part 3 of the Bill beyond those we made in our response to the draft Bill consultation.

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

In relation to Named Persons the McManus Report recommended that if a service user who has not appointed a named person is at the relevant time unable to appoint a named person and has not signed an advance statement or other document expressing a wish not to have a named person, anyone with an interest should be able to apply to the tribunal to be appointed as a named person. The Bill does not provide for this as it seeks to remove the provision of Section 256(1) (a). Whilst we fully adhere to the right of a patient to have autonomy there are situations which could arise where there is no Named Person but it would be appropriate for an individual to be appointed to act as the Named Person to promote the interests of the patient.

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

We note that there is no provision for a register of Named Persons. We believe there may be benefit in holding a register of Named Persons. We believe this would be helpful to practitioners and the Mental Health Tribunal Service alike.

We note that there are no proposals for the addition of Curator Ad Litem as a party who can appeal to the Sheriff Principal in terms of s320 and appeal to the Court of Session in terms of s322 of the Mental Health (Care and Treatment) (Scotland) Act 2003. We would welcome such proposals.

We also note that there are no proposals for the inclusion of recorded matters in respect of orders under the Criminal Procedure (Scotland) Act 1995. We believe that the Tribunal should be able to make recorded matters in appropriate cases. We would welcome such proposals.
Finally we note that there is no provision to allow for interim CTO to be made where an application for a CTO is being made for someone on a HD or TTD which is due to expire. We would welcome such a proposal.

Information about Legal Services Agency’s Mental Health Representation Projects
Legal Services Agency (LSA), Scotland’s National Law Centre, is a registered charity and public service organisation. Its objectives are to assist disadvantaged persons in Scotland by undertaking casework to a high volume and quality, by conducting legal research and by providing legal education and training.

LSA runs two specialist Mental Health Legal Representation Projects comprising of eight solicitors and one Solicitor Advocate based in Glasgow and Edinburgh. The Projects provide specialist legal advice, assistance and representation to people with mental health problems, acquired brain injury and dementia, their families and carers in these areas. The Projects, generally, aim to provide a holistic legal advice, assistance and representation service on all aspects of civil law relevant to the needs of their client group specifically in the areas of mental health and incapacity law and where there is an interface with other aspects of civil law the Projects look to provide the service in those areas for example family law, reparation, debt, housing, community care etc. The primary areas of activity of the Projects are, however, in the areas of detention, compulsory treatment and guardianship.

The Projects are widely regarded as two of Scotland’s main providers of legal advice, assistance and representation in the field of Mental Health and Incapacity Law.

We would welcome the opportunity to give oral evidence to the Committee.

Legal Services Agency Mental Health Representation Project
August 2014
Autism Rights

Mental Health (Scotland) Bill

Autism Rights has submitted responses to a number of relevant consultations, including the Scottish Government's consultation on the Draft Mental Health Bill and their Mental Health Strategy. We are the only autism organisation who has submitted responses to any of these consultations. Given that current mental health legislation creates serious human rights issues for people who are on the autistic spectrum, we think that the Health and Sport Committee of the Scottish Parliament should pay particular attention to our written evidence and would urge the committee to invite us to give oral evidence to them. It is clear that the Mental Health Act will not be reviewed again in the near future, and the Scottish Parliament needs to take this opportunity to enquire into these issues. We hope to submit the appropriate Amendments to the Bill.

We would also ask the committee to take the opportunity to invite Professor David Healy to give oral evidence. Professor Healy is an internationally respected psychiatrist with expertise in the side effects of pharmaceutical drugs. He is an acknowledged international expert on antipsychotic, antidepressant and mood-stabilising drugs and has submitted written evidence to the committee at our request. As someone who is only too well aware of the dangers of psychotropic drugs, Professor Healy is deeply concerned at the often dismissive attitude of his fellow psychiatrists towards patients and carers who report recognised side effects of these drugs.

I have split our evidence into sections that address the questions in your Call for Evidence:

1. Do you agree with the general policy direction set by the Bill?
2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
1. Do you agree with the general policy direction set by the Bill?
We would say ‘No’. This Bill is ostensibly a tidying up exercise to address the remaining recommendations of the McManus Review of 2009, but we fail to see that this is the case. What it certainly does not do, is to address those issues that were referred to by both the Millan committee and the McManus Review as needing review – specifically the inclusion of people with Learning Disabilities and Autistic Spectrum Disorders (ASD) within the provisions of the Act.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?
We have no further comment to make, beyond what we have already stated in our response to the Scottish Government’s consultation on the Draft Bill.

3. Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
We have no further comment to make, beyond what we have already stated in our response to the Scottish Government’s consultation on the Draft Bill.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?
We have no further comment to make, beyond what we have already stated in our response to the Scottish Government’s consultation on the Draft Bill.

5. Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.
See response to Question 1 and see quotation below from the McManus Review – the italics are my emphasis.

http://www.scotland.gov.uk/Publications/2009/08/07143830/0
- Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report (McManus Review)
http://www.scotland.gov.uk/Publications/2009/08/07143830/7
Chapter Seven
Other Issues
`In the course of our consultation, we received extensive submissions from several bodies, especially the Mental Welfare Commission, the Royal Colleges, carers and users groups and the Tribunal service. Many of the points raised are covered in the substantive text above. However, some of the points did not fall neatly within our headings and we propose, in this chapter, to address the outstanding points with which the Review Group is in agreement.`

`Learning disability and the law
Persons with learning disability complained to the Review Group about the inclusion of learning disability in the Act. We understand the Millan Committee recommended that this should be reviewed and that the then Government accepted this in its policy paper “Reviewing Mental Health..."`
Law”. Now, eight years on from Millan, the Review Group feels that it is time this was done.

It is indeed `time this was done.`

Autism, or Autistic Spectrum Disorder, is not directly mentioned within the Mental Health Act, but is most definitely incorporated within the definition of `mental disorder`, by being classed as a `learning disability, however caused or manifested`ii Autism Rights has been campaigning for more than 2 years for the Act to be reviewed, to take people with ASD out of the provisions of the Act. The current incorporation means that people with ASD, irrespective of their mental health status, are included in the provisions of the Act. This fact has actually been denied by the Scottish Government's civil servants, but the wording of the Act is very clear and its operation is confirmed by the Millan Committee's report, by the McManus Review and by the Mental Welfare Commission's Learning Disability Census. The latest census puts the percentage of men with Learning Disabilities who are being compulsorily `treated` within the mental health system who do not have a co-diagnosis of mental illness at a staggering 42%. The MWC has explained the large discrepancy between the percentage of men with Learning Disabilities who do not have a co-diagnosis (or `co-morbidity`) of mental illness and the percentage of women in the same category (15%) mainly by the fact that the Learning Disability statistics include people with Autistic Spectrum Disorders and the male to female ratio within the ASD diagnosis of roughly 4 to 1. It should also be recognised that, on top of these figures, there is a problem of misdiagnosis and outright incompetence in ASD within the profession of psychiatry, acknowledged at least in part by the MWC's admission that some psychiatrists believe ASD to be mental illness, not a developmental disability. The experience of Autism Rights members is that autistic behaviours are almost universally interpreted by psychiatrists as symptoms of mental illness.

All of this must be placed in a wider context of issues that sustain the misconception that people with ASD are more prone to mental illness:-

1) Adult Services do not exist for people with ASD. Current access to services is either through Adult Learning Disability or Mental Health services. Many adults with ASD are directed to Mental Health services, which are geared towards the use of psychotropic drugs.

2) Psychiatrists do not recognise key autistic behaviours, at least partly because of a lack of training. The diagnosis for ASD is currently a behavioural one and there is little or no training of psychiatrists of the behavioural, let alone the medical, characteristics of ASD.

3) People with ASD suffer from the almost total absence of services that are designed to meet their special needs, even to the extent of being subject to abusive practices, and they will exhibit, quite naturally, signs of distress that are then diagnosed as mental illness.

4) There are medical illnesses that can present as mental illness, the most well-known of which is porphyria (as per `The Madness of King George`). People with ASD are known to possess immunological and metabolic disorders, some of which can result in behaviours that are misdiagnosed as mental illness.
5) It is known that, within the population as a whole, about 10% are unable to metabolise psychotropic drugs. Given the immunological and metabolic disorders experienced by people with ASD, it is clear that there is a much greater danger to people with ASD from psychotropic drugs. The associations between violence and self-harm and some anti-depressants are recognised, albeit not widely publicised. So, even the prescribing of these group of drugs to people with ASD is potentially dangerous, as it can be the beginning of a treadmill of psychotropic intervention.

6) Physical illness is often overlooked: `challenging behaviour` can often be the result of pain from medical conditions as diverse as a brain tumour, acid reflux, impacted wisdom tooth, chronic gut disorders

Once in the mental health system, it is almost impossible for someone with ASD to be free of it.

The collective situation of people with ASD in the mental health system is never investigated. As stated by the recently retired chief executive of the Mental Welfare Commission (MWC) - `We do not record or monitor ASD specifically and this not (sic) required by us under the Mental Health (Care and treatment) (Scotland) Act, 2003.`:

1. The MWC does not collate statistics on the numbers of people with ASD who are subject to compulsory treatment under the Mental Health Act
2. MWC Monitoring Reports do not monitor people with ASD, as they are not one of the `client groups` of the MWC
3. The MWC will only conduct individual investigations on people with ASD, from which lessons are supposed to be learned, but there is no evidence of their application.
4. The MWC does not hold information on the numbers of requests to investigate treatment under the Mental Health Act made by the families of people with ASD
5. The Mental Welfare Commission does not record the number of contacts made by families of people diagnosed with ASD who ask for further information or advice from it, nor does it record when contact was made during visits to services.

These statistical and informational `black holes` are further exacerbated by a more general absence of data and checks and balances in the mental health system.

6. There are no published statistics on deaths and no data for suicides within the Scottish mental health system. The MWC does not publish annual statistics on the numbers of deaths of people who are receiving compulsory treatment under the Mental Health Act, and can only give a breakdown of these statistics according to the type of order. 4 months after I made an FOI request to the MWC about deaths and other `adverse events` in the mental health system, they published a report which had retrospectively trawled for further data on these deaths. There are some very big assumptions made in this report. Even though drugs are the leading cause of death in the mental health system, there
is no acknowledgement in this report or in any other MWC publication of even the possibility of this cause of death. These statistics should be open to public scrutiny, as they represent basic measures of compliance with human rights in the mental health system. Given that deaths statistics for the penal system have been available for a number of years, this is a significant and very serious omission in Scotland's official statistics.iv

7. There are no mandatory FAIs in the mental health system (unlike the prison system)
8. The MWC does not collate statistics on any of the other notifications, such as assaults, that should be reported by healthcare staff
9. The MWC does not have the authority to conduct general inquiries
10. Decisions on which individual investigations to pursue are not based on written objective criteria
11. Formal procedures for individual investigations are based mainly on the skills and experience of MWC officers
12. Complaints about treatment within the mental health system are made to the Scottish Public Services Ombudsman, and cannot be made if legal action is to be taken. Mental Health Tribunals are, by definition, legal action.
13. Complaints about the conduct of Mental Health Tribunals can only be made to the body that runs these – the Mental Health Tribunals for Scotland (MHTS)

The MWC does not collate any information other than from those who work in the mental health system.v How can you possibly enforce compliance to guidance, regulation or law, when all the power to scrutinise this is held by those who are employed in the mental health system? When the Westminster government has decided that people with Learning Disabilities need to be moved from hospitals, where they are often kept for years at a time, there should at least be a recognition of similar problems within Scotland and a willingness to do something about it. It is not acceptable that people with Learning Disabilities and ASD make up 11% of those in mental institutions when they represent just 2 – 3% of the population and stay, on average, more than twice as long as those without a Learning Disability within these institutions. It is estimated that the average lifespan of people who are subject to mental health ‘treatment’ is 25 years less than the general population. Therefore, the average lifespan of people with Learning Disabilities and ASD within this system must be even less.

There are some pretty tortuous arguments put forward for the use of drugs to ‘treat’ autism or its supposedly ‘co-morbid’ conditions. There is no understanding, let alone investigation, of the ‘antecedents to the presentation of challenging behaviours’ observed in autism. How can you have ‘functional analysis’ of behaviour, as advised in the NICE guidelines for adults with autism, when those who are employed to care for people with autism are entirely ignorant of ASD and its associated behaviours, never mind its associated health issues?vi And how can you put in these same guidelines that physical disorders should be ruled out first when carrying out a diagnosis, when the ASD training recommended some years
ago by the Royal College of Psychiatrists is not happening or is being repudiated by individual psychiatrists who are supported in their beliefs and attitudes by Mental Health Tribunals and indeed the Mental Welfare Commission itself? vii

Treating Autism have managed to persuade NICE to change their clinical guidelines to take at least some account of ‘co-morbidities’ other than mental illness. Their excellent publication on these co-morbidities is now in its 2nd edition:-
http://treatingautism.co.uk/resources/research-science/

We do know that there is a wider inequality of healthcare for people with autism, and that also needs urgent investigation. In spite of the existence of NHS Scotland's Quality Indicators for Learning Disabilities, children with ASD in large parts of Scotland are being denied treatment for bowel disorders. As a consequence of this, they then require surgery because of faecal impaction and mega colon, the latter of which is usually a condition found in elderly people who are seriously ill. Imagine the distress that you would feel if you had such a disorder - and then imagine not being able to communicate this distress, and how a psychiatrist might interpret this.

Medical professionals should know that epilepsy and autism are closely associated – a proportion of the autistic population has epilepsy – but these problems go further than that: over 80% of people with ASD have some sort of seizure activity going on, which is often sub-clinical, and this can cause hallucinations.viii These are then improperly medicated by medical professionals who are ignorant of the problems faced by people with ASD.

There are no statistics for the proportion of people with ASD being prescribed psychotropic drugs, but the fact that, in one health board area, there are more than 1 in 5 schoolchildren being given Methylphenidate ix (Ritalin), is a very good indication that children with ASD in some Scottish health board areas may be being drugged at levels seen in the US, where it is estimated that over half (56%) of the children with ASD are prescribed at least one psychotropic drugx

As with the revelations of abuse contained in BBC Panorama's exposé of Winterbourne View hospital, the vulnerability of people with ASD, combined with the absence of parental access to these facilities, can mean that it is people with ASD who are accused of violence (which is then controlled by drugs), when they are actually the victims of assaults and other abuse.

Basic monitoring of health within mental hospitals is haphazard and inadequate – with 25% of long stay patients being found to have no record of health checks.xi The MWC and the government think that annual and 15 month health checks are adequate for people who are being forced to take some of the most toxic drugs on the market. Absolutely no account is being taken of individual tolerance of these drugs, in spite of guidance recommending psychiatrists seek specialist medical advice where this is needed.xii
Diagnosis of ‘mental disorder’ is made upon leaving compulsory treatment, not at arrival, so this is further scope for misdiagnosis of people with ASD.

The McManus review (2009) of the Mental Health Act recognised that there is a low take-up of Advance Statements, where people can set out how they wish to be treated if they become mentally ill. No such right exists for people with ASD, because they are not deemed to have capacity.xiii

Legal representation at Mental Health Tribunals is wholly inadequate: there is a paucity of appropriately qualified or experienced lawyers working in mental health law – around 20 lawyers specialise in this area of law. Just 3 legal firms in Scotland carry out three-quarters of all legal aid work for such tribunals.xiv For people with ASD, there is the added complication of their disability, which is not well understood by members of the legal profession, any more than the other professions. It has been claimed that some lawyers fail to prepare adequately prior to tribunal.xv

The only right of appeal to a tribunal decision is to go to Judicial Review, which involves a lengthy wait of many months and substantial amounts of legal aid.

**Why the Mental Health Act and system is discriminatory**

We do not see the removal of people with ASD from the provisions of the Mental Health Act as a panacea, but a first step in eradicating a historical anomaly in which people with ASD were deposited in mental hospitals – indeed it was not until the 1974 Education Act that children with ASD were given the right to be educated. The mental health system should not be the ‘default setting’ for the ‘care’ of people who have an Autistic Spectrum Disorder – and the Royal College of Psychiatrists recognises that this is happening.xvi

People who are addicted to drugs or alcohol are specifically not included within the provisions of the Act. This is entirely discriminatory towards people with mental disabilities, as it is overwhelmingly the case that ‘substance abusers’ pose the biggest threat of serious violence towards the public.xvii

Autism Rights is calling for these actions to be taken:-

- The removal of people with Learning Disabilities and Autistic Spectrum Disorders (ASD) from the provisions of the Mental Health Act.
- Equality of healthcare for people with autism.
- An inquiry into the treatment of all people with ASD within the mental health system.

Given the number of Autism Rights’ submissions to consultations on mental health legislation and policy, we can draw on a significant amount of research and the personal experience and expertise of our members. I’ve appended summaries of some relevant news articles, to give further context to the
arguments we make.

6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?
Yes – these News articles are relevant to the Mental Health Bill

- Urgent review as nearly half of health boards ignore pharma disclosure rule
Paul Hutcheon
Investigations Editor
Sunday 18 May 2014
A Government investigation has been launched after nearly 50% of health boards ignored NHS guidance requiring GPs to register their financial interests with the pharmaceutical industry.
Dr Peter Gordon, a consultant psychiatrist at NHS Forth Valley, says it is disappointing that so few NHS boards have a register of interest
Six out of 14 boards, including Greater Glasgow, failed to record if doctors are being paid by drug companies. Civil servants have launched an urgent review of the oversight. Several exposes have revealed the financial links between doctors and Big Pharma.

- Warning over patients too afraid to complain
Thursday 1 May 2014
PATIENTS and relatives are afraid to complain about NHS treatment in Scotland for fear it will result in repercussions, warns an official report. The Scottish Health Council report recommends that health boards be more proactive in gathering and using feedback to improve health services. The report, Listening and Learning, finds that NHS Scotland has made progress since the introduction of the Patient Rights (Scotland) Act 2011. However, it urges health boards to remove the "fear factor" around complaining, warning that one of the main barriers highlighted by the public to giving feedback or making a complaint is fear of repercussions for their own or relatives' treatment.

- Depression pill bill goes up by £10m in a year
Jody Harrison
Reporter
Thursday 3 July 2014
THE cost of prescribing antidepressants has risen to £40 million, an increase of more than £10m on the year before.
New figures have revealed that soaring numbers of the drugs were dispensed during the last 12 months, with nearly 5.5 million items given to patients in 2013/14, up by 275,000 compared to the previous year.
Research by the Scottish Conservatives found the total cost to the taxpayer of antidepressants is now more than £40 million, compared to £29.5 million in
2012/13.

- Deaths due to alcohol and prescription drug cocktails
Thursday, January 23, 2014 - 12:13 PM
The number of deaths due to alcohol and anxiety-treatment-drugs are increasing.
Death as a result of poisoning from a cocktail of both substances soared by 28% between 2010 and 2011.
The Health Research Boards National Drug index found the most commonly used substances were alcohol, methadone, anti-depressants and Benzodiazepines.

- 12:55pm, Tue 29 Apr 2014 Anti-psychotic drugs 'given to learning disabilities patients'
Anti-psychotics given to 68.3% with learning disabilities
Last updated Tue 29 Apr 2014
SEE ALSO
http://www.hscic.gov.uk/mentalhealth
http://www.hscic.gov.uk/article/2742/Mental-Health-Bulletin---new-analysis-for-201112

http://www.huffingtonpost.com/2013/10/21/medication-autism_n_4136870.html
- Catherine Pearson
Catherine.Pearson@huffingtonpost.com
High Psychotropic Medication Rates For Children With Autism, Study Shows
Posted: 10/21/2013 1:51 pm EDT
http://pediatrics.aappublications.org/content/early/2013/10/16/peds.2012-3774.abstract
- * Article
Psychotropic Medication Use and Polypharmacy in Children With Autism Spectrum Disorders

Autism Rights
August 2014

SOME INFORMATION ABOUT AUTISM RIGHTS

Autism Rights is established to research, lobby and campaign for the human rights of people with Autistic Spectrum Disorders (ASDs) in Scotland, in particular to campaign for the provision of appropriate health treatment, education, social welfare and justice.
The founding members of Autism Rights are all parents and carers of people with an ASD and were long-standing members of the now defunct Cross-Party Group on Autistic Spectrum Disorders of the Scottish Parliament.

We are the only national service user-led group in Scotland campaigning for the rights of people with an Autistic Spectrum Disorder and their families. Full membership of Autism Rights is open to people with an ASD resident in Scotland and parents and non-professional carers of people with an ASD who support our aims and objectives. We do not provide services for people with ASD, so we can speak up without fear of the loss of funding for services.

One parent summed up our feelings about `the system` - "It just seems to me that, over the years, we have spent more and more money employing more and more people to stop our children getting the things they need."

'EQUAL RIGHTS - NOT ENDLESS FIGHTS'
www.autismrights.org.uk

________________________________________________________________________
i
Autism Rights' documentation on mental health

The Scottish Human Rights Commission's Scottish National Action Plan on Human Rights
- see pages 190-220

The Mental Health (Care and Treatment)(Scotland) Act 2003 Consultation in relation to section 268 appeals against conditions of excessive security

Consultation on proposed Amendment to Rule 58 of the Mental Health Act

Mental Health Strategy

MHB 106 - draft Mental Health (Scotland) Bill
http://www.scotland.gov.uk/Publications/2014/04/7902/0
http://www.scotland.gov.uk/Publications/2014/04/7902/downloads#res448698

We also made 2 submissions to Petition PE01494: Mental Health
Legislation (which called on the Scottish Parliament to urge the Scottish Government to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 to ensure that it is compatible with the European Convention on Human Rights):

http://www.scottish.parliament.uk/GettingInvolved/Petitions/mentalhealthlegislation

I gave a presentation in February 2013 to the Scottish Parliament's Cross Party Group on Human Rights, entitled ‘Should people with Learning Disabilities and Autism be included in the provisions of the Mental Health Act’? The fully referenced version of this presentation formed part of the response that I submitted on behalf of Autism Rights to the Scottish Human Rights Commission’s ‘Scottish National Action Plan’ (SNAP) on Human Rights (see above for weblink). These 3 documents are attached to the email that accompanies our Written Evidence to the committee.

The Scottish Human Rights Commission included a number of the arguments made by Autism Rights in their Participation Report, especially in their section on mental health:-


- Mental Health (Care and Treatment) (Scotland) Act 2003

328 Meaning of "mental disorder" (1) Subject to subsection (2) below, in this Act "mental disorder" means any-

(a) mental illness;
(b) personality disorder; or
(c) learning disability,

however caused or manifested; and cognate expressions shall be construed accordingly.

Deaths
Compulsory Treatment Order: 43 Community Compulsory Treatment Order: 20
Emergency Detention: 2 Interim Compulsory Treatment Order: 2
Short Term Detention Certificate 11
Total = 78

My FOI revealed that there were 78 deaths over the past year in the Scottish mental health system. This compares to 98 deaths in England over the same period:-


and 97 Deaths over a 5 year period in Scottish Prison Custody:-
My recent FOI to Police Scotland confirms that they do not hold, nor are they required to hold, any information on deaths or injuries to people who are the subject of police restraint while receiving compulsory treatment under the Mental Health Act:

https://www.whatdotheyknow.com/request/police_restraint_of_people_who_a/new

This is spite of the fact that almost half of those who die in police custody in England are being treated in the mental health system.

Another activist's FOI discovered that health boards are not required to collate data on restraints of patients within the mental health system. This is in contrast to the Westminster government's decision to ban face-down restraints, after their statistics revealed that 40,000 of these type of restraint, which are acknowledged to be risky, were carried out in just one year in England's mental institutions.

http://www.whatdotheyknow.com/user/pwhite

Ministers will consider a ban on the use of face-down restraint in English mental health hospitals after new figures that show nearly 40,000 incidents of physical restraint were recorded in just one year.

Quite how Scottish psychiatrists are going to abide by these guidelines, we don't know – they state that psychotropic drugs should be tried for 3-4 weeks, and ‘if there is no indication of a clinically important response’, that they should be discontinued after 6 weeks. The people with ASD who are currently under CTOs who are known to us have been forced to take these drugs for many years.

PARLIAMENTARY QUESTIONS ON AUTISM TRAINING
Question S2W-26126: Rosemary Byrne, South of Scotland, Scottish Socialist Party, Date Lodged: 22/05/2006
To ask the Scottish Executive what the costs were of providing training in the treatment of autism in each year from 1999 to 2005, broken down by NHS board.

Answered by Lewis Macdonald (01/06/2006): There are a range of therapies and interventions for managing autism spectrum disorders and the SIGN guideline currently being developed will contain recommendations for effective interventions based on current evidence.

Information about the costs of training in this range of interventions is not held centrally.

Current Status: Answered by Lewis Macdonald on 01/06/2006

Question S2W-26127: Rosemary Byrne, South of Scotland, Scottish Socialist Party, Date Lodged: 22/05/2006
To ask the Scottish Executive what the costs were of providing training in the diagnosis of autism in each year from 1999 to 2005, broken down by NHS board.

Answered by Lewis Macdonald (01/06/2006): Information about the costs of training in the diagnosis of autism is not held centrally.

The Scottish Executive is supporting four training pilot projects in the use of diagnostic tools to develop expertise in diagnosis across a wider range of professionals.

Current Status: Answered by Lewis Macdonald on 01/06/2006

http://psychoticdisorders.wordpress.com/
- Styrene and toluene can cause apparent ‘mental illness’

Schizophrenia-like psychosis and epilepsy: the status of the association.
Sachdev P.
Neuropsychiatric Institute, Prince Henry Hospital and School of Psychiatry, University of New South Wales, Sydney, Australia.

ix Methylphenidate can, as with SSRIs, create psychosis – which is then
‘treated’ with antipsychotic drugs.

A National Needs Assessment Report on Child Mental Health in Scotland pointed out that there was a steep rise in the numbers of children with ADHD and ASD suffering from mental health problems. This is undoubtedly caused by poor service provision, but also by the use of psychotropic drugs. There is also a basic problem with identifying mental illness in the absence of knowledge of autistic spectrum disorders and their attendant behaviours.

The quotes below, from this MWC report, give a clear indication of the incompetent and wholly inadequate monitoring of physical health within the Scottish mental health system:-

`A record of physical health checks, as required in „Delivering for Mental Health“, was absent in around 25% of case files examined.`

`We expect Individuals who are in hospital for lengthy periods should have physical health checks on at least an annual basis.`

`The Scottish Government”s “Delivering for Mental Health” (2006) requires, where possible and appropriate, that every individual with severe and enduring mental ill-ness has a physical health assessment at least once every 15 months.`

`Acting on abnormal physical findings
Psychiatrists are medically trained doctors. Some remain highly involved in physical healthcare throughout their careers and other specialise in areas where physical assessments are performed less frequently. All prescribers must remain competent to detect and minimise physical consequences of prescribed drugs. However, not all psychiatrists will feel competent to interpret abnormal tests (such as abnormal glucose measurement) and to manage them. Liaison with colleagues from primary and secondary care is essential when results of physical assessments fall beyond an individual's level of competence.`

One of the founding members of Autism Rights was forced to seek refuge
in Spain, after her son indicated that he could not continue to live under the restrictions imposed upon him by his CTO and the attitudes of mental health practitioners towards him. His parents have paid for many thousands of pounds of medical tests over a number of years which have shown that he has some apparently rare medical conditions which mean he presents as mentally ill. Although these tests have been performed by reputable medical laboratories under the direction of internationally renowned doctors, his health board refuse to conduct their own tests to check these results. The original press article appeared in the 30th September edition of `The Sunday Post`. 

http://www.paisleydailyexpress.co.uk/renfrewshire-news/2012/10/04/mum-forced-to-flee-with-autisitic-son-calls-for-inquiry-into-his-treatment-87085-31961612/
- Mum forced to flee with autistic son calls for inquiry into his treatment Oct 4 2012 by Chris Clements, Paisley Daily Express

- * By Heather Greenaway * 1 Oct 2012

- MONDAY 1 OCTOBER 2012
 Autistic son and mother flee UK

- Gran fled to save son’s life
 By BEN ARCHIBALD
 Published: 01st October 2012

There is an inconsistent and lax approach to capacity within the mental health system, as this MWC report on long stay patients illustrates:

http://www.mwcscot.org.uk/publications/visit-monitoring-reports/
- Left Behind 1st January 2012
  `However, 34% of individuals, for whom it would have been appropriate, did not have an assessment of their capacity recorded. In some wards staff said it was not an issue, the staff member did not know or there was no system in place to record this.`

http://www.heraldscotland.com/news/health/cuts-spur-fears-for-mental-health-tribunals-1.1085548  Link no longer active
- Cuts spur fears for mental health tribunals
 Wednesday 16 February 2011

http://www.mhtscotland.gov.uk/mhts/News/News
- Law Society for Scotland - Code of Conduct for mental health tribunal work (28 September 2012)
The Law Society of Scotland by way of its Mental Health and Disability Sub-Committee, supported by its Professional Practice Committee, has published a new code of conduct for those solicitors conducting mental health tribunal work. The Code of Conduct was developed following a number of concerns from stakeholders in this field (including the Mental Welfare Commission, the Scottish Independent Advocacy Alliance and the Scottish Legal Aid Board) and to provide support and guidance to the profession.

http://www.rcpsych.ac.uk/publications/collegereports/cr/cr136.aspx
- CR136. Psychiatric services for adolescents and adults with Asperger syndrome and other autistic-spectrum disorders

http://www.guardian.co.uk/society/2010/sep/06/substance-abuse-mental-illness-crimes?INTCMP=SRCH
- Substance abuse, not mental illness, causes violent crime
  Study finds people with drink or drug addictions have similar rates of violent crimes whether or not they have a mental illness
  Randeep Ramesh, social affairs editor guardian.co.uk, Monday 6 September 2010

- Mentally ill not more violent, says study
  By Jeremy Laurance, Health Editor Tuesday, 7 September 2010
  People with mental illness are no more likely to commit violent crimes than ordinary members of the public – unless they have abused drink or drugs, researchers say.
  Substance abuse is the chief cause of violent crime and increases the risk equally in people with and without mental illness, researchers at the University of Oxford found.

- Mentally ill people nearly five times more likely to be victims of murder than general population
  Jeremy Laurance Wednesday, 6 March 2013
Glasgow City Council Social Work Services

Mental Health (Scotland) Bill

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

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

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

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

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

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

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

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

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

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

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

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

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

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

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

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

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

Glasgow City Council Social Work Services
August 2014
Inclusion Scotland

Mental Health (Scotland) Bill

1. Introduction

1.1 Inclusion Scotland is a network of disabled peoples' organisations and individual disabled people. Our main aim is to draw attention to the physical, social, economic, cultural and attitudinal barriers that affect disabled people’s everyday lives and to encourage a wider understanding of those issues throughout Scotland.

1.2 It is essential that Mental Health legislation takes account of obligations under the United Nations Convention on the Rights of Disabled People (UNCRPD) and not just those under the European Convention of Human Rights (ECHR).


2.1 Inclusion Scotland has been consulting disabled people across Scotland about whether the Scottish and UK Governments are meeting their obligations to protect, promote and enhance the human rights of disabled people under the UNCRPD.

2.2 Our consultation has highlighted a number of issues of concern regarding the care and treatment of people with mental health problems that are relevant to this Bill, particularly in relation to compulsory detention and treatment orders, advance statements and named persons, which inform our responses below.

2.3 In an online survey of disabled people conducted by Inclusion Scotland this summer, 42% of those responding said their experience of mental health treatment had got worse the last 5 years, and only 15% said it had got better. 29% said that mental health treatment was rarely or never adequate to meet their needs, 14% said it was sometimes adequate and only 14% said it was mostly adequate. 42% said that other mental health services had got worse, with only 24% saying they had got better.

2.4 In a General Comment on Article 12 of the UNCRPD (Equal recognition before the law) published in April this year, the United Nations Committee on the Rights of Persons with Disabilities makes some important observations about State Parties’ obligations regarding people with cognitive or psychosocial disabilities being disproportionately affected by substitute decision-making regimes and denial of legal capacity.

1 Information around Inclusion Scotland’s work on the UNCRDP. http://www.inclusionscotland.org/

2 http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement Link no longer active
2.5 Substitute decision-making regimes can take many different forms, including plenary guardianship, judicial interdiction and partial guardianship. However, these regimes have certain common characteristics: legal capacity is removed from a person; a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; and any decision made by a substitute decision-maker is based on what is believed to be in the objective “best interests” of the person concerned, as opposed to being based on the person’s own will and preferences.

2.6 It states that “States Parties have an obligation to provide persons with disabilities with access to support in the exercise of their legal capacity”. This would include supported decision making, and can include as peer support, advocacy (including self-advocacy support), or assistance with communication.

“States Parties’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.

2.7 The UN Committee’s General Comment also makes significant observations relevant to compulsory detention and compulsory treatment:

“The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention.”; and

“Forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16).”

2.8 The Health and Sport Committee may wish to ask the Scottish Government how it intends to review existing mental health policy and practice in light of the UNCRPD General Comment.

3. Compulsory Detention Orders and Compulsory Treatment Orders

3.1 We welcome that the Policy Memorandum to the Bill recognises that, given that the provisions of the Mental Health (Care and Treatment) Act
2003 allow for compulsory treatment and detention, they have an effect on the human rights of the persons subject to such measures.

3.2 Given that recognition, it is essential that the changes proposed by this Bill are made only if there is overwhelming evidence that the present provisions are having a detrimental effect on the human rights of persons affected by them, including their health and well-being. Amendments should be judged on whether they enhance human rights, and not on administrative convenience.

3.3 Inclusion Scotland are therefore concerned about the following proposals:
- To increase the period of short term detention pending a determination of an application by the Tribunal from 5 days to 10 days.
- To extend the power of a registered nurse to detain a person for the purpose of an examination from two to three hours.
- To reduce the period when a person can appeal against a transfer to the state hospital from 12 weeks to 28 days.

3.4 The Committee should ask the Scottish Government what evidence it has to support these changes; how they enhance rights of persons affected; and how they are compatible with the Scottish Government’s obligations under the UNCRPD.

3.5 Where a person’s liberty is being restricted, it is vital that any period where they are being detained without independent review or examination is minimised, and that rights of appeal are maximised.

3.6 The use of compulsory treatment orders and compulsory detention orders (CTOs), by definition, restrict the rights and freedoms of the service users. They should be used only when absolutely necessary. They should also be regularly reviewed, including when requested by the service user.

3.7 The extent to which CTOs are used in Scotland should be monitored and benchmarked against practice elsewhere in the UK to ensure that the rights of service users are not being unduly restricted, and that mental health services are being provided in a way that best meets the mental health needs of service users.

4. Named Persons

4.1 Inclusion Scotland agrees with the policy memorandum that a person should only have a named person where they choose to have one. We also agree that the named person should consent to being the named person. Both these decisions should be based on informed choice and both the individual and the named persons should be fully aware of the rights and responsibilities of the named person.
4.2 We share the concerns of the SAMH, in their written evidence, that the Tribunal will retain the power to appoint a primary carer or nearest relative as named person by default unless the individual opts out. This would seem to be contrary to the policy memorandum.

4.3 We welcome that the Scottish Government has not included in the Bill the proposal that was in the draft Bill that would have removed the automatic right of the named person to be involved in tribunal and court hearings. We also agree with SAMH that the named person should be consulted by the Mental Health Officer (MHO) on the proposed care plan and notified if the person is taken to a place of safety, or any other significant change in treatment or detention.

5. **Advance Statements**

5.1 Inclusion Scotland support the proposal to establish a central register for advance statements. Advanced statements are an important safeguard for protecting human rights by allowing an individual to state what forms of treatment are acceptable to them if they are subject to a compulsory treatment order.

5.2 However, as advance statements will contain highly sensitive information about the person, it is important that there are safeguards built in to the register to protect the privacy of the individual, and ensure that advance statements are only accessible to those who need to know what is in them.

5.3 Disabled people have told Inclusion Scotland that, although pockets of good practice do exist, advance statements are not widely promoted by mental healthcare providers and many service users are unaware of them.

5.4 Inclusion Scotland therefore believes that there should be a statutory duty on Health Boards to promote advance statements.

6. **Advocacy**

6.1 Whilst the 2003 Act established a right to independent advocacy, provision varies across Scotland. Where it is available, it is often only when a condition has reached a critical stage. Early independent or peer advocacy support in planning and considering treatment options can help prevent a deterioration of mental health, and thus avoid the need for critical intervention, including compulsory treatment.

6.2 The Committee may wish to explore with the Scottish Government and Health Boards what is being done to improve the availability of advocacy services to meet the needs of service users and duties under the 2003 Act.
7. Learning Disability

7.1 People with learning disabilities and autistic spectrum disorders (ASD) are being included under the Mental Health (Care and Treatment) (Scotland) Act as having mental disorders, even where they have no mental health problems. This leads to inappropriate diagnosis and treatment.

7.2 Section 328 of the 2003 Act defines "mental disorder" as "any mental illness, personality disorder, or learning disability, however caused or manifested." Persons deemed to have a mental disorder can be subject to any of the provisions of the Act, including Compulsory Treatment Orders or Compulsory Detention Orders.

7.3 People with learning disabilities have told Inclusion Scotland of their concerns that they can be subject to "compulsory treatment" as a result of their learning disability alone. They are told what they can and cannot do, who they can and cannot meet and be compelled to undergo treatments because they "don't know what is good for them".

7.4 Inclusion Scotland believes that including those with learning disabilities or ASD as having mental disorders is discriminatory and would urge the Committee to raise with the Scottish Government amending the 2003 Act to remove them from its scope.

8. Conclusion

8.1 Inclusion Scotland would like to see the provision of mental health services in Scotland improved to meet the standards described in the McManus Report. In particular we would like to see high quality preventative and reactive mental health treatment and services, and improved access to independent and peer advocacy, to meet unmet need and reduce the need for compulsory treatment.

Inclusion Scotland
August 2014
Mental Health Foundation

Mental Health (Scotland) Bill

1. About Mental Health Foundation

The Mental Health Foundation is the UK’s leading mental health research, policy and service improvement charity. The Foundation operates across four offices in London, Newport, Edinburgh and Glasgow. Just over a third of our staff are based in Scotland.

We work across all areas of mental health, from promotion and prevention activities at all levels, to supporting organisations in evaluation and development of mental health services. At our core is a belief that inequality is a critical determinant of population wellbeing, and a major inhibitor of recovery from mental illness. We are therefore committed to addressing structural inequality, poverty, discrimination and exclusion at every level, using a human right based approach to highlight the role of mental health in the cross-policy solutions to these wide ranging issues.

We bring high quality research and development skills, and experience of supporting policy at local, national and international levels. Critical to our work is supporting those with lived experience of mental ill health and inequalities to have a voice. We host VOX, the national mental health service user organisation, and additionally have on-going programmes to enable some of the most excluded populations, such as refugee and asylum seeking women to improve their mental health. We coordinate the Scottish Mental Health Arts and Film Festival, which takes place annually in October, and with SAMH we jointly manage ‘see me’, the national programme to end stigma and discrimination in mental health.

2. Comments on Specific Questions in the Consultation

Do you agree with the general policy direction set by the Bill?
In general we support the policy direction of the Bill. Though the bill is quite technical in places, we would urge the committee to bear in mind two things as the bill progresses:

- Firstly, the extent to which the provisions update mental health law in such a way as to maximise the promotion, understanding and assertion of human rights by people who are subject to the provisions. This is particularly important where provisions streamline processes to maximise efficiency.

- Secondly, the extent to which the Bill updates mental health law so as to maximise the opportunity to address inequality and failure demand both arising from and contributing to mental disorders.

To a great extent these considerations should be easily included if the Millan principles are at the front and centre of consideration of this Bill.
Along with the majority of mental health organisations, we warmly welcomed the McManus report and its recommendations. The Scottish Government’s 2010 response to the McManus review demonstrated the fact that not all of the recommendations needed primary legislation, and indeed set out the means by which many recommendations would be implemented in other ways. We would welcome an updated report which showed progress against these recommendations, including those now proposed in the Bill. That would better allow all interested parties to identify remaining gaps.

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Sections 18-20: Representation by Named Persons
We agree with the Policy Memorandum statement that that a person should only have a named person if they wish to have one. This facility provides a key point where a person can express their wish not to permit disclosure of confidential medical and personal data to third parties, consistent with the ECHR.

We continue to have concerns about whether the ‘opt-out’ system as proposed in the Bill achieves that. Having the option to formally refuse to have a named person, though welcome, is not the same thing as only having a named person if desired.

If a person does not formally opt-out of having a named person then a default named person will still be appointed under s251, even if the person they will act for does not or would not consent. We are concerned that in those circumstances, a patient may not have the agency to challenge such an appointment if it appears to them that their wishes have been overridden.

At the same time we realise that it is generally in a person’s interest to have a named person who gives informed consent to act in that capacity, and is supported to do so.

We feel therefore that all efforts must be taken to promote the benefits of having a named person, as well as to create space to enable a person to choose an appropriate named person mindful of the requirements of the role.

Equally, patients should be aware that they can change their named person at any time. This might be particularly important following first admission and default named person appointment, or in circumstances where failure to appoint led to the tribunal making an appointment.

We therefore are very supportive of proposals to ensure that named persons consent in writing to their nomination as such.

Once selected, it is critical that named persons give informed consent to serve and are offered on-going support. Ahead of this nomination it is desirable that a person who may be asked to act as a named person has appropriate,
accessible information about the role. Named Person guidance may need to take consideration of the dynamic in populations with particular hierarchies in families or social groups to consider whether a person is selecting a named person that best suits their wishes.

We note that under s19 the nominated person’s signature must be witnessed by a ‘prescribed person’. That opportunity might be a time where information and appropriate support might be offered the prospective named person.

This could be further emphasised combining a duty to support named persons with the statutory duty, as proposed by McManus, to promote advance statements.

The McManus review, and indeed the membership of VOX both picked up that having joint named persons might be desirable. We agree with this, particularly where a person may wish to nominate a person they trust and respect but who might not always be able to fulfil all the requirements of the role.

Section 21: Advance Statements, Support and Services

We are broadly supportive of any measures that enable people subject to the act to express their wishes in relation to their care and treatment. The ability to express wishes and see these respected at a time where detention may be considered is key to both least restrictive alternative and reciprocity principles.

Importantly, the ability to express wishes and see them respected can be important in setting out foundations for recovery, and for addressing self-stigma. We believe that advanced statements remain a key tool for achieving this, particularly with the rise in self-management strategies which could dovetail easily with advanced statements. As such we welcome the proposals to increase the usability of advance statements.

Register of Advanced Statements

We believe that collection of advanced statements on a central register is a good idea, provided the register of advance statements is appropriately held. Appending to health records as well as collection in a central register makes sense, and should increase the likelihood of advanced statements being consulted at key moments.

A central register could also provide good data about the number of active advanced statements in use, where now the only intelligence relates to circumstances where MWC is notified of times where advance statements are overridden. It is also possible that if basic demographic information were collected with statements that good data could be gathered about uptake of advanced statements by particular population groups, to enable targeted awareness work or support to be offered.
We have some concern that confidential personal and medical information shared in advanced statements, including details on traumatic experiences and personal preferences could be made available to a relatively large audience, potentially taking away to some extent a person’s ownership of their story. We are sympathetic to the view that the Commission should only hold basic details about the presence of a statement, its date, and where it is held. Although this might mean that an out of area professional might not be able to ascertain the wishes of a person out of hours, it would mean that only minimal information was available away from the ‘protection’ of the patient’s medical records. We would be interested to see the views of other stakeholders on this balance.

If patients, carers, and named persons aren’t sufficiently aware of the safeguards around access to advanced statement content, individuals may be inhibited from making statements for fear of their intensely personal material being widely known. At the same time, bringing advanced statements and personal stories into medical records may reassure patients that this information is subject to the highest possible level of confidentiality.

At the least, we would like to see medical records and the central register contain only the current advanced statement, meaning that previous statement versions would be purged at the time they were superseded. This would prevent any potential for the advanced statement history to be used in any assessment of a person’s health.

Section 22: Communication at Medical Examination

We welcome the requirement to meet communication needs. We assume this covers both the communication needs of people with learning difficulties and sensory impairments and the need for interpreters for those for whom English is not their first language.

Section 23: Services and Accommodation for Mothers

We very much welcome the extension of parental support to include all mental disorders. Whilst we recognise that the majority of cases would involve a mother requiring to be admitted with a baby, as primary caregiver, it is possible that fathers that are primary caregivers might also require this service. We would therefore prefer section 22 to refer to services and accommodation for parents, and section 24 of the amended Act to refer to “certain parents with a mental disorder”

Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
Not at this time
Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

The Foundation has concerns about the victim notification scheme in general. Many of our concerns were shared in consultation responses from colleagues in the Mental Welfare Commission, the Law Society of Scotland, SAMH and Support in Mind Scotland in the initial consultation on Disclosure of Information to the Victims of Mentally Disordered Offenders.

We recognise that such a scheme will be implemented, and recognise the right that all victims of crime should have to appropriate information about the circumstances and whereabouts of the offenders responsible. We welcome some of the changes to proposed scheme that have been implemented since the consultation on the draft bill, including the requirement that an MDO about whom information can be sought by a victim must have both a compulsion order and a restriction order.

We would be interested to see research on the use and uptake of the VNS for MDOs compared to that for other offenders, as we suspect that stigma around crime perpetrated by those with mental disorders might lead to a greater interest, at a lower level of severity, where the risk posed by an offender is less than some victims may perceive.

We would be interested to see in time whether victim notification around for instance the suspension of a compulsion order had an effect on the offender’s recovery and rehabilitation, or on media coverage of such important opportunities for rehabilitation.

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

Duty to Promote Advanced Statements

We feel the Bill misses an opportunity to place a duty on appropriate public bodies to ensure that advanced statements are promoted, as proposed by McManus.

Advanced statements fit well with the movement towards integrated health and social care services and personal outcomes, and the opportunity to promote these alongside self-directed support.

At the very least, we would like to see guidance or code of practice reference to the duty of care and treatment services to promote advanced statements to people as early as possible in their experience of service use and recovery.

This would hopefully ensure that an advanced statement, and the right to assume that one would have a right to state preference for treatment and question practice that one did not want was part of any care and treatment for
new patients. This may have a substantial positive effect on both recovery and self-stigma, and may in time prevent the learned helplessness some people express at the thought of asserting their rights in inpatient settings.

**Named Persons for Children and Young People**

We note that the Bill does not take up McManus recommendation 4.16, that “a person under the age of 16 with an adequate understanding of the consequences of appointing a named person should be allowed to do so”.

In our submission to Scottish Government on the draft bill, we noted the Scottish Government’s intention to “consider the most appropriate ways in which young people might have more of a say as to the identity of their named person” and we hoped to see this developed in the Bill presented.

We would recommend consideration of the ways in which young people’s views are taken into consideration for instance in the Children’s Hearing system and in other legislation facilitating the wishes of children and young people to be heard in statutory processes affecting them.

We feel that promotion of advanced statements and understanding of named person roles could be very beneficial for young people making the transition from CAMHS to adult services.

**Medical Reports**

We welcome changes made between the draft bill and the bill as presented, regarding medical reports. We do feel however that there remains scope for a holistic report from a person’s GP, particularly where a patient’s social circumstances or their wider health has an impact on their mental disorder, or where treatment for multi-morbid conditions might be affected by their detention.

**Advocacy**

We note the extensive set of recommendations in the McManus review with regard to access to independent advocacy for people with mental health problems. As these do not require legislation to take forward, we understand why they are not included in the Bill.

We do however assume that the Bill proposed, in particular the changes in Advanced Statements and Named Persons will increase the demand for Independent Advocacy, potentially beyond the resources made available.

This demand may be from people covered by the Act but not currently detained or being considered for detention, a client group who sometimes need to wait for access where the needs of those subject to imminent or current detention are prioritised when resources are stretched.
We believe that the potential value of advanced statements and appointing a named person in terms of self-stigma and self-management is great. The window of opportunity for this where people are nervous, sceptical or only well for short periods may be short, and therefore access to advocacy when people feel sufficiently empowered and motivated to change is key.

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

**Duties of Local Authorities**

Sections 25-27 of the 2003 Act confer certain duties on Local Authorities with regard to the provision of services to people subject to the Act. These duties have encouraged a range of good practice in Local Authorities, and alongside with measure in Single Outcome Agreements on promoting wellbeing and addressing suicide have secured a place for mental health on Local Authority strategic agendas.

There is currently no specified monitoring structure for assessing implementation of these provisions, and we would like to see that developed, especially in the light of health and social care integration, self-directed support, and the 2011 Public Sector Equality Duty in relation to non-discrimination towards people with mental disorders, all of which have been introduced since the Act was passed and which connect with Local Authority obligations towards those with mental disorders.

We would welcome a re-visiting and updating of the guidance document ‘With Inclusion in Mind’ following the passage of this legislation.

**Use of Advance Statements to support self-management and address multi-morbidity and complexity**

We would like to see guidance recommend that advance statements explicitly invite patients to discuss ways in which their care and treatment can encourage the development/ resumption of self-management strategies as soon as practicable, for example including information about a person’s use of online peer support, WRAP plans or similar self-management strategies and their preferences around being offered these.

Equally we would prefer to see guidance cover details of process for appending other tools such as WRAP plans or SDS outcomes to advance statements.

We would like to see future guidance on advance statements recommend inclusion of sections on general health, on equality and access.

A section on general health would enable multi-morbid patients to explain their other health conditions, treatments, self-management strategies, and the effects of these treatments on their mental health. We are often told that explaining complex or rare illnesses at admission or subsequently can be
additionally stressful for patients, or that the care and treatment they need for physical illness can be hard to put in place at the start of admissions. Additionally, where patients have a strong clinical connection with a district nurse, physiotherapist or other NHS provider, an opportunity to at least notify that person so as to facilitate picking up that connection post discharge may prevent interruptions that can seriously affect a person’s ability to live independently later.

Finally, the health section of an advanced statement could also enable people to request support with health concerns, with smoking cessation or healthier eating when admitted, helping to address health inequalities and diagnostic overshadowing.

Similarly a section on equality and access would enable patients to disclose any barriers that membership of any protected characteristic groups might present that may be difficult to discuss at admission. This may be particularly helpful for patients who culturally find it difficult to address authority figures or people of the opposite gender, people with autistic spectrum disorders or learning disabilities who may find communication difficult, or transgendered people who may not want to disclose this verbally in case they are inadvertently outed.

**Ensuring Access for Underrepresented Groups**

We would like to see specific efforts concentrated on reaching underrepresented groups with promotion of advance statements and appointment of named persons, and assurance in guidance that independent advocacy is available and utilised by people with protected characteristics. This may be of particular relevance to young people, older people in isolation, BME groups and asylum seekers and refugees. Where people have access issues, such as sensory or physical impairments or language barriers, we welcome measures in the bill to improve communication but would reiterate the need to support this during care and treatment as well as at assessment.

**Mental Health (Scotland) Bill**

**August 2014**
Mental Health (Scotland) Bill

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

Carers Trust Scotland welcomes the Scottish Government’s efforts to amend the Mental Health (Care & Treatment) (Scotland) Act 2003 (the Act); however we do not agree with the overall policy direction set by this Bill. We feel that it is a very narrow, clinical approach, which does not help promote recovery of the service user or enhance the involvement of carers. As one of the guiding principles to the Act is “Respect for Carers”, we are disappointed to note the changes made in relation to Named Persons and role of carers within that (see answer below.)

Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Opt out from having named person
Carers Trust Scotland agrees with this amendment as it places considerable stress on a carer if they are automatically appointed to a role they have no knowledge of. However we would have welcomed the inclusion that, where a service user is unable to appoint a named person, the carer (or nearest relative) should have an automatic right to appeal against orders, the extension of orders and against hospital transfers. This is in line with McManus recommendations, but also provides respect for carers and takes their views into account. We do not think, however, that the carer (or nearest relative) should act as named person, but should have certain powers to act (as outlined.)

Consent to being a named person
Carers Trust Scotland welcomes the amendment to the consent to being a named person (Sections 250, 251 and 257 of the Act). However we feel that the Scottish Government should take on board the recommendation within the McManus Report around a nationwide publicity campaign to highlight the role of named person and the need for consent to this. Otherwise there is a risk of a situation where a person thinks they are the named person but, due to there not being a signed and witnessed document to that effect, the person ceases to be the named person and therefore can play no part in tribunal proceedings.

Many carers report that the only time the role of named person is mentioned is at a point of compulsory powers being applied, or thought about. In many situations this does not give service user or carer time to think about what this role entails, and may not give time for written consent to be given and witnessed. Greater recognition to the need to promote role of named person would have been welcomed within this Mental Health Bill. Indeed it would have been preferable to have seen the inclusion of recommendation 4.11
from the McManus Report: “[A signed form for appointing a named person] should also contain a box setting out the consequences of appointing a named person, including sharing information. The box should be signed by the person nominating and confirm that the information set out in the box has been read out and the person signing it understands it.”

This would give greater safeguards to both the service user and the named person, particularly where the named person is the primary carer. We know that in situations where the primary carer becomes the named person there can be potential for conflict with the relationship; by clearly stating what is expected of the named person around sharing information, this potential situation could be reduced.

Carers Trust Scotland and many of the carers we support believe fervently in the inherent value of a named person’s right to be party to Tribunal hearings. There is clearly a need for more information to be provided about the role and functions of named persons, how this differs to role of primary carer and more support offered in order for the named person to be able to fulfil their role in a meaningful way.

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

Carers Trust Scotland is disappointed to note that, in the proposed amendments, scant attention has been made to the McManus Report recommendations around named person. In particular we regret that recommendation 4.16, “A young person under the age of 16 who has adequate understanding of the consequences of appointing a named person should be able to do so”. We feel this does not respect the rights of a young person, especially where they have the capacity to consent (or otherwise) with medical treatments. By allowing the nomination of named persons to under 16 it would bring the Act into line with Age of Legal Capacity (Scotland) Act 1991, which allows a young person with capacity to decide about medical treatment. Carers Trust Scotland would have also welcomed the inclusion into the Bill recommendation 4.19 from the McManus Report: “The Scottish Government should draw up a Code of Practice for named persons, covering such matters as confidentiality.” This would have given service users and carers the chance to properly decide who to nominate, and whether to accept the nomination to act as named person.

We would welcome greater recognition to recommendations from the McManus Review that there should be a nationwide campaign to advise everyone about the role and function of the named person and consequences of appointing or not appointing one.

Overwhelmingly carers, Network Partners and Carers Trust Scotland would like to see the Scottish Government bring into force the Limited Review
recommendation 4.19\(^1\) that a Code of Practice for named persons be drawn up, covering matters such as confidentiality. Carers were concerned about the amount and nature of some of the information shared and would like to see this information shared only on a need to know basis, and on one which is relevant to the application being made.

We would also like to see the implementation of McManus’ recommendation 4.15, that a Mental Health Officer (MHO) should have a duty to consult with the Named Person on the proposed care plan. McManus further recommended that Named Persons should be notified when a person is taken to a place of safety – again, we would like to see this enacted.

**Carers Trust Scotland**  
**August 2014**

Scottish Disability Equality Forum

Mental Health (Scotland) Bill

Scottish Disability Equality Forum (SDEF) works for social inclusion in Scotland through the removal of barriers to equality and the promotion of independent living for people affected by disability.

We are a membership organisation, representing individuals affected by disability, and organisations and groups who share our values. Our aim is to ensure that the voices of people affected by disability are heard and heeded within their own communities and at a national and political level.

General point:
SDEF recognises the technical nature of some of the changes proposed in this consultation. We believe, however, that the overall number of responses will be limited by the consultation document’s complicated drafting, the lack of an easy-read version and the failure to explain, or provide a glossary.

As a result, only the very determined or professionally trained are likely to understand and respond to this consultation. This is a shame as many of the proposals are important and will have relevance to a range of people with mental ill-health, their carers and family members.

We have outlined our concerns below:

Accessibility
The structure of the consultation document is too complicated ‘jumping back and forth’. An easy read format needs to be produced to ensure all those affected can understand the implications; this will also widen responses to such consultations.

Target Audience
Those detained under the Mental Health Act should have access to information in an easy to read, inclusive format.

Inaccessible for ‘joe public’ – families affected would not find this an accessible document.

When asking for individuals to respond, this structure is not accessible or easy to understand.

Organisations are not in a position to comment from a professional perspective unless a Mental Health Organisation, reducing scope for wider and balanced views.

Explanation
No explanation of the implications the changes will have for those it affects.

Medical model – based on the procedures without due regard for the well-
being of those it affects.

**Representation**
Over 50,000 people detained under mental health act in UK, representation must be broadened.

Take into account the experiences of those detained under mental health act and assess impact of for example, increased detention, etc.

**Criminal Justice**
We seek assurance that the relevant departments have been consulted and provided comments on detention in State Hospitals; aspects of arranging transfers and the protection of wellbeing; and the individual's ability to prepare a defence.

**Scottish Disability Equality Forum**
**August 2014**
Social Work Scotland Mental Health Sub Group

Mental Health (Scotland) Bill

Introduction
The Social Work Scotland Mental Health Sub Group welcomes the opportunity to respond to the consultation on the Mental Health (Scotland) Bill and would support the general policy direction set by the Bill.

The Bill proposes further increases to the existing duties and responsibilities of our Mental Health Officer Services which need to be viewed in the broader context of our national MHO workforce and workload capacity. Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Consideration of any implications of the Public Bodies (Joint Working) (Scotland) Act, 2014 will need to be made and there is an opportunity for clarification of any Issues for MHO services in regard to health and social care integration to be addressed if required.

Comments on Part 1
The proposed amendments to the Advance Statement are welcomed. Consideration should be given to the potential to introduce a recommended proforma which incorporates an advisory note to the effect that it requires to be submitted within a specified timeframe following completion to be effective, will require to be reviewed annually or where there are a change of circumstances and that it revokes any preceding statement. The proforma should be signed, dated and include reference to the fact that the Health Board must forward the proforma to the Mental Welfare Commission to be added to the register.

Clarity will be required on the central point within Health Boards to which the proforma should be submitted.

There remain questions around the potential need for 24 hour accessibility to the Advance Statement for those parties who require access and a few data protection considerations that will require to be addressed in the operationalisation of the register.

The introduction of an opt out system is welcomed as is the named person’s consent to undertaking the role. There is an assumption that issues around capacity in this area will be addressed within the Code of Practice.

Consideration should be given to the expansion of the proposed Advance Statement register to incorporate a Named Person Register.
The proposed Tribunal rules which will be subject to a separate consultation are welcomed in relation to mentally disordered offenders or where there may be victim considerations. There are however concerns that the proposal erodes the rights of the Named Person and this will require to be addressed within the regulations.

Whilst acknowledging the difficulties experienced to date with suspension of detention measures, particularly immediately following the Acts inception, the proposal to remove the 9 month restriction in any 12 month period was rejected. It was the consensus that this was a retrograde step which would replicate the issues identified with Section 18 Leave of Absence under the 1984 Act.

It was suggested that an upper limit of 6 months in any 12 month period be considered with a disregard for short periods such as one day, one overnight, one weekend in the cumulative period.

There were also a few concerns that RMOs can add more restrictive conditions during periods of Suspension of Detention than those originally approved by the Tribunal.

The Part 13 proposals were supported but would require clarification on the thresholds and it was suggested that the upper time limit of 6 months suspension of detention be equally applicable under section 224.

Whilst elements of the section 87 proposal are unquestionably good practice, there are however major workload concerns for the MHO service.

The proposed changes to section 87 would require an additional 1789 reports by MHO’s each year (1789 over the period 2012/2013, Mental Welfare Commission figures). There may be considerations around whether the requirement for an MHO report is limited to extensions but not variations of the order or alternatively limited to those orders where there is likely to be a hearing (issue related to diagnosis, MHO disagrees with the proposed action, or, where there is a revocation of the application).

The introduction of a recommended form would be of benefit in this area together with clarification around the role of the SCR, section 57c and section 59.

Within the current Act, MHOs should complete an SCR following any relevant event or a letter to advise that the completion of an SCR would serve no practical purpose.

Good practice would also suggest that an SCR is completed at least annually for individuals on long term orders and that an SCR should be completed at each renewal of order for individuals who are parents. The Mental Welfare Commission annual report notes a sizeable deficit in the report submissions nationally.
There are concerns around the proposal to place further administrative duties around notification on MHOs which may sit better within the MHTS. Concerns were also expressed around thresholds for significant harm and the need to limit the information in the MHO report given the proposed circulation.

Timeous notification to MHOs from RMOs of plans to extend a CTO also require to be addressed.

Questions were raised around whether these proposals would also apply to Compulsion Orders.

Whilst the proposals to the emergency, short term and temporary steps provisions were viewed as a positive development, it was felt that hospital managers would require a statement from the RMO / GP to advise of sensitivities in order to facilitate the exercising of their discretion.

Whilst there were no concerns with the notification of the granting of the order to the various parties, concern was noted around the circulation of the full papers, particularly if the default Named Person role is retained.

The proposal to place a duty on the MHO to notify the Mental Welfare Commission when making an application for a removal order to enable the Mental Welfare Commission to consider whether it should make a section 295 recall or variation of the removal order was viewed positively.

The proposal to extend Nurses holding power from 2 to 3 hours to enable an informal patient to be detained for the purposes of enabling medical practitioner examinations irrespective of whether a doctor is immediately available or not was viewed positively.

It was noted however that Nurses should notify both the RMO and the MHO at the start of the holding power to facilitate attendance at the earliest opportunity.

The removal of the restriction for the convener of the tribunal panel to be either the tribunal president or to be selected from the Shrieval panel was viewed positively in relation to cost efficiencies and increased flexibility of scheduling hearings.

Whilst this was viewed as good practice, concern was noted around the notification to Scottish Ministers of the making of a CTO application to follow a TTD, although it was generally conceded that this was more related to any potential intervention in the hearing process which could be dealt with within the Code of Practice.

The proposal to involve the MHO in the process for making a decision under section 136, TTD was viewed positively. Mental Welfare Commission figures suggest that there were 45 of these orders in the last financial year.
Operationally local authorities would require to put in place arrangements for the responsible authority to respond to the request in relation to prisoners whose ordinary residence was in their area with the hosting local authority providing a backup MHO service for those instances where the relevant local authority MHO is unable to respond within the specified timeframes.

The proposal to extend cross border transfer to include patients from outwith the UK from other EU member states was welcomed but would require further guidance.

**Comments on Part 2**
No comments to be added on the provisions in Part 2 of the Bill on criminal cases

**Comments on Part 3**
The proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders is welcomed although will require clear guidance on definitions, entry and exit points, roles, responsibilities, boundaries, accountabilities and any inconsistencies in applicability addressed.

There are questions around whether this should be restricted to CORO patients only and particular offences of a serious nature which will require further clarity and guidance.

There are also questions around transition points from the criminal procedures elements of the Mental Health Act to the civil elements such as TTDs to CTOs and how this is dealt with for both patient and victim or their relatives.

The proposal that victims should be prevented from making representation under the existing Mental Health legislation once they have the right to do so under the proposed Victim Notification Scheme is problematic and inconsistent for example, the RMO would notify victims when orders are being suspended but not when being revoked.

From the limited proposals noted in the bill it is difficult to fully ascertain the potential ramifications of extending the scheme but it was agreed in principle that the extension of the scheme was welcomed.

There was general consensus that this is both a complicated and complex area involving the balancing of the rights of the patient and the rights of the victim. It was noted that the proposal may result in those with a learning disability or lacking in capacity being treated less favourably which was of concern.

More detailed proposals and notional guidance on how the VNS may operate in practice is required to facilitate discussion in the first instance.
General Comments on the Bill
It was generally agreed that the proposals were positive in most areas although there was concern that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.

The Bill proposes further increases to the duties and responsibilities of our Mental Health Officer Services which equally need to be viewed in the broader context of our national MHO workforce and workload capacity.

Whilst many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, improving the quality of assessment options and outcomes for individuals with a mental disorder there is an increasing requirement to review our national MHO workforce and workload capacity to ensure that local authorities are sufficiently resourced to enable them to meet their statutory functions in these areas.

Not withstanding the year on year increase in MHO workload demand, which is not matched by any increase in the existing MHO infrastructure, the additional roles and responsibilities for MHOs contained within the proposals will incur further significant costs to local authorities which needs to be considered by the Scottish Government

Social Work Scotland Mental Health Sub Group
August 2014
W. Hunter Watson

Mental Health (Scotland) Bill

In my opinion, when the Health and Sport Committee considers the Mental Health (Scotland) Bill it should consider the issues raised in the two attached papers even though the Government has made clear that it does not wish any substantial amendments to be made to the 2003 Act. However, if Parliament does not take account of the many developments since the passage of the 2003 Act and the evidence that the Act is not being implemented as Parliament expected then there is a risk that a mental health patient will raise an action on the grounds that his or human rights have been breached. That could not only lead to Parliament being require to amend Scottish legislation to bring it into line with judgments of the European Court of Human Rights but could also lead to many past and present mental health patients being awarded significant compensation, a possibility that the Committee might wish to avoid.

I hope that the Committee will permit me to give oral evidence. It was I who submitted petition PE01494 which called on the Scottish Parliament to amend the Scottish mental health legislation to ensure that it is compatible with Convention rights. As a result of the information received from the many people who contacted me, I learned much about how the 2003 Act was being implemented. Unfortunately, the Petitions Committee was instructed to close my petition and did so without discussing any of the many submissions made. I had expected that it would refer my petition to the Health and Sport Committee so that it could examine the important issues that had been raised. I hope that, notwithstanding the views of the Government, this can happen.

W. Hunter Watson
August 2014
AMENDMENT OF 2003 MENTAL HEALTH ACT

When the 2003 Act is amended full account should be taken of the following five judgments of the European Court of Human Rights. These judgments are legally binding and it is possible, therefore, that if the 2003 Act is not suitably amended then an individual subjected to forced treatment would have grounds for raising an action under section 7(1) of the Human Rights Act. (This does not require medical negligence to be established; it only requires it to be shown that, on the balance of probability, the complainant’s human rights had been breached.) If the action were successful and compensation awarded then other patients might also be awarded compensation which could amount in total to many millions of pounds. Parliament (i.e. the Scottish Parliament) should consider carefully whether it wishes to expose Health Boards, and ultimately taxpayers, to this risk. Parliament should note that in 2004 a judge awarded compensation to a prisoner on the grounds that being forced to “slop out” had breached his human rights and that this set a precedent which gave rise to similar claims and ultimately to huge compensation payments.

As well as judgments of the European Court, this paper also draws attention to a number of other matters of which account should be taken when amendments to the 2003 Act are being considered.

Winterwerp v the Netherlands (para 39), 1979
In this judgment it was made clear that the detention of an individual on the basis of unsoundness of mind is unlawful unless, at a minimum, he or she has reliably been shown to be of unsound mind. However, there is no requirement in the 2003 Act to reliably show someone is of unsound mind either prior to or after their detention. Even though an individual’s liberty is at stake, the Act requires mental health tribunals to assume that the individual in question was of unsound mind when detained. Tribunal transcripts reveal that tribunals are prepared to accept that the individual continues to be of unsound mind if that is the opinion of the responsible medical officer. Parliament should take account of the David Rosenhan experiment which demonstrated that psychiatrists cannot reliably tell the difference between people who are sane and those who are insane.

Herczegfalvy v Austria (para 82), 1992 The Court found that where patients are “entirely incapable of deciding for themselves”, forced treatment does not constitute inhuman or degrading treatment, if it can convincingly be shown to be a medical necessity. As far as the 2003 Act is concerned there are three points to note:

1. The ruling does not authorise forced treatment unless legal capacity is lacking.
2. Beyond reasonable doubt not all forced treatment can convincingly be shown to be a medical necessity.
3. The 2003 Act does not provide for an appeal on the grounds that legal capacity is not lacking or that the proposed forced treatment is not a medical necessity.
One questionable feature of the 2003 Act is that it permits forced treatment to begin before the patient has an opportunity to appeal. The Health Committee should discuss whether this part of the Act should be reviewed in the light of developments since the passage of the Act.

Pretty v U.K. (para 52), 2002:  
This ruling provides a definition of inhuman and degrading treatment, something that is prohibited in all circumstances. Yet it is clear that in psychiatric institutions treatment does occur which falls into this prohibited category. Unless Parliament addresses this issue, mental health patients will continue to be subjected to inhuman or degrading and hence be exposed to the risk of dying prematurely: two of those who made submissions to my petition blamed the deaths of loved ones on the inhuman and degrading treatment to which they had been subjected while another two who made submissions were fortunate to have survived since prescribing guidelines had not been followed when they were forcibly injected with drugs for quite indefensible reasons.

The transcripts of the debates that preceded the passage of the 2003 Act reveal that no MSP raised the possibility that certain forms of forced treatment, notably involuntary ECT and drug treatment that could not convincingly be shown to be a medical necessity, might be inhuman or degrading. Parliament should not neglect to examine this possibility when the 2003 Act is amended.

Salontaji-Drobnajak v Serbia ( paras 143, 144, 155), 2009:  
According to this judgment, individuals can only be deprived of their legal capacity by a court at which they receive a fair hearing. In Scotland it is in practice considered sufficient for a psychiatrist to assert that patients “lack insight” for them to be deprived of their legal capacity and hence of their right to refuse treatment. This would appear to provide grounds for patients who have been subjected to forced treatment to raise a court action.

Ibrahim Gurkan v Turkey (para 14), 2012:  
This judgment emphasised that a tribunal must be “impartial from an objective viewpoint in that it must offer sufficient guarantees to exclude any legitimate doubt in that respect”. However, a mental health tribunal set up under the 2003 Act cannot be regarded as impartial for the following reasons:

1. One of the tribunal members is a psychiatrist who is likely to give undue weight to the views of the fellow psychiatrist who is opposing the patient’s appeal.
2. When a tribunal considers an appeal against detention, it is required to determine whether the conditions “continue to be met” Any assumption that they had been met when the patient was detained must militate against impartiality.
3. The tribunal is expected to assume that mental health professionals are always truthful because the Act does not require them to give evidence on oath at tribunals. This also makes impartiality less likely.
The empirical evidence confirms that mental health tribunals are not impartial and that not all witnesses are truthful. (See submissions to petition PE01494.) Parliament should not assume that there can be no doubt concerning the impartiality of the mental health tribunals set up under the 2003 Act and should, therefore, consider whether appeals should again be heard in sheriff courts.

Council of Europe Recommendation Rec (2004) 10
This Recommendation is concerned with “the protection of the human rights and dignity of persons with mental disorder”. Article 20.1 states that “The decision to subject a person to involuntary placement should be taken by a court or another competent body”.
Under the 2003 Act it is too easy for a psychiatrist to have an individual detained in hospital. The adoption of Article 20.1 from the Council of Europe Recommendation would reduce the risk of individuals being wrongly deprived of their liberty in breach of Article 5 of the European Convention.

General Comment No 1 issued in April 2014 by the UN Committee on the Rights of Persons with Disabilities.
This General Comment gives the views of the UN Committee about legal capacity. The legal capacity to make a treatment decision is highly relevant to the issue of forced treatment since, as the legal annex to the GMC’s consent guidance makes clear, case law has established that “A competent patient has the right to refuse treatment and their refusal must be respected, even if it will result in their deaths”. That, however, is not the only reason why this UN Committee has instructed states which have ratified the Convention to abolish legislative provisions that allow forced treatment. Another reason is that the effect of the forced treatment on the individuals concerned is such that it can fall within the definition of inhuman or degrading treatment. As far as Scotland is concerned, this is made clear in the 2013 report commissioned by the Mental Welfare Commission entitled “Individual’s rights in mental health care” (see page 12), in submissions supportive of petition PE01494 and in other evidence in my possession.

Salduz v Turkey, 2008
This case concerned the fairness of a criminal trial of a juvenile (under 18) but the judgment has relevance to Scottish mental health legislation. Mr Yuzuf Salduz was convicted of a criminal charge by a Turkish court mainly on the evidence of a statement which he had allegedly made to the police. However, he repeatedly denied the content of his statement to the police, both at the trial and on appeal and there was no lawyer present when Salduz was being questioned.
The European Court found that this constituted a breach of Article 6 of the European Convention (right to a fair hearing) since “the absence of a lawyer while he was in police custody irretrievably affected his defence rights”.

Cadder v HM Advocate, 2010
Peter Cadder had been convicted of a criminal offence in 2009. He appealed against his conviction on the grounds that no lawyer had been present when
he was interviewed by the police. His appeals failed even though he cited the case of Salduz v Turkey: the Scottish courts maintained that there were sufficient safeguards in the Scottish legal system for there to be no need to ensure that a suspect had access to legal advice when detained for questioning! However, Cadder was able to appeal to the UK Supreme Court on the grounds that his appeal related to Scotland’s compliance with Convention rights. The Supreme Court took account of the Salduz judgment and found that Cadder’s right to a fair hearing under Article 6 of the European Convention had been breached because he had been denied access to a lawyer before being interviewed by the police. As a consequence, the Scottish Parliament passed emergency legislation to amend the Criminal Procedure (Scotland) Act 1995 which had permitted a person suspected of having committed a criminal offence to be detained and interviewed by the police for up to 6 hours without a right of access to a solicitor.

The Scottish Parliament should consider whether the Cadder judgment might have implications for Scottish mental health legislation: if the purpose of an interview by a psychiatrist is to determine whether an individual should be detained in a psychiatric institution then perhaps that individual should have the right to be accompanied by a lawyer or a trusted friend.

Police and Criminal Evidence Act 1984
Under this Act, when a suspect is taken into custody and questioned, a recording is made of the interview. It would help to protect the rights of patients if it were made obligatory to make a recording of an interview if its purpose is to determine whether forced treatment is necessary: there is compelling evidence that mental health professionals do not always give truthful accounts of interviews and that, in one case, no interview had taken place even though the consultant psychiatrist claimed it had! Of course, if as recommended by the UN Committee, psychiatrists were deprived of the right to subject their patients to forced treatment then such a safeguard might not be necessary.

Concluding remarks
The Government is opposed to any fundamental changes being made to the 2003 Act. It may have been for this reason that the Petitions Committee was instructed to close petition PE01494 and provided with a spurious reason for doing so. As can be confirmed by referring to section 25 of the analysis of responses to proposals for a Mental Health (Scotland) Bill, the Government is attempting to use the same pretext to dissuade the Health Committee from considering human rights issues, including the legally binding judgments of the European Court of Human Rights.

One recent judgment of that Court that is obviously relevant to the Bill is the ruling that individuals can only be deprived of their legal capacity by a court in which they receive a fair hearing. The Health Committee will be failing in its duty to carefully scrutinise the proposed Mental Health (Scotland) Bill if it does not discuss the implications of this ruling.
The Health Committee will also be failing in its duty if it does not properly discuss the General Comment issued in April 2014 by the UN Committee on the Rights of Persons with Disabilities. This explains the significance of Article 12 of the Convention on the Rights of Persons with Disabilities, an Article which guarantees persons with disabilities equal recognition before the law. The UN Committee stated that “forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law... This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention”.

It is possible that the Government’s opposition to fundamental changes being made to the 2003 Act is a consequence of advice given to it by those whom it regards as “experts”, namely psychiatrists. Psychiatrists have a vested interest in maintaining the status quo which they have sought to defend by implying that Scotland need not fundamentally amend its mental health legislation unless a court requires it to do so. This is hardly an adequate reason for failing to comply with legally binding judgments of the European Court. Parliament should recognise this and also take account of the fact that not only do psychiatrists lack expertise in the field of human rights but that they may even lack expertise in the field of psychiatry! Doubts have been expressed of late about both the validity of psychiatric diagnoses and the theoretical basis of the drug treatments upon which psychiatrists rely. What is certain is that patients find those drug treatments unpleasant, that they not always effective and that they can do more harm than good. It is time that Parliament took account of information that has been supplied by mental health patients, their families and their representatives. This reveals that some mental health professionals are incompetent, dishonest and callous and that the safeguards within the 2003 Act are virtually worthless. However, the Government is not prepared to fulfil its obligations under the Convention on the Rights of Persons with Disabilities and legislate to ensure that mental health patients have the same rights as other NHS patients. As an alternative, the Government proposes to produce a “disability delivery plan”. It seems safe to assume that the Government is producing this plan merely as an excuse for not complying with the instructions of the UN monitoring Committee. Parliament should not accept that there is no need to make fundamental changes to Scottish mental health legislation merely because the Government is opposed to them. It should recognise that a patient with legal capacity cannot lawfully be subjected to forced treatment and also that a patient lacking in legal capacity cannot lawfully be subjected to forced treatment unless it is both a medical necessity and not inhuman or degrading. Parliament should, therefore, legislate to ensure that no patient can be subjected to forced treatment unless a court has properly tested the evidence that the following three conditions are satisfied:

1. the patient lacks legal capacity;
2. the proposed forced treatment is a medical necessity;
3. the proposed forced treatment is not inhuman or degrading.
In addition, Parliament should legislate to ensure that persons allegedly of unsound mind are no more likely to be wrongfully deprived of their liberty than persons who are suspected of having committed a criminal offence. Given the resources that are currently allocated to the detention and/or the forced treatment of mental health patients such legislation would have the potential to significantly reduce expenditure on the National Health Service though that, of course, would not be the principal justification for reducing compulsory measures to the absolute minimum consistent with the rights of those patients and the rights of others.

GOVERNMENT GAMBLING

In April of this year a UN Committee issued a General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD). This General Comment requires various countries, including Scotland, to “abolish policies and legislative provisions that allow or perpetrate forced treatment...” If the Government does not comply with this instruction and a court later rules that the forced treatment of mental health patients breaches their human rights as set out in the European Convention on Human Rights (ECHR) then the total of compensation awarded to them could run into many millions of pounds. It would appear, therefore, that the Government is gambling by assuming that no involuntary mental health patient will raise a successful action on the grounds that the forced treatment inflicted on him or her breached Article 3 ECHR, i.e. that it was or was inhuman or degrading. That is not a safe gamble because in 2004 a court ruled that “slopping out” in jails amounted to degrading treatment: the judge ruled that there had been a violation of Article 3 ECHR because he was “entirely satisfied that the petitioner was exposed to conditions of detention which taken together, were such as to damage his human rights, his human dignity and to arise in him feelings of anxiety, anguish, inferiority and humiliation”. This ruling was based on a judgment of the European Court of Human Rights: the European Court in its judgment in the 2002 case of Pretty v UK emphasised that Article 3 ECHR “is cast in absolute terms, without exception or proviso” and that states which have ratified the ECHR must “take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman and degrading treatment or punishment.” It also ruled that “Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3”.

It clearly follows from this definition that involuntary ECT falls within the prohibited category of treatment. During the debate that preceded the passage of the 2003 Mental Health Act, Shona Robison quoted from an appraisal consultation document on ECT produced by NICE, the National Institute for Clinical Excellence. This stated that some patients given ECT “report feelings of terror, shame and distress, and find it positively harmful and an abusive invasion of personal autonomy”. Further, in 1996
it was reported in the Houston Chronicle that a woman called Melissa Holliday stated "I've been through a rape, and electroshock therapy is worse". (Electroshock therapy = ECT). It may be that, as far as an unwilling patient is concerned, being given a course of ECT is as bad as being repeatedly raped.

A course of ECT involves electricity being passed through the patient’s brain from six to twelve times over a period of weeks. On each occasion the patient is held down and injected with an anaesthetic and a muscle-paralysing agent prior to electrodes being placed on his or her head. This must be found highly distressing by any patient who fears, not unreasonably, that this procedure could damage his or her brain. Nevertheless, Parliament agreed that ECT could be given to patients who resist or object to the treatment provided that an approved medical practitioner consents. That is an inadequate defence of involuntary ECT since inhuman or degrading treatment, which involuntary ECT appears to be, is prohibited in all circumstances. Parliament should not fail to debate this matter merely because the Government is opposed to any fundamental changes being made to the 2003 Act.

Article 1 of the European Convention on Human Rights requires states to secure to everyone within their jurisdiction the rights and freedoms set out within the Convention. Parliament should consider carefully, therefore, whether the comments which the judge made in the 2004 “slopping out” case might be equally applicable to the forced treatment of mental health patients, particularly to forced ECT. If they are, then Parliament should comply with Article 1 ECHR and hence with the instruction from the UN CRPD Committee.

Those who seek to rebut the allegation that forced treatment is inhuman or degrading do so by referring to the judgment of the European Court in the 1992 case of Herczegfalfy v Austria; they point out that the Court ruled that forced treatment is not inhuman or degrading if it can convincingly be shown to be a medical necessity. Those apologists for forced treatment, however, conveniently omit to acknowledge that this 1992 judgment applied only to patients who “were entirely incapable of deciding for themselves”, i.e. who lacked legal capacity. The apologists also fail to acknowledge that, as a consequence of the 2009 judgment of the European Court in the case of Salontaji-Drobnajak v Serbia, adults can now only be deprived of their legal capacity, and hence of their right to refuse treatment, by a court at which they receive a fair hearing. When Parliament discusses the forced treatment of mental health patients during the forthcoming debate on the Mental Health (Scotland) Bill it should consider the implications of this judgment.

When considering whether forced treatment might be inhuman or degrading, Parliament should take account of the views of Juan Mendez since he is a UN Special Rapporteur. His report of 1 February 2013 to the General Assembly’s Human Rights Council focused “on certain forms of abuses in health-care settings ...” and made reference to “non-consensual treatment, such as forced medication and electroshock procedures”. (Electroshock = ECT). He also expressed the opinion that it was appropriate to question the doctrine of “medical necessity” established by the European Court of Human Rights in the case of Herczegfalfy v Austria in 1992. Thus the only possible defence of forced treatment is being questioned by this UN Special Rapporteur. That
might be considered significant if an involuntary mental health patient raised a court action, especially since the “medical necessity” doctrine was formulated prior to that 2002 definition of inhuman or degrading treatment provided by the European Court of Human Rights.

If an involuntary mental health patient were able to find a good lawyer to raise an action on his or her behalf under section 7(1) of the Human Rights Act within the one year time limit then he or she would have a reasonable chance of success, especially if the alleged breach of Convention rights concerned involuntary ECT: given the facts, it would be difficult to argue successfully that involuntary ECT did not fall within the definition of inhuman or degrading treatment. If the court then found that compensation should be paid on the grounds that the treatment complained of had been inhuman or degrading then the consequences could be serious if, as in the “slopping out” case, another court later ruled that all victims of such treatment were entitled to compensation. Each year there are over 3000 people detained on the basis of a short-term detention certificate and then subjected to forced treatment before they can appeal. Also each year there are over 100 people given ECT against their will. The judge who ruled that “slopping out” constituted degrading treatment awarded £2400 to the prisoner who had raised the action. If a judge ruled that the forced treatment of a patient was inhuman or degrading then it possible that the compensation awarded to that patient would be greater than £2400 by a factor of 100 or more, especially if the patient had experienced a serious and irreversible side-effect of the treatment.

When it discusses the Mental Health (Scotland) Bill, Parliament should not fail to consider the feelings of mental health patients who are subjected to forced treatment since, by virtue of the 2002 judgment of the European Court, these are relevant when a decision is made as to whether that treatment is inhuman or degrading. Parliament should take note of reports that the forced treatment of mental health patients is at best only 75% effective but that it causes them great distress, that it can cause significant harm and even causes some to die prematurely. When it debates the Bill, Parliament should consider carefully the implication of the ruling of the European Court concerning inhuman and degrading treatment and also of the ruling regarding legal capacity. Parliament should consider whether it is necessary for it to act in order to comply with Article 1 ECHR and Article 12 CRPD and hence legislate to ensure that mental health patients have their Convention rights safeguarded and are not unlawfully deprived of their right to refuse treatment nor, indeed, of their liberty without a fair hearing.
General Medical Council

Mental Health (Scotland) Bill

The GMC is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do this by:

- keeping up-to-date UK registers of qualified doctors
- fostering good medical practice in the UK
- promoting high standards of medical education in the UK
- dealing firmly and fairly with doctors practising in the UK whose fitness to practise is in doubt.

As part of these functions we provide guidance for doctors on standards of professional conduct. In commenting on the Bill, our aim is to ensure that any obligations it might impose on doctors will not be inconsistent with the standards we set for doctors’ professional practice.

We responded in March to the Scottish Government’s consultation on the draft Bill. Our comments on the earlier draft still stand. We believe the Bill will enhance patient safety, especially by helping doctors to fulfil their professional duties as outlined below.

- We welcome the proposal that hospital managers should exercise discretion as to whether or not to give notice of certain matters listed in section 37 to persons listed in 38(4). We believe this will better protect patients from possible harm (for example, if family members learning of the reasons for their detention is likely to cause deterioration in the patient’s mental health) and reassure doctors that they are able to protect patient confidentiality.

- We welcome the proposal to extend the provision of assistance to patients with communication difficulties to those who are the subject of applications for orders as well as those who are subject to a detention order. This is consistent with our guidance to doctors that:

  32. You must give patients: the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients’ language and communication needs (From Good medical practice)

- We welcome the proposal to allow detained mothers with children aged under one to keep their children with them in hospital. We advise doctors that:

  When treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor’s first concern; but doctors must also consider and act in the best interests of children and young people. (From 0-18 years: guidance for all doctors)
We welcome the acknowledgement that mentally disordered offenders may themselves be vulnerable and that it is therefore be appropriate to limit the information that is given to victims, in some circumstances, to avoid harm to the patient. Whilst our guidance on Confidentiality allows doctors to disclose personal information when that is required by law, we nonetheless welcome this change in the law, which we believe strikes a good balance between maintaining confidentiality in mental health services and in supporting victims of crime.

General Medical Council
August 2014
Introduction
The opportunity to provide written evidence on the Mental Health (Scotland) Bill is welcomed and the following are comments on the Bill. It is, however, recommended that the opinions of those directly affected by the legislation which the Bill seeks to amend and practitioners should be taken into account in terms of the potential practical implementation and procedural aspects of the Bill.

Question 1: Do you agree with the general policy direction set by the Bill?

The Bill takes forward some of recommendations of the limited review by the McManus Committee of the Mental Health (Care and Treatment) (Scotland) Act (the 2003 Act) and provides clarification of some aspects of this legislation. It also takes into account other matters raised by service users and practitioners in response to the Scottish Government’s own consultation on such McManus Report recommendations and following consultation on the introduction of a notification scheme for victims of mentally disordered offenders. It is also noted that the Bill incorporates some of the recommendations made in response to the recent Scottish Government consultation on the draft Bill. These include the retention of the requirement for two medical reports on applications for compulsory treatment orders (CTOs) and removal of the power of the Mental Health Tribunal for Scotland to appoint a named person for an adult where one has not been appointed both of which are welcome given the consequences in terms of an individual’s liberty and autonomy.

However, several of the McManus Review recommendations and other matters which could be usefully incorporated in primary legislation have been omitted and the Bill provides an opportunity to take forward them all forward. These will be discussed in the following sections.

In terms of policy direction the importance of the role of the 2003 Act in promoting and respecting the right to the highest attainable standard of health and supporting individuals with mental disorder towards effective living and recovery cannot be over-
emphasised. The Millan Report recommendations, which shaped the form and content of the 2003 Act, reflect that this is most effectively achieved in an unrestricted environment as is possible, with respect for patient autonomy and without discrimination. This is reinforced by human rights standards identified in the European Convention on Human Rights (ECHR) and in other international treaties that the UK has ratified such as, amongst others, the Convention on the Rights of Persons with Disabilities (CRPD). Not only must the Act’s implementation be undertaken in accordance with its underlying principles and the criteria required before compulsory measures are used, but also the content and implementation of the Act must be compatible with such human rights standards. Compliance with ECHR rights is required regarding legislative content and implementation and legislation can be prevented or set aside if it fails to comply with the UK international human rights treaties obligations. This also applies to any amendments to the 2003 Act and their subsequent implementation.

Relevant human rights

**European Convention on Human Rights (ECHR)**

It is vital to appreciate that compulsory care and treatment of individuals with mental disorder is without their consent. This accordingly has significant implications in terms of an individual’s legal capacity and thus autonomy, their liberty and dignity, and their right to due process and not to be subjected to discrimination. For this reason, Articles 5 (the right to liberty), 8 (the right to private and family life (in other words, autonomy), 3 (freedom from torture and inhuman or degrading treatment or punishment), and 14 (non-discrimination) ECHR are particularly relevant. Additionally, Article 6 (the right to a fair trial) ECHR clearly has important application to proceedings before the Mental Health Tribunal for Scotland and the right to life in Article 2 may be engaged whilst a person is in the care and control of the state.

**International human rights standards: UN Covenant on the Rights of Persons with Disabilities (CRPD)**

Several CRPD rights correspond with, and reinforce, those ECHR rights that are particularly relevant to the proposed amendments in the Bill. Moreover increasing references to the CRPD are being made in European Court of Human Rights cases which, given its superior status under international law, means that it is likely to influence the interpretation of ECHR rights.

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6 ss1(3), 1(4) and 2(4).

7 See, for example, s64(5) regarding compulsory treatment orders and s44(3)-(4) regarding short-term detention certificates.

8 ss29(2)(d) and s.57 Scotland Act 1988 and s.6 M Human Rights Act 1998.

9 ss.29(2), s.35(1) and s.58 Scotland Act 1998. Even where the rights are not specifically incorporated into UK law, the UK nevertheless has an international law obligation to ensure their recognition and protection nationally.

10 Article 5 (equality and non-discrimination), Article 12 (equal treatment before the law), Article 14 (the right to liberty), Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), Article 17 (protecting personal integrity), Article 19 (independent and community living), Article 22 (respect for privacy) and Article 23 (respect for home and family).
Application of human rights standards in the context of compulsory treatment

Legal capacity and autonomy

In order to make fully autonomous decisions about any aspect of one’s life an individual requires recognition of their legal capacity. Where legal capacity is denied the consequences may be far-reaching and can often lead to, amongst other things, the restriction of a person’s autonomy, and deprivation of liberty and involuntary medical treatment. To be compatible with Article 8 ECHR any legislation, or its amendment, providing for the compulsory care and treatment of persons with mental disorder must therefore reflect that:

1. There is a presumption of legal capacity for persons with mental disorder.
2. Capacity must be assessed on a functional basis.\(^{11}\)
3. Non-consensual treatment is permissible only where national law provides for such intervention, the intervention is in pursuit of a legitimate aim, appropriate safeguards exist and, where there is a degree of discretion in its implementation, the scope of such discretion is defined.\(^{12}\)
4. Medical intervention does not have to amount to inhuman or degrading treatment before the right to private and family life in Article 8 is violated.\(^{13}\)

Additionally, Article 17 CRPD identifies an unqualified right to respect for physical and mental integrity and it seems that it is intended to apply in situations of involuntary detention and treatment.\(^{14}\) This therefore arguably strengthens the Article 8(1) ECHR right and thereby provide an additional constraint on unwarranted and excessive treatment that may otherwise be justified under Article 8(2).

What is clear is that incapacity or significantly impaired decision-making ability resulting from mental disorder (as required by the 2003 Act\(^ {16}\)) should not equate with a total disregard for autonomy even in involuntary treatment situations. Patients must be involved in decisions about their care and treatment whenever possible.\(^ {18}\)

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\(^{11}\) Shtukaturov v Russia (44009/05) (2008) 54 EHRR 27, paras 90, and 93-95. Although note that the UN Committee on the Rights of Persons with Disabilities in its General Comment of Article 12 CRPD (see below) states that such assessment must not be discriminatory.

\(^{12}\) Silver v United Kingdom (5947/72) (1983) 5 EHRR 347, paras 88 and 90.

\(^{13}\) Bensaid v United Kingdom (44599/98) (2001) 33 EHRR 10, para 46. See also Costello-Roberts v United Kingdom (13134/87) (1993) 19 EHRR 112, para 36.


\(^{16}\) See s36(4)(b) (emergency detention), s44(4)(b) (short term detention) and s64(5)(d) (compulsory treatment orders).

\(^{17}\) Glass v UK (61827/00) (2004) 39 EHRR 15, para 84; Storck v Germany (61603/00) (2006) 43 EHRR 6, paras 143-44.

Finally, the implications of the UN Committee on the Rights of Persons with Disabilities’ General Comment on Article 12 CRPD (the right to equal recognition before the law) adopted on 11 April 2014 are yet to be fully realised. However, it is highly likely that it will reinforce the requirement for genuine and demonstrable respect for legal capacity, and therefore the autonomy, of all individuals with mental disorder and even greater emphasis on supported decision-making. Indeed, the Bill provides the opportunity to address the strengthening of all forms of supported decision-making particularly independent advocacy, named persons and advance statements.

**Detention for care and treatment purposes**

Legislation, or its amendment, and its implementation requires that certain criteria are satisfied to ensure that detention for the purposes of treatment of mental disorder does not also violate an individual’s right to liberty under Article 5 ECHR. It must provide that:

1. The individual is genuinely suffering from mental disorder (Article 5(1)(e)) which has been “reliably shown” by “objective medical experts”.
2. It must be a proportionate measure. This means that detention must be demonstrated to be necessary for, and only be for long as it is necessary for, treatment of the condition and/or to prevent harm being caused to the individual or to others.
3. Detention must be in a place where the individual can receive the treatment they require. Indeed, detention in a place that is inappropriate for

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21 Winterwerp v the Netherlands (6301/73) (1979) 2 EHRR 387, para 39. Winterwerp, para 39; Shtukaturov, para 114; Stanev, para 45. This accords with the least restrictive treatment principle See, for example, Reid v United Kingdom (50272/99)(2003) 37 EHRR 9, paras 48-52. See also Articles 8, 18-20 and 27-28 Council of Europe Recommendation Rec(2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder (adopted by the Committee of Ministers on 22 September 2004). The principle is also reflected, in general terms, in Article 14 (right to liberty) CRPD.

the needs of an individual with mental disorder may even engage and violate Article 3 ECHR\textsuperscript{24}.

4. Procedural safeguards are available such as (a) the ability to challenge the lawfulness of the detention through the courts\textsuperscript{25}; (b) regular reviews of the detention where it is lengthy or indefinite\textsuperscript{26}; and (c) timely release of a person where their detention is found to be unlawful\textsuperscript{27}.

It should also be remembered that whilst deprivation of liberty engaging Article 5 clearly includes detention in a prison or psychiatric institution, restrictive measures amounting to a deprivation of liberty may be employed in other settings (for example, residential care homes, in community and domestic settings)\textsuperscript{28}.

The above-mentioned human rights requirements have been taken into account in this response.

Question 2: Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment)(Scotland) Act 2003 as set out in Part 1 of the Bill?

Section 1 - Measures until application determined

Although included as a recommendation in the McManus Report the Bill’s proposal to increase from the existing 5 to 10 working days the period within which the Mental Health Tribunal must make a determination regarding a compulsory treatment order where a person is subject to short term detention is unacceptable. Whilst it is noted that the reasoning behind the McManus Report recommendation was to avoid multiple hearings which can be distressing for the person concerned such as the Bill’s proposal does extend the period of time a person is subjected to detention without proper review. This has Article 5(4) (the right to liberty) and 6 (1) (the right to a fair trial) ECHR implications in terms of timely review of the necessity for compulsory measures.

It is noted that it is proposed to deduct from the ultimate period of compulsion (under ss64 and 65) the time during which the person has been detained in hospital on short term or extended short term detention pending the Mental Health Tribunal’s determination. It would be useful to know exactly how this will be calculated.

Section 2 - Information where order extended

In addition to the proposed amendment in section 2 of the Bill it is considered that section 85(3) of the 2003 Act should be repealed. This is so that the Mental Health

\textsuperscript{24} MS v UK (24527/08) judgment of 3 May 2012; Claes v Belgium (43418/09) judgment of 10 January 2013.

\textsuperscript{25} Winterwerp, para 55; Stanev, paras 168-171; DD, paras 163-167.

\textsuperscript{26} Stanev, paras 168-171; DD, paras 163-167.


\textsuperscript{28} See Scottish Law Commission (2012) Discussion Paper on Adults with Incapacity, Discussion Paper No 156, Edinburgh: The Stationery Office, Chapters 2 and 6 on the relevant ECHR principles and also P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent) [2014] UKSC 19.
Officer obligation under section 85(2) to interview the patient and inform them of their rights in relation to determination and the availability of independent advocacy services is provided at all times not only when it is “practicable” to do so. Knowledge of rights and the means of support to ensure they are observed are essential for the effective realisation of rights.

**Sections 11-12 - Conditions relating to non-state hospitals and qualifying non-state hospitals and units**

The 2012 Supreme Court ruling in *RM v The Scottish Ministers* made it clear that the necessary regulations must be made to ensure that the right not to be detained in conditions of excessive security in non-state hospitals can be effectively exercised. This has important Article 8 ECHR and, potentially even Article 3 ECHR (with corresponding Articles 17, 22 and 15 CRPD), implications.

The Bill does address the matter to some extent but not entirely. It amends the 2003 Act by clarifying who may appeal against detention in conditions of excessive security in a hospital other than in the State Hospital, namely patients detained by virtue of a restriction order, a compulsion order a hospital direction or a transfer treatment direction and provides some clarity regarding the definition of non-state hospitals. However, the regulations that the Supreme Court stressed are vital remain absent. Moreover, the proposed amendments only refer to patients held in medium secure settings and not those in low secure settings. This latter category of patients also have the protection of the rights mentioned in the above paragraph and it is likely to amount to discrimination to exclude them from exercising this right under the 2003 Act.

**Section 14 - Nurse’s holding power**

The Bill retains the provision extending the maximum period for a nurse’s holding power from two to three hours. There is no ability for a patient to challenge this. It is respectfully submitted that the comment in the Policy Memorandum “This additional time seeks to balance the need for flexibility to arrange for a medical examination with maintaining the need for minimum restriction on patients.” does not demonstrate why this is a reasonable and proportionate measure justifying the potential risk to a patient in terms of their liberty and autonomy.

**Section 15 Appeal on hospital order**

The Bill proposes the reduction of the existing 12 week period, in section 220, within which a patient may appeal against an order for transfer to the State Hospital to 28 days.

The Policy Memorandum states that this is to avoid delays in a patient’s treatment.

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29 *RM v The Scottish Ministers* [2012] UKSC 58.
30 S.11.
31 Indeed, *RM v The Scottish Ministers* concerned a patient in such a setting.
32 Article 14 ECHR in conjunction with Article 8 ECHR and Article 5 CRPD.
33 S.299.
34 Para. 75.
35 Para 80.
However, it should be noted that, notwithstanding this, Section 220(4(b)) still permits the Mental Health Tribunal to order the transfer where an appeal is pending “if satisfied that, pending determination of the appeal, the patient should be transferred as proposed…”. Whilst the Tribunal will be aware of its obligations in regard to the patient’s Article 5,6 and 8 ECHR rights an additional safeguard of such rights would be to repeal Section 220(4)(b).

Sections 18-20 Named Persons

The McManus Review noted that there is a lack of understanding by many service users, named persons and even by professionals about the precise role of named persons. It would therefore be very useful if the Bill were to provide clarity on this.

The Policy Memorandum states that the Scottish Government considered that an individual should only have a named person if they chose to have one. However, the opt out provision proposed in section 18 of the Bill does not achieve this. The opt out provisions requires specific action on the part of the patient to choose not to have a named person but they may not be in a position to exercise this right owing to being unwell or unaware of their right to opt out. This raises the potential that a named person may be involved in decisions about care and treatment and be provided with confidential information concerning a patient without that patient’s explicit consent to this. This has important implications in terms of the individual's legal capacity, autonomy and privacy supported and the requirements of Article 8 ECHR and Articles 12 and 17 CRPD, as mentioned above, must be taken into account.

Section 21 - Advance statements

Psychiatric advance statements are an important expression of individual autonomy identified in Article 8 ECHR and, even in compulsory treatment situations, are of considerable importance. The fact that advance statements also provide an indication of whether a patient would consent to a particular measure is also arguably integral in assessing whether a deprivation of liberty engaging Article 5 ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR). They also reflect supported decision making which is reinforced by the Committee on the Rights of Persons with Disabilities (see above). The problem is, however, that relatively few advance statements are actually made. There are various reasons for this but significant factors include a lack of awareness about them and patient misunderstanding about their effectiveness.

The proposed amendments are to be welcomed. That being said, whilst legislation alone cannot increase the number of advance statements made it can provide greater opportunities and encouragement for patients to make such statements. It is therefore recommended that the Bills provides for a statutory duty be placed on specified medical staff to discuss the making of an advance statement, and to explain their effectiveness, as part of their after-care plan.

36 Para 90.
Question 3: Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

Section 29 - Periods for assessment orders

Section 29(4)(c) of the Bill increases the period the court may extend an assessment order from 7 to 14 days. Whilst it is noted that the draft Bill provided for an increase to 21 days and the Bill has reduced this period there nevertheless remain important Article 5(4) and 6(1) ECHR requirements for timely hearings. It is questionable whether the proposed amendment is a necessary and proportionate extension of the period in question.

Question 4: Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

Section 44 - Right to information: compulsion order

Offenders subject to compulsion orders have often committed only minor offences and the Bill therefore contains an additional provision that the right to receive information concerning an offender subject to a compulsion order applies only where “an offence has been perpetrated against a natural person”\(^{39}\). However, care will nevertheless still have to be taken to ensure that the Victim Notification Scheme is not operated discriminatorily with mentally disordered offenders being treated differently to other offenders as this would be contrary to the requirements of Article 14 ECHR in conjunction with Article 8 ECHR and taking into account of Articles 3(b), 4(1)(b) and 5 CRPD.

Question 5: Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation?

Independent advocacy

The McManus Review Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland\(^{40}\). Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision has been made in the Bill to strengthen the duty to provide for such advocacy so that the right to independent advocacy can be fully realised by those who are entitled to it under the 2003 Act. It is therefore recommended that this be addressed in the final draft Bill. This is particularly important in light of the previously mentioned interpretation of legal capacity in the General Comment on Article 12 CRPD that strongly advocates supported decision-making.

Matters beyond the McManus Report

In addition, outside the scope of the McManus Report, there remain other issues which the Scottish Parliament should consider incorporating in the Bill. These include:

1. The use of covert medication and restraint

At present, there is little reference to the use of force, restraint or covert medication in the 2003 Act’s Code of Practice. The manner in which any non-consensual

\(^{39}\) Section 44.

\(^{40}\) pp10-12.
treatment is administered must be considered with the Act’s underlying principles and human rights standards firmly in mind. However, notwithstanding this, given the potential for Articles 2, 3, 5 and 8 ECHR to be engaged in such situations, and taking in account the aforementioned comments on Article 12 CRPD, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.

2. Deaths of psychiatric patients
The state has an operational duty, under Article 2 ECHR, to protect the right to life for detained psychiatric patients and this may also extend to non-detained psychiatric patients. Moreover, Article 2 requires an effective national legal framework that will provide for an independent and impartial investigation into the deaths of individuals in custody and following hospital care and treatment. The European Court of Human Rights appears to permit a degree of domestic discretion as to the manner and form of such investigations provided they fulfil certain criteria identified in its developing jurisprudence relating to this issue. Notwithstanding this, it is questionable whether the investigative framework in Scotland is fully compliant with Article 2. This was partially explored in the 2009 Report of Findings of Review of Fatal Accident Inquiry Legislation but remains to be addressed in terms of putting in place necessary legislative changes and any outstanding procedural measures. This should be undertaken now in order to give full effect to the requirements of Article 2.

3. Areas of incompatibility between s242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000
A full consideration of any areas of incompatibility between the two Acts may be more productive following the anticipated amendment of the 2000 Act in light of the forthcoming Scottish Law Commission report on adults with incapacity and deprivation of liberty. However, at this stage, the opportunity should be taken to amend section 242 of the 2003 Act in order to provide clarity. This raises issues under Article 8 ECHR and Article 12 CRPD and the role of substituted decision-makers in compulsory treatment situations.

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43 Shumkova v Russia (App no 9296/06) judgment of 14th February 2012, para 109.
Section 50 of the 2000 Act permits substituted decision-makers (welfare attorneys and guardians) to consent to medical treatment on behalf of an adult with incapacity. However, where such an adult falls to be treated for mental disorder under the 2003 Acts, section 242, which relates to treatment for mental disorder other than that requiring special safeguards, it is unclear as to whether such consent is permitted.

4. **Section 244 2003 Act Scottish Ministers’ power to make provision in relation to treatment for certain informal patients**

It is submitted that the regulations referred to in this section should be made and that they state that where artificial nutrition is given informally to a child under the age of 16 years this is supported by a second specialist opinion which is recorded.

Centre for Mental Health and Incapacity Law, Rights and Policy Edinburgh
Napier University
August 2014
The Mental Welfare Commission is grateful for the opportunity to comment on the provisions of the Mental Health (Scotland) Bill. We answer below the six questions you raise.

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

1. As the Scottish Government has said, the Bill does not seek to radically reform the regime for compulsory care and treatment established by the Mental Health (Care and Treatment) Scotland Act 2003. It is a series of relatively modest and incremental changes.

2. In broad terms, we support these changes, which address some of the practical issues which have arisen in the operation of the legislation. We are also pleased to note that some proposals in the original Government consultation, about which we raised concerns, have not been taken forward – particularly the suggestion that a compulsory treatment order might only have one medical recommendation; and that others, such as the proposals for suspension of detention and victim notification, have been modified.

3. So we broadly welcome this Bill, although we have some specific comments about particular proposals, and we are slightly concerned at the time it has taken for these modest reforms to be considered and brought forward for implementation. In our view, a more thorough consideration of the Act will soon be needed.

4. While we remain very supportive of the principles and approach of the 2003 Act, there are two broad areas not covered in the Bill we would highlight which require attention, namely:

**Areas where the aspirations of the 2003 legislation have not been fulfilled**

5. The 2003 Act was a huge step forward in protecting the human rights of mental health service users who are subject to compulsory care. However, the Millan committee was concerned to protect the rights of all mental health service users, and maximise the extent to which care was received on a voluntary basis. The 2003 Act was carefully constructed to achieve this.

6. This approach fits well with the broader aspirations in health care and public services of user empowerment and prevention. It is disappointing, therefore, that the intentions and, in some cases, the explicit provisions of the 2003 Act have not been fully borne out, particularly in respect of advocacy, the duties of local authorities to deliver services, and the role of mental health officers.
Advocacy

7. Section 259 of the 2003 Act could hardly be clearer in stating that every person with a mental disorder shall have a right of access to independent advocacy, and in setting out duties on health boards and local authorities to achieve this. Our experience, supported by evidence from the Scottish Independent Advocacy Alliance, is that this is still not the case, and that advocacy services, where they exist, are often targeted explicitly at supporting people subject to compulsory proceedings.

8. Good advocacy services play a vital role in assisting service users to negotiate effectively with care providers, which can prevent the need for compulsory care. In many cases, this will ultimately be cheaper and lead to better outcomes.

Local authority services

9. Sections 25-27 of the 2003 Act set out a clear set of duties for local authorities to provide care and support services for persons who have, or have had, a mental disorder; including services to promote their wellbeing and social development, which must include social, cultural and recreational activities, training and assistance in obtaining employment.

10. These duties fit well with the recovery approach, but we are concerned that there is insufficient recognition within some local authorities of their importance. The Commission is undertaking some themed visits to investigate this further.

11. We appreciate the pressures on public services, but people with mental disorders have a right to expect that statutory duties will be delivered. We would urge the committee to consider what can be done to ensure that local authorities and health boards are genuinely accountable for fulfilling these statutory expectations.

Role of MHOs

12. The mental health officer rightly plays a vital role in the 2003 Act, but the service is increasingly under pressure. This is partly attributable to a rise in workload associated with the 2003 Act, but largely reflects the very large rise in guardianship cases under the Adults with Incapacity Act 2000. This has led in some cases to a degradation of the service, with statutory reports late or not provided, and a reduction in the fulfilment of the duty to monitor guardianship cases.

13. The MHO workforce is ageing, and there are difficulties in attracting new social workers to the role – it requires a very significant commitment to extra training, with few incentives for either the worker or the employer.

14. There is an urgent need for a national strategy to improve recruitment, training and retention of MHOs to ensure the legislation can work properly, and we have approached the Scottish Government seeking their commitment.
to this. The provisions in the Bill relating to MHOs need to be considered in this context.

**Implications of recent human rights case law, and interaction with other legislation**

15. The Millan report recommended that, in due course, mental health and incapacity legislation should be brought together into a single act, to ensure there was a consistent, principled and complete legislative framework for non-consensual care and treatment. At the moment, there are a number of areas of doubt and uncertainty, for example over when a physical condition is sufficiently linked to a mental disorder to authorise use of the 2003 Act, the lack of emergency provisions in the AWI Act, and the extent to which incapacity legislation authorises forcible treatment against a person’s will.

16. The situation was further complicated by adult protection legislation, which introduces another framework which allows non-consensual health and social care interventions on vulnerable people, including those with mental disorders.

17. We may now be approaching crisis point with the decision of the UK Supreme Court in the *Cheshire West* case. This has greatly widened the circumstances in which care of a severely disabled adult counts as a deprivation of liberty requiring legal authorisation under Article 5 of the European Convention on Human Rights. We await proposals from the Scottish Law Commission to address this, and it seems likely that this will result in another statutory scheme to cover gaps in the AWI Act and the 2003 Act.

18. Having four routes to non-consensual treatment, involving two different forums (the sheriff court and the mental health tribunal) is likely to prove expensive, cumbersome and increase the risk of mistakes and service failures.

19. It is also not clear that our current legislation is compliant with Article 12 of the UN Convention on the Rights of Disabled People. The General Comment on Article 12 suggests that *all* forcible treatment for mental illness should be banned. We do not agree with this, but we do agree that there needs to be more emphasis on supported decision making and assisting patients to be more involved in treatment decisions.

20. In our view, it is now time to review the overall framework for non-consensual care and treatment, to make it clearer, more consistent, and compatible with developing human rights norms.

**Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?**
Procedure for compulsory treatment

Measures until application determined

21. On balance, we do not agree with the provision in section 1 to increase from five to ten working days the period of automatic extension of a short term detention certificate if an application for a compulsory treatment order is made. We believe it is unnecessary and undesirable to increase the period of detention to a full six weeks before there is judicial scrutiny, and that the situation has moved on since the McManus report.

22. We accept that, for understandable reasons, applications are often made late in the 28 day period, and that this places pressure on the Tribunal to arrange the hearing in time. We also agree that it is highly desirable to avoid multiple hearings, particularly because of the additional stress this places on the patient, and the risk that they will disengage from the process.

23. However, since the McManus report, we have seen a significant reduction in the number of cases requiring more than one hearing, in large part due to the efforts of the Tribunal to improve their performance in this regard. We do not believe the argument from administrative convenience justifies this change.

24. The argument that the extension allows more time to instruct legal representation and an independent report has more force, and in some cases it is no doubt true that it will allow the matter to be determined in one rather than two hearings. Against that, this change will in principle apply to all cases, and there must be a risk that those involved will tend to work to the new, relaxed deadline, resulting overall in longer periods of pre-hearing detention.

25. We would add that paragraph 23 of the policy memorandum states that the proposals in section 1 and 2 of the Bill were welcomed in the draft Bill consultation. In fact, this particular proposal was omitted from the draft Bill consultation.

Information where order extended

26. We are not entirely clear what is proposed in relation to additional duties on MHOs to prepare reports for renewal of detention. The Bill and paragraph 13 of the Explanatory Notes suggest that an MHO report will be required where the MHO disagrees, where the diagnoses has changed, or where the Tribunal has not reviewed the case for 2 years, while paragraph 47 of the Financial Memorandum only refers to cases where the MHO disagrees with the RMO’s assessment, and suggests there will be less than 20 cases a year.

27. In our response to the Government’s consultation, we said that a requirement for the MHO to give reasons when not agreeing to the RMO’s decision to extend the order was reasonable and proportionate. Our initial calculations suggest that the wider category of cases which the Bill provides for would involve significantly more than 20 cases a year. We are checking our figures, and would be concerned if large numbers of additional MHO
reports were required, given the pressures on MHOs discussed above, without a clear commitment to a strategy to improve retention and recruitment.

**Emergency, short term and temporary steps**

28. We agree with the proposals in sections 3 and 4.

**Suspension of orders and measures etc.**

29. We agree with the proposals in sections 6, 7 and 8.

*Maximum suspension of detention measures*

30. We agree that the current system for calculating the maximum period of suspension of detention is excessively complex. We are also pleased to see that the Government has modified the original proposal to remove altogether the time limit on suspension of detention. The time limit was recommended by Millan for a good reason – to avoid a person in the community being made subject for very long periods of time to conditions imposed at the discretion of the responsible medical officer, without scrutiny by the Tribunal. We believe that 200 days is a reasonable compromise.

31. We do not agree, however, with the proposal to allow a further 100 day extension of the suspension order with the authorisation of the Tribunal. If a patient has been in the community for over six months, and it is felt that he or she should remain in the community but subject to compulsion, the appropriate next step should be to invite the Tribunal to vary the order to a community-based compulsory treatment order.

**Orders regarding levels of security**

32. Subject to the comments below, we welcome the fact that some progress is being made to implement the intention of the 2003 Act that patients should have the right to appeal against the level of security at which they are held. It is extremely disappointing that this has taken over 10 years, and required a decision of the UK Supreme Court. We would urge the Committee to seek firm assurance from the Government as to the timescale for implementing this revised proposal.

33. We agree with the amendment to allow for a transfer to a lower level of security to take place within a hospital, rather than it having to be to a different hospital.

34. We have some concerns about the proposal to restrict the appeal right to medium secure settings, and deny a right of appeal on the level of security in low secure settings.

35. We are not persuaded by the argument in paragraph 62 of the policy memorandum that the next step for such patients would be to release them into the community, which the tribunal can already do by varying a CTO. That
may be true for some cases, but we believe there will be others who might move from a low secure setting into a mainstream hospital setting, and for whom the right of appeal could be valuable.

36. We recognise, however, that there are complex issues of definition at this level, and the nature of the security imposed on a patient may vary from day to day, or even hour to hour. If the Committee are persuaded that extension of this right to low secure patients is impractical, we would nonetheless urge that the Government provides clarity and a timescale on the suggestion at para 66 of the Policy Memorandum that, in addition to the new right, they will consider a new approach to assessing whether a patient is held at an appropriate level of security in the longer term.

Removal and detention of patients

37. We are content with the proposal at s13.

Detention pending medical examination

38. We are not in favour of extending the nurse’s power to detain to up to three hours.

39. The nurse’s power to detain allows a nurse of the prescribed class to detain a patient pending medical examination. The intention of this is to allow nurses to detain a patient in hospital for a period of two hours for the purpose of enabling arrangements to allow for a medical examination of the patient to be carried out.

40. The Commission reports annually on the use of this section. We were notified that the power was used on 177 occasions in the year 2013-2014. We have commented in recent years that Section 299 has probably been under-reported to the Commission and we have undertaken work to increase the rate of reporting.

41. Last year we carried out a limited analysis of 100 randomly selected NUR1 forms for closer scrutiny. The NUR1 form records the time the doctor was contacted and the time they arrived to carry out an assessment.

42. We found on all occasions that a doctor attended within the specified timescales. At the end of the period of detention, 74% of those went on to be further detained (40% under an emergency detention certificate and 34% under a short term certificate). 23% remained in hospital on an informal basis and 3% were discharged from hospital.

43. We are supportive of MHO consent being sought where possible, but are not convinced that extending the time period to three hours will result in an increase of MHO involvement which is sufficient to justify the general extension of this time period.
44. The NUR1 also confirms if the nurse contacted the Mental Health Officer to tell them that the detention period had started but does not record if the MHO had any further involvement or was unable to attend within the time limits. We therefore cannot provide firm data to support or rebut the suggestion that extending to three hours would increase the likelihood of their attendance and therefore reduce the number of emergency detentions. However, given the pressures on MHOs, and the likelihood that they will prioritise cases where the patient is vulnerable in the community, we are doubtful that it will make a major difference.

45. We have not heard concerns that the current time limit is inadequate and our limited analysis supports this. In the absence of any clear evidence that the current time limit is inadequate, we do not believe the case has been made to increase the time limit.

**Time for appeal referral or disposal**

46. We understand the reasons for this change, but 28 days is a short amount of time to expect a person who is already detained and who may be acutely unwell to initiate an appeal against a transfer to the State Hospital. We would invite the Committee to explore whether there is any compromise which might allow people in urgent need of appropriate treatment to be transferred quickly, while allowing a longer period for appeal, even after the transfer has taken place.

**Periodical referral of cases and recording where late disposal**

47. We support the changes in sections 16 and 17.

**Named persons**

48. The Commission recently carried out a study into the views of named persons (to be published shortly). We found that many named persons were unclear as to the role, and not well informed about other measures to support patients such as powers of attorney and advance statements. Half of the named persons interviewed raised issues about paperwork including late paperwork, and volume and complexity of paperwork to absorb at a time of crisis.

49. On balance, we agree with the policy position that an individual should only have a named person if they choose to have one (policy memorandum para 90). However, it is not clear that this is what the Bill provides. It appears that a person can actively choose not to have a named person but, if they do not do so, the default provisions regarding the named person being the primary carer or nearest relative will still operate.

50. We recognise an argument for retaining a default named person where the service user has not explicitly opted out. This might be an additional protection where the person is not well enough to express a view either way, or where the primary carer wishes their insight into the person to be taken
properly into account by the tribunal. However, the difficulties experienced with the system, particularly the sharing of large amounts of private and sometimes upsetting information with relatives, lead us to the view that maintaining a default named person is not the best solution. Alternatives could be explored, which would give carers and close relatives an opportunity to participate appropriately in the tribunal process without the burdens of named person status.

**Advance statements**

51. We support the proposal that advance statements should be registered with the Commission, although it will be important to provide reassurance to service users that appropriate privacy is being maintained, particularly where advance statements are not confined to issues of medication and compulsory care, but address a much wider set of personal views and wishes.

52. We strongly support wider use of advance statements, but do not believe that this small change will achieve this on its own. We would like to see a clearer commitment from the Government to work to promote advance statements amongst service users, and to identify and overcome the barriers users experience to using them.

**Support and services**

53. We agree with these changes. However, as we set out above, the experience of the duties to provide services in the 2003 Act is not encouraging, and we will be interested to see how the Government proposes to ensure that these new duties will be delivered.

**Cross border and absconding patients.**

54. We are content with these proposals. However, we raised two others issues in our response to the Government consultation which we would still wish to see addressed. We said: 
"Firstly, a patient transferred from, e.g. England may lose a right of appeal because the Act specifies that no appeal can be made within three months of the order being granted. But in this case, the order is granted by reports from two medical practitioners and an approved social worker. There would be an immediate right of appeal to a Tribunal. The right of appeal is lost if the patient is soon transferred to Scotland. The provision in the 2003 Act assumed that the order had been granted by a tribunal in Scotland. We recommend an amendment to the Act or the Cross-Border regulations to allow an earlier appeal to the Tribunal in this situation.
Secondly, the regulations in respect of removing a patient from Scotland give a right of appeal to the patient but not the named person. This is an anomaly as the named person can appeal a decision to transfer the patient between hospitals in Scotland."
Arrangements for treatment of prisoners

55. We agree with paragraph 113 of the Policy Memorandum that it would be beneficial for MHOs to be involved in the transfer of prisoners to hospital. However, given the pressures on MHOs, we are not persuaded that this should be a mandatory requirement, which could delay a transfer in some cases. We would prefer a provision that MHO consent should be obtained where practicable, with appropriate guidance in the Code of Practice.

56. We are content with the proposals regarding the make-up of Tribunals in section 27.

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

57. We have no major concerns with the adjustments to the calculation of time periods in sections 29-33, or the power in s33 for the court to vary the specified hospital. We understand the point about aligning the way time periods are calculated with criminal cases. That said, the approach now appears to be inconsistent with that for comparable civil orders, and we would wish reassurance that the Government has considered the possibility for confusion arising in other settings as a result of this, and has plans to mitigate it.

58. We are pleased that the proposal to allow a 21 day extension of an assessment order has been scaled back to 14 days. However, we are still not convinced that the case has been made for increasing the period of extension from the current 7 day period. The Government’s consultation asserts (para 57) that an extension of 7 days does not provide sufficient flexibility ‘given the vagaries of situations that may be met within the criminal justice system’. We would wish to see clearer evidence from the Government of the kind of issues that can arise, and that these are not issues that can be addressed by better organisation of the system, rather than extending detention periods.

Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

59. We suggested in our response to the Government’s consultation scheme that the victim notification scheme in respect of patients given compulsion orders should be restricted to those also placed under a restriction order, and we are pleased to see that this change has been made. We would suggest that the heading of s16A be amended to make clear that it is not applicable to compulsion orders generally.

60. We are not persuaded that the Bill yet strikes the right balance in cases where the offender is vulnerable. Paragraph 164 of the Policy Memorandum points out that human rights considerations necessitate consideration of the position of a vulnerable person subject to a mental health disposal, and states that Ministers should consider if releasing information might cause harm to
that person. But the provision in s16A only allows Scottish Ministers to withhold information in 'exceptional circumstances'. This is a narrow test, and we believe there needs to be greater clarity that Ministers should not release information where there is a significant risk of harm to the mental or physical health of the person subject to the mental health disposal. A comparable example would be the provisions in data protection legislation about when information can be withheld.

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

61. See our comments above in relation to the duty to provide advocacy. McManus raised concerns about this in Chapter 3 of his report. We feel consideration should be given to some legislative strengthening to address the McManus recommendations on this, particularly 3.1, 3.3, 3.5. and 3.6.

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

62. Annexed is a list of other issues concerning the operation of the 2003 Act which have come to the attention of the Commission. This was provided to the Government in response to its consultation.

Mental Welfare Commission for Scotland
August 2014
Part 7 – Compulsory Treatment Orders

<table>
<thead>
<tr>
<th>Section</th>
<th>Type of Recommendation</th>
<th>Details</th>
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| Section 77 | Improvement | This section includes persons to be consulted when the Responsible Medical Officer carries out a “first review”. This list of persons should be consulted under Section 86 when further reviews are undertaken. Subject to the outcome of consultation over the role of a named person, we suggest that the named person should be specifically consulted under Section 77(3)(c).

Also, in relation to first and subsequent reviews, there is no mention of “conflict of interest”. This appears to be an anomaly. There are regulations that apply to the granting of a short term detention certificate or application for a CTO in relation to conflict of interest, notably for practitioners working in independent hospitals who may stand to gain financially from the person’s detention. It seems anomalous that such a doctor could examine the patient, comply with the other measures and extend a CTO where such a conflict of interest exists. We recommend that, where the RMO has a conflict of interest as specified in regulations, that the RMO obtains an examination from an Approved Medical Practitioner who is not on the staff of the independent hospital or who is not contracted to provide services at that hospital. |
<p>| Section 124 | Improvement | This section gives authority for the transfer of a detained patient. There appears to be no procedure for a hospital to transfer the responsibility for a person treated under the act without the requirement for detention. For example, where a person moves address from Glasgow to Edinburgh, the managers of, say Leverndale Hospital cannot transfer responsibility to the Royal... |</p>
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<th>Section</th>
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<td>Edinburgh Hospital. The only remedy appears to be an application to vary the order. We do not think this was the intention of legislation and that the omission of such a transfer of responsibility was an accidental omission that could be corrected.</td>
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<tr>
<td>Section 126</td>
<td>Clarification/improvement</td>
<td>We know of a case where a person successfully appealed against her transfer to the State Hospital. The transfer had already taken place. However, the hospital from which she was transferred declined to receive her when the application was successful. The Act is silent on transfer back following a successful application, the timescales for such a transfer and the remedy if the transfer does not take place.</td>
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**Part 9**

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<tr>
<td>Section 139</td>
<td>Improvement</td>
<td>This is the situation where the RMO reviews a Compulsion Order and applies to the Tribunal for an extension. The same requirement to examine the patient apply to any subsequent extensions. As per our recommendation on CTOs, Conflict of Interest Regulations should apply here and, where there is a confliction of interest, the RMO should arrange for an Approved Medical Practitioner not on the staff of, or contracted to, the independent hospital to carry out a medical examination. Also, the tribunal should be able to make “recorded matters” for such orders</td>
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### Part 10 – Compulsion Orders and Restriction Orders

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<tr>
<td>Several</td>
<td>Improvement</td>
<td>We suggest abolishing conditional discharge. It should be possible to vary a compulsion order and restriction order in the same way as varying a compulsion order. We have encountered problems where the Tribunal revokes the restriction order in a patient subject to conditional discharge but does not vary the compulsion order at the same time. Our suggestion would bring COROs into line with the rest of the Act. Powers to impose other conditions and powers to recall can be retained and included in the measures in the CORO following variation to remove the detention measure. This would make this part of the Act easier to operate while losing none of the safeguards necessary for this small group of people. NB – we recognise that this is quite a radical step given the limited nature of the amendments but we still think this is worth considering.</td>
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<tr>
<td>Section 198</td>
<td>Improvement</td>
<td>We have indentified a major issue with Section 198. Where the Restriction Order is revoked but the Compulsion Order is not revoked, Section 198 (2) states that “Part 9 of the Act shall apply to the patient as if the Compulsion Order to which the patient is subject with a relevant Compulsion Order made on the day which the Tribunal revoked a Restriction Order”. However, were Scottish Ministers to appeal, it is possible that the appeal to the Court of Session would not be heard within the timeframe of the review required under Part 9 of the Act. We strongly recommend that this section is amended to “made on the day on which the Restriction Order no longer has effect”. Effectively, the “new” Compulsion Order would commence on the date specified by Section 196, not the date of the Tribunal hearing. This would appear to be an</td>
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<td>essential amendment.</td>
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**Part 15 – Preliminary Duties on making of Orders etc**

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<td>Sections 231 &amp; 232</td>
<td>Improvement</td>
<td>We place great value in the provision of a Social Circumstances Report. However, we think the requirements to prepare a report or provide a statement as to why such a report would serve “little or no practical purpose”, in relation to every relevant event as specified in Section 232 is excessively onerous and, in any case, is not being complied with. We advise a change in the wording of the Act. Only one SCR is necessary in relation to a single relevant event or a series of consecutive relevant events within a short timescale and there should be no requirement to make a “little or no practical purpose” statement where a further relevant event occurs. However, the SCR should be update if there are significant changes and, for long term treatment, should be reviewed and updated at least annually</td>
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**Part 16 – Medical Treatment**

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<td>Section 240(3)</td>
<td>Correction of drafting error</td>
<td>We think it is an error to include “without consent” in the part of this section on artificial nutrition. If mentioned in section 240(3), there must either be written consent in terms of S238 or a DMP opinion under S241. In relation to treatment given over a period of time, we have</td>
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<td>agreed that this includes treatment given in terms of section 243 while the patient is subject to emergency detention. This may need to be clarified in the Act or could be left as an issue for the code of practice to clarify.</td>
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<tr>
<td>Section 241</td>
<td>Improvement</td>
<td>Under this section, the designated medical practitioner is required to make an additional statement as to the reasons for treatment being given where a patient who is not incapable refuses treatment under section 240 (medication beyond 2 months etc.). The requirements are not as great as the requirements for notification in writing as to the reasons for giving treatment that conflicts with an advance statement (S276). In terms of the principle of participation, it is hard to justify greater safeguards for an advance statement than a contemporaneous one made by a patient with capacity. Should treatment given in conflict with a “capable” refusal carry the same requirements for notification as an override of an advance statement?</td>
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<tr>
<td>Section 242</td>
<td>Improvement/Clarification</td>
<td>This is an extremely difficult section of the Act to read and understand. We take it to mean that, where special safeguards do not apply to medical treatment under the Act, there is a general requirement either to obtain the person’s written consent or to provide a best interests statement as to whether the treatment should be given. However, several of us have examined this section and tried to read across to, in particular, Section 240, and failed to find clarity in what it is trying to achieve. We recommend that this section is reworded.</td>
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<tr>
<td>Section 242</td>
<td>Improvement/clarification</td>
<td>This section also prohibits the use of force to administer medical treatment where the patient is not in hospital. Because of the</td>
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<td>wording of this section, it is not clear whether this applies to treatments subject to safeguards – the heading for this section is “Treatments not mentioned in section 234” etc. The intention of the Act was to prohibit force – for example to give depot injections forcibly in a person’s own home. We support this and it therefore needs to be clearer that this part of section 242 also applies to safeguarded treatment.</td>
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However, there are two problems with this statement as worded. Firstly, medical treatment has a broad definition and includes “care”. There are times when care must be delivered by force where the person is not in hospital – e.g. during supervised/escorted visits outside hospital. Should the act state that “medication” cannot be administered by force where the patient is not in hospital?

Even then, we have encountered situations where a person with learning disability, being supported in accommodation outside hospital and subject to a “community” CTO, refuses to allow care staff to attend to personal care needs and where sedation for a short period, on infrequent occasions, is needed. A similar problem occurs in the case of the person with dementia in a care home under the authority of a “community” CTO or suspension of detention. The Act appears not to authorise this. Readmission to hospital under these circumstances does not comply with the principle of least restriction of freedom and could be disorientating and harmful. |
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<td>Section 244</td>
<td>Improvement</td>
<td>New and potentially controversial or relatively unevaluated treatments for mental disorder emerge from time to time. We recommend an extension of Ministers’ power to make regulations to prescribe conditions that must be satisfied before certain types of medical treatment specified in regulations are given to any patient regardless of age and regardless of whether the giving of medical treatment is or is not authorised by virtue of this Act or the 1995 Act. As well as providing regulations for new treatments, this would correct an apparent anomaly whereby regulations pertaining to people under the age of 16 but where treatment is authorised by virtue of the 2003 Act and who give consent to treatments specified under Section 237 could, in theory, be treated without the requirement for independent opinion.</td>
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<td>Part 16</td>
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of the Commission in relation to possible conflict of interest for the DMP. We would not appoint a DMP who is contacted to provide services to the hospital in which the patient is detained, or whose managers have responsibility in the case of community treatment.

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<td>Sections 264-273</td>
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1. **Do you agree with the general policy direction set by the Bill?**

Yes. We support the policy direction set out in the Bill. However as the Bill proposes further increases to the existing duties and responsibilities of staff this needs to be considered within the context of the existing workforce and workload capacity. This will have potential resource implications that need to be addressed.

2. **Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?**

The proposed amendments to the Advance Statement are welcomed. Clarity around the timescales, evaluations and Health Board processes to inform the Mental Welfare Commission would be useful, especially in noting the future role of Health and Social Partnerships.

There are also questions around the need for 24 hour accessibility to the Advance Statement for those who may require access. This may require additional systems infrastructure.

Further consideration should be given to the expansion of the proposed Advance Statement register to incorporate a Named Person Register.

The proposal to extend Nurses holding power from 2 to 3 hours to enable an informal patient to be detained for the purposes of enabling medical practitioner examinations irrespective of whether a doctor is immediately available or not was viewed positively.

It was noted however that Nurses should notify both the RMO and the MHO at the start of the holding power to facilitate attendance at the earliest opportunity.

The proposal to extend cross border transfer to include patients from outwith the UK from other EU member states was welcomed but would require further guidance.

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

We note the continued underprovision of female, adolescent and low secure services. We hope that the spread of appeals against security in the medium secure estate will lead to development of low secure services.
4. **Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?**

The proposal to extend the Criminal Justice Victim Notification Scheme to the victims or their relatives of mentally disordered offenders is welcomed although will require clear guidance on definitions, entry and exit points, roles, responsibilities, boundaries, accountabilities and any inconsistencies in applicability addressed.

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

It was generally agreed that the proposals were positive in most areas although, there were concerns highlighted that certain proposals could potentially be discriminatory to particular care groups such as those with a learning disability, those with capacity issues and mentally disordered offenders in some instances.

We would welcome the removal of (Care and Treatment) from the name of the Mental Health Act Scotland 2003 as this focus on care and treatment is adequately enshrined in the Act without the need for it to be in the title.

**NHS Forth Valley**

**August 2014**
SUPPLEMENTARY AND LATE WRITTEN EVIDENCE TO THE HEALTH AND SPORT COMMITTEE

Supplementary Evidence

Victim Support Scotland
COSLA

Late Submissions

Mental Health Tribunal for Scotland
People First (Scotland)
Lesley D McDade - Individual
Edwin Zarthrusz
A Burns
Thomas Leonard - The Edinburgh Equality Collective Advocacy Forum
Walter Buchanan
Claire Muir
W. Hunter Watson
W Hunter Watson 3
Chrys Muirhead
Anne Greig
Claire Muir 2
W Hunter Watson 4
Chrys Muirhead
W. Hunter Watson - 5
Mrs Judith Gilliland
W. Hunter Watson - 6
W. Hunter Watson - 7
W. Hunter Watson - 8
In anticipation of giving oral evidence on 18th November, Victim Support Scotland welcomes the opportunity to provide supplementary evidence to the Committee on the Mental Health (Scotland) Bill, with specific reference to the rights of victims of mentally disordered offenders (MDOs).

As stated in our written evidence to the Committee, Victim Support Scotland welcomes the introduction of a Victim Notification Scheme for victims of mental disordered offenders (MDOs). Being a victim of crime can be a particularly distressing and challenging experience if the crime has been perpetrated by an individual whom society believes needs care, support or treatment; victims can often be more fearful in these circumstances and are in particular need of reassurance and protection. As such, VSS strongly supports the introduction of a VNS for victims of MDOs.

**Compulsion Orders**

We highlighted our concern in our written evidence over the restriction of the proposed scheme to cover only CORO patients and offenders who move between prison and hospital (through HDs and TTDs), to the exclusion of CO patients. VSS believes that all victims should be able to access information about the release or escape of prisoners, regardless of sentence length or whether or not the offender is mentally disordered, and therefore would like the VNS for MDOs to include victims of offenders subject to compulsion orders. It is our view that this would also make practical sense, especially considering that victims of patients subject to a CO “already have the right to make representations or lead or produce evidence before the Tribunal under the existing provisions of the 2003 Act”.¹

We note the concern of advocates such as the Law Society of Scotland and the Scottish Human Rights Commission that including offenders subject to a compulsion order (CO) in the scheme may be discriminatory and disproportionate to MDOs subject to this order. For example, the Law Society for Scotland argue that “it would be discriminatory for mentally disordered offenders to be treated differently to other offenders in this respect...The provisions must not, therefore, go beyond that which would apply to other offenders.”² Furthermore, Health and Social Care Alliance Scotland agrees that “balancing the rights of...offenders and victims...should be addressed in the same way for all offenders, regardless of whether the offender is a Mentally Disordered Offender.”³

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¹ [http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf) p.12
Our original suggestion to address the balance was to include victims of offenders subject to a CO in the scheme if the compulsion order was extended at the 6 month review. After discussion with the Scottish Association for Mental Health (SAMH), we accept their contention that “while the length of a prisoner’s sentence can be taken as an indication of the severity of their offence, the length and type of an MDO’s detention is reflective of the severity and duration of their illness and not reflective of their offence.” Currently the Criminal Justice VNS is restricted to victims whose offender is sentenced to a period in custody of at least 18 months. As there is no way of knowing the length of the custodial sentence the offender would have been given if a mental health disposal was not ordered as an alternative, it becomes impossible to make directly comparable restrictions to the scheme for MDOs.

In order to address this issue, Victim Support Scotland strongly suggests that the sentence length restrictions currently in place within the Criminal Justice Victim Notification Scheme should be removed. We are aware that the Scottish Government have committed to lowering the threshold of sentence length to 12 months through their current order making powers within the Criminal Justice (Scotland) Act 2003. It is our belief however, that removing the eligibility restrictions altogether would be preferable; not only would we move towards fuller compliance with article 6 of the Victim’s Directive, which provides that victims should be able to access information about the release or escape of the offender without limitations or exclusions, a solution to the issue of proportionality in relation to the VNS for MDOs would also be provided.

The results of this would be a fair system in which every victim of an offender given a custodial sentence or mental health disposal as an alternative to custody has access to information, and is provided with the opportunity to make representations, as appropriate.

Clarity
Victim Support Scotland believes that it would be preferable to have a single notification scheme through which victims and prescribed relatives can access information and provide representations rather than having a system in which victims are required to negotiate a complex legal landscape to achieve the same aims. For example, in addition to compulsion orders, victims are also able to provide representations to the Tribunal in relation to excessive security applications although this is not included in the proposed VNS. We agree with the Mental Health Tribunal for Scotland that there is a need to “avoid overlap and duplication” with the existing provisions, as it is essential that victims should be able to easily understand and participate in any system that is put in place to benefit them.

4 http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/MHB026_-_SAMH.pdf p.8
5 http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf p.13
Conclusion
Victim Support Scotland supports the general principle of Part 3 of the Bill, as regards the introduction of a Victim Notification Scheme for victims of Mentally Disordered Offenders. In order to maximise the number of victims who would benefit from these proposals, we suggest that the scheme should also cover victims of offenders subject to compulsion orders, and propose that the Scottish Government remove the current restrictions on the Criminal Justice VNS to ensure that there are no concerns over the proportionality of the information provided in relation to MDOs. VSS believes that the proposed scheme should take into account all of the areas within which existing legislation allows victims the chance to provide representations to the Tribunal, to provide a comprehensive Victim Notification Scheme that is easy to understand and take part in. We look forward to discussing our suggestions with the Committee on 18th November, and will continue to work in partnership with other agencies in developing practical suggestions and options for the implementation of the updated legislation through our involvement in the short-life working group.

Victim Support Scotland
COSLA

Supplementary evidence on the Mental Health (Scotland) Bill 2014

Introduction

1. COSLA recently participated in a Health and Sport Committee oral evidence session, convened to support scrutiny of the Mental Health (Scotland) Bill 2014. At that session, COSLA raised a number of issues in relation to discrepancies within the Bill documentation and the resulting questions this raises over the accuracy of Financial Memorandum estimates of potential costs to councils. It was agreed COSLA would provide further written detail on potential costs to councils, and this is provided below along with some background information on COSLA’s policy position on the Bill.

Background – pre-existing pressures on the MHO workforce

2. Our initial perspective is that many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, and improving assessment options for individual councils and professional associations. However, the introduction of new statutory duties on local authority mental health officers (MHOs) to prepare reports for a tribunal hearing places another burden on an already overstretched and limited resource. There is a risk that proposals to require these reports, while welcome in policy terms, will result in an increased burden on local authorities.

3. New duties need to be considered against the backdrop of historic pressure on MHO capacity arising from the Adults With Incapacity Act, which introduced a demand-led system over which local authorities have no control. Since the Act’s introduction, there has been a year on year increase in MHO workload arising from AWI duties. For example, guardianship applications have been increasing by 10-12% per annum since 2000, and there are questions over whether the funding originally provided was sufficient. This burgeoning demand is occurring within the context of reducing MHO capacity. The Scottish Social Services Council recently published a report which showed that the MHO workforce is shrinking. It reduced by 3.4% between 2012 and 2013, and is now the same size as in 2008 despite increasing demand. Moreover, the workforce is ageing; about three-quarters of MHOs are over 44 years old, and one in three MHOs is 55 or older, meaning many will be retiring and recruitment has not kept pace.

4. Furthermore, the Scottish Law Centre published a report earlier in October which recommends changes to AWI legislation, to ensure compliance with the ECHR, which would significantly increase burdens on MHOs. The report proposes new AWI legislation to ensure compliance with Article 5 of the ECHR on deprivation of liberty. This would require local authorities and health boards to implement formal schemes for the ‘authorisation of significant restriction of liberty’. Such schemes would require increased use of guardianship and so would place a significant additional burden on MHOs in the form of increased guardian applications and new MHO reports.

5. All of these points underpin COSLA’s support for the Mental Welfare Commission’s call for a national strategy on recruitment, training and retention. We are aware that the Scottish

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Government Chief Social Work Adviser is carrying out work that will consider the role of MHOs as part of wider work on developing future social work strategy. The Committee may wish to reflect on whether the scope of this work will provide sufficient information about current and future resourcing to support the development of a robust strategy going forwards. COSLA would assert that any national strategy on recruitment, training and retention must be based on a fundamental review of MHO workload and capacity; this should include consideration of the wider policy and legislative landscape, what this means for longer-term capacity requirements, and how those requirements will be resourced.

6. In the interim, there is a case for the position that there should be no new duties which place an additional burden on MHOs until this work has been carried out and sufficient resources are in place to support change going forwards. Should Parliament nonetheless decide to proceed with new duties, the resulting financial burdens on local authorities must be properly understood and funded in full by the Scottish Government.

Scope of the Bill

7. The Bill proposals in relation to additional duties on Mental Health Officers (MHOs) are not clear due to inconsistencies between the various documents published with the Bill, and as a result, nor are the financial implications. COSLA is seeking clarification from Scottish Government regarding this inconsistency, but irrespective of the response, the Financial Memorandum significantly underestimates the financial implications of the Bill as currently drafted.

8. Specifically, the Bill explanatory notes (page 5, paragraph 13) which deal with section 2 of the Bill regarding hearings relating to compulsory treatment orders, suggest that an MHO report will be required in any of three different circumstances – where there is a change of diagnosis, where the MHO disagrees with the determination, or when the tribunal has not the compulsory treatment order within a certain timeframe. However the financial memorandum (page 34, paragraph 32) suggests a report will only be required in one of those circumstances – where the MHO disagrees with the determination. It estimates this to occur in about 20 cases per year, and goes on to give estimates of costs based on that incorrect narrower scope.

9. The same discrepancy exists in respect of section 41 of the Bill, which would introduce a requirement for an MHO report in relation to compulsion or compulsion and restriction order hearings. The FM estimates these to be ‘less than 20’ per annum. Again, the financial memorandum estimates are based on a narrower set of duties than described within the Bill.

10. Both the Mental Welfare Commission (MWC) and the Mental Health Tribunal for Scotland (MHTS) have also highlighted these discrepancies in their responses to the Health and Sport Committee. The Mental Health Tribunal for Scotland clearly states, in paragraph 16 of its response, that reports will be “triggered more often than is anticipated by the FM, and so the costs involved will be greater than those estimated.”

Resource Implications

11. The financial memorandum uses a unit cost per report of £475, provided by Social Work Scotland, and an estimate of 20 reports per annum to arrive at cost to councils of £9000 – although this would actually give a figure of £9,500. The ‘less than 20’ reports it assumes for s41 are written off as absorbable. As noted by COSLA and others, including the MWC, these figures are based on an incorrect interpretation of the Bill duties.

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4 Mental Health Tribunal for Scotland evidence submission, paragraph 16. [http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf)
12. COSLA’s submission to the Finance Committee indicated that the number of additional MHO reports could be as high as 1800, but that additional time was required to conduct further and these figures would need to be re-visited. COSLA has since obtained hearings data, for the financial year 2012/13, from MHTS and these show that the actual number of hearings where a report would be required under s. 2 of the Bill are 493. The provisions under s.41 would add a further 100.\textsuperscript{5} This gives a total of 593, not somewhere between 20 and 40 as the financial memorandum states. Assuming a unit cost of £475, this would give a total cost of £281,675.

13. However, even the figure of £281,675 may not be an accurate reflection of the full costs to councils for four main reasons:

   i. \textit{Travel costs}
   The unit cost of £475 does not allow for travel costs, which can be considerable in some cases – for example where an MHO is required to carry out visits to a person’s home, a hospital, or a prison, as part of gathering the information needed to be able to prepare a report. These costs will obviously vary a great deal across the country and are likely to be higher in rural areas. Estimates from our members ranged from £575 per report, to £675 (including travel).

   ii. \textit{Differential complexity of orders}
   The unit costs of compulsion and restriction orders can be significantly higher than the £475 estimate which the financial memorandum applies to reports across the board. Compulsion and restriction orders are more complex than other types of orders and consequentially can require more MHO time. Estimates from our members ranged from agreement with the £475 figure (excluding travel), to £847 per report.

   iii. \textit{Bill measures not considered by the financial memorandum}
   The financial memorandum does not include any estimated costs for new provisions introduced under sections 22 and 26 of the Bill. Section 22 extends the requirement for an appropriate person (often the MHO) to arrange assistance for people with communication difficulties, from not only those who are the subject of certain orders, but also to those who are subject to an application for these orders. Our members have indicated that the costs associated with this are difficult to estimate and further work will be required to estimate costs across Scotland.

   Section 26 introduces a new requirement for an MHO to agree before a transfer for treatment direction can be used (to remove someone from prison to hospital). This will normally require an MHO to visit the relevant prison, sometimes on more than one occasion. Given the distribution of prisons across Scotland, this is likely to require significant travel in many cases. Cost estimates from our members vary due to local circumstances, but the most commonly-reported figure was between £500 and £600. Estimates of the number of cases in each council where this is likely to apply ranged from two to ten, meaning the costs across Scotland could be significantly more than for the other measures which merited inclusion in the financial memorandum.

   Individual members also highlighted a range of other costs that could arise as a result various measures within the Bill. There is no clear pattern in relation to

\textsuperscript{5} Mental Health Tribunal for Scotland, case management database information request response, 30/09/2014
these costs, with different councils highlighting different issues – for example in relation to removal orders and named person requirements, and including a need for requirement for additional MHO posts with admin support. This suggests that costs are likely to impact differentially across councils, due to varying local circumstances, and that further work to scope these costs is required.

iv. **Year-on year fluctuations**

All of the additional costs outlined above, will be subject to year-on-year variations and these need to be taken in to account when estimating future costs. The financial memorandum considered a snap-shot of demand, during 2012/13. Looking at the most resource intensive measures – i.e. new duties on MHOs in relation to compulsion and retention orders, reveals a 120% increase from 2012/13 to 2013/14. Similarly, compulsion orders also increased by 30% over the same period. Compulsion and treatment orders have shown a more erratic pattern over recent years, suggesting future sharp increases cannot be ruled out. These fluctuations will have the effect of multiplying the additional costs described above, and there is a need to consider demand in a more robust manner by using a wider range of historical data to arrive at future demand projections.

**Conclusion**

14. In summary, although many of the policy intentions within the Bill are broadly welcomed, COSLA has significant concerns about the burden these will place on an already overstretched and limited resource. As previously noted, many of these concerns are shared by others, including the Mental Health Tribunal for Scotland and the Mental Welfare Commission. COSLA is also concerned that the scope of new duties on MHOs is unclear at this stage, with the financial memorandum and Bill explanatory notes disagreeing on the scope of duties. However, it is clear that the additional cost set out in the financial memorandum is an underestimation of the costs associated with the measures contained in the actual Bill.

15. Given that the introduction of new statutory duties on local authority MHO’s places a significant burden on a workforce which is already facing capacity problems, COSLA is requesting a fundamental review of MHO workload and capacity is carried out. Moreover, this review should include consideration of the wider policy and legislative landscape, what this means for longer-term capacity requirements, and how those requirements will be resourced. Should Parliament then decide to proceed with new duties, the resulting financial burdens on local authorities must be properly understood and funded in full by the Scottish Government.

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6 Mental Health Tribunal for Scotland, case management database information request response, 30/09/2014
Mental Health Tribunal for Scotland

Mental Health Scotland Bill

1. The Mental Health Tribunal for Scotland ("the Tribunal") was established by section 21 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") and became operational in October 2005. The Tribunal is responsible for making and reviewing decisions concerning the compulsory care, treatment and detention in hospital of people in Scotland with mental disorder.

2. The Tribunal welcomes the opportunity to respond to the questions posed by the Committee.

Question 1: Do you agree with the general policy direction set by the Bill?

3. The stated policy objectives of the Bill are—
   (1) to improve the efficiency and effectiveness of the mental health system in Scotland by implementing certain changes which the Scottish Government said it would bring forward following on from its consultation on the McManus Review of the 2003 Act; to provide a better system for reviewing conditions of security to which patients are subject by adjusting the provisions which allow the Tribunal to consider, on application, whether a patient is being detained in conditions of excessive security and to make a number of technical and drafting amendments to improve the legislative framework;
   (2) to make a number of minor technical amendments to Part VI (mental disorder) of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") to assist in finding clarity of meaning as well as improving operational efficiency;
   (3) to create a victim notification and representation scheme for victims of mentally disordered offenders subject to a hospital direction, a transfer for treatment direction or a compulsion order with a restriction order.

4. The Tribunal broadly supports the policy objectives at 3(1) and 3(3) above subject to detailed comments provided below.

5. The policy objective at 3(2) above is beyond the purview of the Tribunal.

Question 2: Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) (Scotland) Act 2003 as set out in Part 1 of the Bill?

Section 1 Measures until application determined

6. At present, a patient can be detained under a short-term detention certificate (STDC) for 28 days; an extension certificate (EC) for 3
working days; and then – where an application for a compulsory treatment order (CTO) is received by the Tribunal during the lifetime of the STDC or the EC – for 5 working days from the expiry of the STDC or EC under section 68 of the 2003 Act. Thereafter, the patient can be detained under section 65 of the 2003 Act for up to a maximum of 56 days by means of interim CTOs made by the Tribunal; and thereafter for up to 6 months under a CTO made by the Tribunal.

7. Section 1 of the Bill increases the 5 working day period of detention authorised under section 68 of the 2003 Act to 10 working days and provides that any proportion of this 10 working day period during which a patient is detained should be deducted from the period of any interim CTO or CTO subsequently made by the Tribunal.

8. The Tribunal broadly welcomes the proposed increase from 5 to 10 working days during which a patient can be detained under section 68. In practice, for good clinical reasons, applications for CTOs are commonly received by the Tribunal on days 26, 27 and 28 of the STDC or during the period of an EC. This leaves the Tribunal’s Administration with a very tight period of around 5 working days in which to book a venue, allocate the case to a three-member Tribunal panel, circulate the papers to the case to parties and to issue invitations to attend the hearing to those parties and to others who may wish to attend the hearing (for example, witnesses or family members). The result can be that due to the short notice patients are inevitably given of the first hearing the patient may not have had sufficient time to arrange representation or, if desired, to have instructed a psychiatric report. As a consequence, such hearings would be adjourned with the patient being made subject to an interim CTO.

9. Over the years since the McManus Review and the Scottish Government’s consultation on that Review, the Tribunal has made significant efforts to ensure that, where possible and appropriate, a case calling before the Tribunal can be determined at the first hearing. For example, the Tribunal has put in place a system for identifying where a patient is incapable of instructing legal representation so that the Tribunal can appoint a curator ad litem at the earliest opportunity to represent the patient’s interests before the Tribunal. The Tribunal has also put processes in place to allow procedural decisions, e.g. decisions not to disclose documents to certain parties, to grant adjournments and so forth, to be considered at the earliest opportunity. These steps have reduced the number of cases before the Tribunal which require to go to more than one hearing to approximately one third.

10. It appears to the Tribunal that it has done all it can under the existing provisions of the 2003 Act to reduce the requirement for hearings of CTO applications to go to more than one hearing.
11. The Tribunal recognises that the policy intention is to ensure that patients have the best opportunity to be represented if they so wish and to have instructed a psychiatric report if they so wish, so that they are ready and prepared to proceed at the first hearing before the Tribunal. From the Tribunal’s perspective, the increase from 5 to 10 working days is not for the administrative convenience of the Tribunal. If this amendment occurs, the Tribunal will continue to fix hearings and circulate papers and invitations at the earliest opportunity, to ensure that the greatest proportion possible of that 10 working day period is passed over to patients and their representatives, so that they have the maximum opportunity to be ready and prepared to proceed at the first calling of the case before the Tribunal.

12. With regard to the proposal that any part of the 10 working day period during which a patient is detained should be deducted from the period of any interim CTO or from the 6 month period of any subsequent CTO granted by the Tribunal, the Tribunal observes that this would create considerable difficulties for mental health professionals, Tribunal staff and Tribunal members in calculating when an interim CTO or CTO should expire (it is unclear whether the period to be deducted is to be calculated in days, days and hours, or days and hours and minutes).

13. It appears to the Tribunal that such a difficulty may be avoided by providing that where a CTO is made in such circumstances, the CTO should be deemed to commence on the day immediately succeeding the expiry of the STDC.

Section 2 Information where order extended

14. Section 2 of the Bill provides that, where a responsible medical officer (RMO) extends a patient’s CTO and a hearing is triggered before the Tribunal under section 101(2) – i.e. because there is a difference between the types of mental disorder identified by the RMO and the types specified in the CTO; or the mental health officer (MHO) disagrees with the RMO’s decision to extend the CTO or has failed to indicate a view; or a 2-year review is triggered – the MHO must prepare a record providing the name and address of the patient, the name and address of the named person and primary carer if known, what things the MHO has done in compliance with the statutory duties set out in section 85, the details of the personal circumstances of the patient and the details of any advance statement made by the patient, the views of the MHO on the extension of the CTO and any other relevant information.

15. The Tribunal welcomes this provision providing a statutory footing for best practice. The Scottish Government will, of course, require to consider the effect this new provision may have on MHOs and whether additional resources might be necessary.

16. Paragraph 32 of the Financial Memorandum states that section 2 “may cause a slight increase in costs for local authorities”, as MHOs will be
required to prepare a report for a hearing “where a responsible medical officer requires a hearing to review a patient’s compulsion order [sic.] and the mental health officer disagrees with the responsible medical officer’s assessment of the patient”. It appears that the reference to “compulsion order” is a typographical error and should be to a CTO. However, it appears to the Tribunal that a hearing is not triggered under section 101(2) only where a “mental health officer disagrees with the responsible medical officer’s assessment of the patient”. As noted in paragraph 14 above, a hearing under section 101(2) can be triggered in 3 separate circumstances, one of which is an automatic 2-year review. It may be, therefore, that the obligation on the MHO to provide a report is triggered more often than is anticipated by section 32 of the Financial Memorandum, and so the costs involved will be greater than those estimated at paragraph 33 of the Financial Memorandum.

Section 3 Emergency detention in hospital
Section 4 Short-term detention in hospital

17. The principal effect of sections 3 and 4 of the Bill appears to be to prevent a patient being made subject to an emergency detention certificate (EDC) (under section 36 of the 2003 Act) or an STDC (under section 44 of the 2003 Act) where the patient has been living in the community but has then been detained in hospital for a period of 72 hours under section 113 (non-compliance generally with order) of the 2003 Act.

18. Where a patient living in the community is detained in hospital for a period of 72 hours by means of section 113, it is not clear to the Tribunal what courses of action would then be open to an RMO if the patient could not then subsequently be detained under an EDC or an STDC. The only other course would appear to be for the RMO to make an application to the Tribunal for the patient’s CTO to be varied from being community to hospital based. However, in practice it would be extremely difficult to make such an application to the Tribunal and for it to be heard by the Tribunal before the expiry of the 72 hour period under section 113 of the 2003 Act.

Section 6 Suspension of orders on emergency detention
Section 7 Suspension of orders on short-term detention

19. The purpose of section 6 of the Bill appears to be to cause the granting of an EDC to have the same effect on a compulsion order (CO) or interim CTO as it presently has on a CTO, i.e. the measures other than the giving of medical treatment in accordance with Part 16 of the 2003 Act cease to have effect during the currency of the EDC.

20. The purpose of section 7 appears to be to cause the granting of an STDC to have the same effect on a CO or interim CTO as it presently has on a CTO, i.e. all measures specified in it cease to have effect during the currency of the STDC.
21. Sections 6 and 7 of the Bill appear to be useful tidying exercises avoiding the duplication of measures where certificates run concurrently with orders.

Section 8 Suspension of detention for certain purposes
Section 9 Maximum suspension of detention measures

22. Sections 8 and 9 of the Bill make provision in respect of suspension of detention under the 2003 Act. Suspension of detention is the means by which patients being detained in hospital can have their detention suspended for periods of time to allow them to be “tested out” in the community, building up to periods of days or weeks living in the community before progressing on to have their CTO formally varied by the Tribunal from being hospital based to being community based. The judgement of the Outer House in the case of DC\(^1\) made plain that the current suspension of detention provisions of the 2003 Act are not fit for purpose because – by allowing detention to be suspended for the period of an event or for days or weeks at a time and by specifying the maximum period during which detention can be suspended as the cumulative period of “9 months in the period of 12 months” ending with the expiry of the latest period of suspension of detention – it is impossible in many circumstances for RMOs in suspending detention to calculate accurately whether they are breaching the maximum cumulative period (not least because the period of 9 months varies according to what months make up the 9).

23. The purpose of sections 8 and 9 of the Bill is to simplify suspension of detention by providing that the maximum period for which a patient’s detention may be suspended is 200 days in any 12 month period (excluding any period of suspension authorised by the RMO between 9:00 pm and 8:00 am, which is 12 hours or less in duration); the 200 day maximum being able to be increased by 100 days up to a maximum of 300 days.

24. The Tribunal welcomes amendment of the 2003 Act which will make the calculation of any period of suspension of detention clearer so that mental health professionals and the Tribunal can more readily ascertain whether the maximum period allowable for suspension of detention has been breached.

25. It is not clear to the Tribunal that the provisions allowing the Tribunal to increase the maximum period of suspension of detention from 200 days in any 12 month period to 300 days in the same 12 month period operate effectively. The Tribunal has raised these technical concerns with the Scottish Government direct.

26. With regard to the provision whereby the maximum 200 days in any 12 month period for which a patient’s detention may be suspended can be increased by a maximum of 100 days, if that higher total is approved

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\(^{1}\) DC Petition for Judicial Review 2012 SLT 521, 2011 GWD 39-805
by the Tribunal, the Tribunal has considered the comments of Lord Stewart at paragraph [48] of DC ², in which he says that the purpose of the existing 9 month limit is likely “to encourage the RMO to apply his or her mind to the question of whether a hospital based order continued to be appropriate”. Having reflected on those comments, the Tribunal is unclear that it is desirable to replace a 9 month (i.e. approximately 270 day) maximum period with a reduced 200 day (i.e. approximately 6 ½ month) maximum period which can then be increased with the approval of the Tribunal by a further 100 days (i.e. approximately 3 months). This appears to add unnecessary complexity into the system when the very intention is to reduce complexity.

27. The question also arises as to what is to happen if a request to increase the total is refused by the Tribunal. The Tribunal will have no power on such an application to vary the CTO to being community based, and it is not clear that the RMO will have sufficient time to make a separate application to vary the CTO to being community based.

Section 10 Process for enforcement of orders
Section 11 Orders relating to non-state hospitals
Section 12 Qualifying non-state hospitals and units

28. Sections 10 to 12 of the Bill make provision concerning orders regarding the level of security in which a patient may be detained. Sections 264 to 267 of the 2003 Act allow patients detained in the State Hospital to apply to the Tribunal for an order under section 264 of the 2003 Act that they are being detained in conditions of excessive security. If such an application is successful and a declarator is made by the Tribunal, failure to transfer the patient to a hospital in which the patient may be more appropriately detained automatically triggers further hearings before the Tribunal under sections 265 and 266 of the 2003 Act.

29. The effect of the provisions of the Bill is twofold. First, section 266 is repealed (as is section 270, its equivalent in the case of patients in hospitals other than a state hospital). The effect is that the relevant authorities will have only two opportunities to transfer a patient (in compliance with an order by the Tribunal under section 264 or 265 of the 2003 Act or the equivalent provisions for patients detained in a hospital other than the State Hospital).

30. Second, the Bill makes amendments to the 2003 Act in respect of applications to the Tribunal by patients in hospitals other than the State Hospital for declarators that they are being detained in conditions of excessive security. Those provisions at sections 268 to 271 of the 2003 Act have never been made operational, because no regulations identifying a “qualifying patient” or a “qualifying hospital” for the purposes of sections 268 to 271 of the 2003 Act have been made.

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² DC Petition for Judicial Review 2012 SLT 521, 2011 GWD 39-805
31. Scotland has only one high security hospital, the State Hospital. However, Scotland has other hospitals and units of hospitals providing various degrees of security for the detention of patients. Providing a right for patients in hospitals other than the State Hospital to apply to the Tribunal for a declarator that they are being detained in conditions of excessive security is a complex policy and practical matter, not least in deciding which hospitals or hospital units patients are detained in should have that right.

32. It appears to the Tribunal that, by repealing the right to specify “qualifying patient” under section 268(11) of the 2003 Act, all patients specified in section 268(1) of the 2003 Act (namely those subject to a CTO, a CO, an HD or a TTD) will have the right to make an excessive security application to the Tribunal so long as they are in a “qualifying hospital”, which is to be defined by regulations in terms of new section 272A(1) inserted by section 12 of the Bill.

33. Which “qualifying hospitals” the right to make excessive security applications should be extended to is a matter for the Parliament. As the Tribunal will be the body deciding those applications on the basis of the evidence before it, the Tribunal is of the view that it is not appropriate for it to enter into the debate as to the patients in which “qualifying hospitals” this right should be extended to.

Section 15 Appeal on hospital transfer

34. Section 15 of the Bill reduces the period during which a patient is transferred from a hospital to the State Hospital from 12 weeks to 28 days.

35. It appears to the Tribunal that a patient who fails to make an appeal against transfer to the State Hospital within the new reduced period of 28 days would be able to make an application to the Tribunal under section 264 of the 2003 Act for a declarator that the patient is being detained in conditions of excessive security, where that patient is not prohibited from doing so by virtue of section 264(7) of the 2003 Act.

Section 16 Periodical referral of cases

36. Section 189 of the 2003 Act provides that where a patient is subject to a compulsion order and a restriction order (CORO) and during a specified 2 year period no reference or application has been “made to” the Tribunal, then a reference to the Tribunal is automatically triggered. Section 189 essentially ensures that even where a CORO patient’s case has not come to the Tribunal by any other means, that patient’s case will be reviewed by the Tribunal approximately every 2 years.

37. Section 16 of the Bill amends section 189 of the 2003 Act so that the trigger for the 2-year review is not whether a reference or application has been “made to” the Tribunal in the relevant 2 year period, but
whether such a reference or application has been “determined” by the Tribunal in the relevant 2 year period.

38. This amendment is welcomed by the Tribunal bringing, as it does, the manner of calculating whether a 2-year review is triggered for CORO patients into line with the way in which whether a 2-year review is triggered is calculated under section 165 of the 2003 Act for a patient subject to only a CO.

39. It appears to the Tribunal that section 101(3) of the 2003 Act could usefully be amended to provide that, when calculating whether or not a 2-year review is triggered for a patient subject to a CTO, this is calculated by whether in the relevant 2 year period the Tribunal has made a decision under section 103 (powers of Tribunal on application under section 92, 95, 99 or 100) rather than, as at the moment, whether an application has been “made to” the Tribunal under section 92, 95, 99 or 100 during the relevant 2 year period. This would produce a consistent approach throughout the 2003 Act.

Section 17 Recording where late disposal

40. Section 17 of the Bill inserts new paragraph 13B into schedule 2 to the 2003 Act. New paragraph 13B provides that if the Tribunal fails to comply with a time limit, or otherwise fails to do something within a particular period, by reference to which there falls to be determined “an application or appeal made to it under this Act” or “another matter coming before it by virtue of this Act”, the Tribunal must “except where by reason of lapse of time no useful purpose would be served by doing so, determine the application, appeal or other matter without undue delay” and “state in its record of the proceedings” “that the failure has occurred” and “the reason for the failure”.

41. This section followed section 14 (time allowed for disposals) of the draft Bill. Section 14 was removed before introduction of the Bill to the Parliament. It appears to the Tribunal that this section should have been removed along with section 14 of the draft Bill.

42. It is not clear to the Tribunal what “time limit” or “particular period” of the 2003 Act new paragraph 13B could apply to, other than the 5 working day period provided for by section 68 of the 2003 Act. The Tribunal is not aware of any issues around it holding hearings within the 5 working day period provided by section 68. Accordingly, it is not clear to the Tribunal what purpose new paragraph 13B serves.

Section 18 Opt-out from having named person
Section 19 Consent to being named person
Section 20 Appointment of named person

43. At paragraph 90 of the Policy Memorandum it is stated: “The Scottish Government considers that an individual should only have a named person if they choose to have one”. The Tribunal supports this policy
objective. At present, the named person provisions of the 2003 Act (at sections 250 to 258) allow a person to nominate a named person (section 250). However, if a person does not nominate a named person, section 251 of the 2003 Act effectively operates to identify the person’s primary carer or nearest relative as that person’s named person.

44. A named person is a party to proceedings before the Tribunal. As such, a named person is entitled to – indeed is required by the Tribunal’s Rules to be provided with – all the papers, including medical reports, concerning the patient whose case comes before the Tribunal.

45. Essentially, where a person has not nominated a named person, section 251 of the 2003 Act operates to identify that person’s nearest relative, who is then provided with all the papers, including medical reports, which are provided to the Tribunal. Those reports may contain details of the patient’s involvement with mental health services which may include allegations they have made (perhaps allegations made during periods of mental ill health) concerning friends or family members, details of the patient’s sexual behaviour or details of drug abuse. It may be that the patient has not shared any of this information with their nearest relative, and indeed may have no intention of sharing such information with their nearest relative. The sharing of such information may well be distressing for the patient and the named person alike and may be harmful to relations between the patient and their nearest relative. For these reasons, the Tribunal supports the policy “that an individual should only have a named person if they choose to have one”.

46. It appears to the Tribunal that sections 18 to 20 of the Bill do not deliver the Scottish Government’s stated policy objective, as section 251 of the 2003 Act is not repealed and will continue to operate unless a person has either nominated a named person or has made a declarator that s/he does not wish to have a named person (see section 18(3)(b) of the Bill).

Section 21 Registering of advance statements

47. Paragraph 93 of the Policy Memorandum states “The policy objective for these provisions is to ensure that where an advance statement exists, it is used as appropriate, thus underpinning the principle of maximum involvement of the service users in proceedings and treatment”.

48. At paragraph 95 of the Policy Memorandum it is stated “The Scottish Government considers it is important that where an individual has completed an advance statement and thus shown a willingness to participate in their treatment then it is important that the relevant parties are aware of the existence of this document”.

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49. Section 21 of the Bill makes provision in respect of registering an advance statement. It inserts section 276B (advance statements to be kept by the Commission) and section 276C (persons entitled to inspect advance statements) into the 2003 Act. Section 276C provides that the Commission must allow “anything kept in the register” to be inspected by certain people. The only things that must be kept in the register are copies of advance statements or documents withdrawing advance statements.

50. Section 276C(2) sets out the people who must be allowed to inspect the register at a reasonable time:

- “the person to whom the thing relates;
- “with respect to treatment of the person for mental disorder… any individual acting on the person’s behalf”; and
- “for the purpose of making decisions or taking steps with respect to the treatment of the person for mental disorder” the MHO, RMO or Health Board.

51. It appears to the Tribunal that the specified people are not, as of right, simply entitled to inspect an advance statement or document withdrawing an advance statement kept in the register.

52. While section 276C authorises “any individual acting on a person’s behalf” to inspect “anything kept in the register”, it authorises it only “with respect to treatment of the person for mental disorder”. It is not clear to the Tribunal why the entitlement of an individual representing a person to inspect the register is not simply a right to inspect the advance statement or document withdrawing the advance statement, but is instead restricted to “with respect to treatment of the person for mental disorder”. The Tribunal is not clear how this caveat will be interpreted, or by whom. The Tribunal is unclear as to who a person “acting on a person’s behalf” is and how the Commission will judge whether the person is “acting on a person’s behalf”.

53. It appears to the Tribunal that the MHO, RMO and Health Board in respect of the patient do not have an unfettered right to inspect the copy of that person’s advance statement or the letter withdrawing an advance statement kept in the register, rather they have a right of inspection “for the purpose of making decisions or taking steps with respect to the treatment of the person for mental disorder”. The question arises whether the Commission is to judge what the purpose of the MHO, RMO or Health Board is before deciding whether that person can inspect the register.

54. Finally, it appears to the Tribunal that a right to inspect will not include the right to make a copy.
Section 22 Communication at medical examination etc.

55. Section 22 of the Bill inserts section 261A (help with communication at medical examination etc.) into the 2003 Act directly after section 261 (provision of assistance to a patient with communication difficulties). It appears to the Tribunal that there may be some duplication of section 261 in new section 261A. For example new section 261A, it appears, provides that where a medical examination by virtue of section 44(1)(a) of the 2003 Act has to be carried out in respect of a patient detained in hospital and the patient generally communicates in a language other than English, then the managers of the hospital in which the patient is detained must take all reasonable steps to secure that, for the purpose of enabling the patient to communicate during the medical examination, appropriate arrangements are made or the patient is provided with assistance or material appropriate to the patient’s needs. However, it appears to the Tribunal that the Health Board is already under that obligation by virtue of the provisions of section 261 of the 2003 Act.

56. New section 261A(4)(a) refers to section 57A(2) “of this Act”, i.e. the 2003 Act. The 2003 Act does not have a section 57A(2). Section 133 of the 2003 Act inserted new section 57A into the 1995 Act, therefore section 57A is a section of the 1995 Act not of the 2003 Act.

Section 23 Services and accommodation for mothers

57. Section 23 of the Bill amends section 24 of the 2003 Act to place an obligation on Health Boards to provide any woman with post-natal depression or a mental disorder other than post-natal depression with services and accommodation necessary to ensure that the woman is able, if she wishes, to care for the child in hospital. The effect is to extend this obligation beyond women with post-natal depression to include women with another mental disorder. The Tribunal welcomes this provision.

Question 3: Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

Sections 28 to 42 Part 2: Criminal Cases

58. It appears to the Tribunal that these provisions make a number of minor amendments (see paragraph 83 of the Explanatory Notes of the Bill) to the 1995 Act, mainly concerned with timescales and procedure.

59. These amendments appear to the Tribunal to be beyond the purview of the Tribunal and, accordingly, the Tribunal makes no comment on these sections.
Question 4: Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

Sections 43 to 45 Part 3: Victims’ rights

60. Sections 43 to 45 of the Bill establish a scheme for the provision of information to, and the making of representations by, victims and family members of victims of mentally disordered offenders (MDOs).

61. The Tribunal welcomes the establishment of a victim notification and representation scheme in respect of the victims and family members of victims of MDOs.

62. Under the current provisions of the 2003 Act, the Tribunal requires to afford to various persons the opportunity:
   (i) of making representations (whether orally or in writing); and
   (ii) of leading and producing evidence, including to “any other person appearing to the Tribunal to have an interest” in the case before the Tribunal.

63. It is difficult to conceive that victims and family members of victims of a patient would not appear to have an interest in the outcome of a case concerning the patient.

64. The provisions of the Bill provide the right to be notified of certain decisions and the right to make representations in certain circumstances to the victims and family members of victims of patients subject to a CORO, a transfer for treatment direction (TTD) or a hospital direction (HD). The heading to section 44 of the Bill and new section 16A may possibly cause confusion referring, as they do, only to “compulsion order”. In fact, new section 16A(1)(b) makes clear it applies only in respect of a patient subject to a compulsion order and a restriction order.

65. In the cases of patients subject to only a CO, under the existing provisions of the 2003 Act, the Tribunal requires to afford to “any… person appearing to the Tribunal to have an interest” the right “of making representations whether orally or in writing and of leading or producing evidence”. This would appear to include victims and family members of victims of a patient subject to only a CO. The question arises whether the scheme provided for by the Bill should be extended to include victims or family members of victims of a patient subject only to a CO. The Tribunal notes the concerns of the Mental Welfare Commission for Scotland and the Law Society of Scotland in relation to the potential inclusion of patients subject to a CO but, as noted above, victims of such patients already have the right to make representations or lead or produce evidence before the Tribunal under the existing provisions of the 2003 Act. The Tribunal also notes that COs can be imposed where the index offence has been serious.
66. It appears to the Tribunal that it would be preferable if all patients subject to a mental health disposal by the criminal courts (i.e. CO alone or CORO) were subject to the statutory victim notification scheme.

67. Applications under section 264 (detention in conditions of excessive security: State Hospital) are not included within the scheme provided by the Bill. Accordingly, under the scheme victims and family members of victims will be entitled to make representations in certain cases concerning patients subject to a CORO, TTD or HD, but not in section 264 applications. However they will still be entitled to make representations in section 264 applications, whether orally or in writing, by virtue of being a “person appearing to the Tribunal to have an interest” in terms of section 264(9) and (10) of the 2003 Act.

68. If the scheme provided for by the Bill does not cover excessive security applications made by patients detained in a hospital other than the State Hospital, victims and family members of victims of patients subject to the scheme provided for by the Bill will still be entitled to make representations under the existing provisions of the 2003 Act, i.e. by virtue of being “a person appearing to the Tribunal to have an interest” (see section 268(9) and (10) of the 2003 Act).

69. It appears to the Tribunal that the Bill requires clearly to identify those people entitled to make representations under the scheme provided for by the Bill and then exclude those people from making representations or leading or producing evidence under the “person appearing to the Tribunal to have an interest” provisions of the 2003 Act, simply to avoid overlap and duplication.

Question 5: Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation? If so, please set out why.

70. It appears to the Tribunal that the Bill addresses those aspects of the McManus Report that the Scottish Government stated that it would take forward which require primary legislation. However, it does appear to the Tribunal that the Bill provides a useful opportunity to make a small but significant amendment to section 290 of the 2003 Act.

71. Section 290 of the 2003 Act makes provision concerning the cross border transfer of patients subject to a detention requirement or otherwise in hospital. Section 290(2) provides a power to make regulations concerning a person’s removal from Scotland. Section 290(2)(d) provides power for such regulations to make provision for a patient to be able to appeal against “a decision to transfer the patient outwith Scotland”. Such regulations have been made and regulation 13(1) of the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 bestows such a right of appeal on the patient. What is unusual is that it is the patient, and only the patient,
who has a right of appeal. Unusually, no other person (such as, for example, the named person) has a right of appeal. In the circumstances, in particular of young people and patients who may be unwell at the time of a proposed transfer, it appears to the Tribunal that such a right of appeal should be able to be exercised by a patient’s named person. This change cannot be made in regulations because, as referred to above, section 290(2)(f) of the 2003 Act itself only allows the right of appeal to be given to the patient.

Question 6: Do you have any comments to make about the Bill not already covered in your answers to the questions above?

72. The Tribunal has no other comments to make about the Bill not already covered in the answers to the questions above.

Mental Health Tribunal for Scotland

September 2014
People First (Scotland)

Mental Health (Scotland) Bill

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

The overarching objective of the Bill is stated in the policy memorandum as: to help people with a mental disorder to access effective treatment quickly and easily.

The experience of people with learning disabilities is that being identified as “mentally disordered” and included in an Act which clearly has, as its focus, the treatment of people with mental ill-health conditions, achieves quite the opposite for us. Intellectual impairment or learning disability is not a treatable condition and it is not a condition from which we will ever recover. While we agree that some of the provisions of the Bill are sensible for people with mental health conditions, they are all misdirected in respect of people with a learning disability.

2. Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment) Scotland Act 2003 as set out in Part 1 of the Bill?

Most of the proposed amendments are not major amendments to the meaning and purpose of the Act. As long as people with learning disabilities are considered to be mentally disordered and covered by the Act, we believe that there should be opportunity to appeal against excessive restriction in all settings (section 11) and not only high secure settings. Our experience is that even in settings categorised as low secure, the restrictions are very severe indeed and are subject to arbitrary and sudden change depending on which staff are on duty. In addition, we want to point out that Compulsion Orders and Compulsory treatment orders (relevant orders) are very differently applied to “patients” with learning disabilities than to people with mental health issues. For us, the Compulsion is always about where we’re allowed to go, what we’re allowed to do, what kinds of juice we’re allowed to have, whether we’re allowed to smoke, what toilets we may or may not use, when we can eat or drink, what TV programmes we’re allowed to watch. They are never about treatment as we would normally understand the word except to say that we must follow the guidance, advice or instruction of health services. What isn’t said is that instruction is usually about freedom of movement or activity or association and thereby removes nearly all of our human rights under the pretence of “treatment”.

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

We believe that the application of the term “mental disorder” to people with learning disabilities allows the criminal justice system to buy into the myth that the “disorder” (learning disability) is somehow the cause of any offence we might have committed. The provisions of the Criminal Procedures Act allow for us to be denied a full and fair hearing (Article 6, Right to a Fair Trial ECHR) and diverts us into the mental health system. This is quite simply wrong. In our meetings with the Procurator Fiscal’s service, it was clear that once we are diverted away from the justice system, there is
no interest in, or understanding about, what happens to us and it is simply assumed that we are being looked after, cared for and appropriately treated. This is not our view and it is not the view of people with learning disabilities who are detained or compelled in this way. It feels to them that they are imprisoned and punished for, usually, much longer than other citizens who have committed similar offences. We believe that all human beings should be entitled to a fair trial in open court with support to understand the proceedings and engage with them.

4. Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders?

We have no objection to this arrangement but we believe that victim notification where the offender has a learning disability should follow the same process as for any other offenders in the general population.

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

We would wish to draw the Committee’s attention to page 74 of the McManus Report which says:

“Learning disability and the law Persons with learning disability complained to the Review Group about the inclusion of learning disability in the Act. We understand the Millan Committee recommended that this should be reviewed and that the then Government accepted this in its policy paper “Reviewing Mental Health Law”. Now, eight years on from Millan, the Review Group feels that it is time this was done.” P74

Now, a further five years on from the McManus Report, this recommendation has still not been addressed and we are told by civil servants and MSPs that there are “no plans to review the definition of mental disorder” and that allowing us to come out of the Mental Health Act and have a new piece of legislation covering learning disability is “not seen as desirable”.

This strikes us entirely dismissive of our argument. There is general acceptance that the Mental Health law in Scotland does not adequately address leaning disability and we are simply clumped together with people who have mental ill-health, for which they are treated and from which they can recover. We further believe that continuing to include us in the Act and refusing to listen to our claims of mistreatment and undue and excessive restriction places the Scottish Government in breach of its obligations under the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities.

People First (Scotland)
September 2014
Schizophrenic does not mean Evil

Mad does not mean Bad

The Royal Edinburgh 'Hospital' is not a hospital, it is something between an open prison and a concentration camp, depending on which ward you are in.

One in four people are diagnosed with a 'Mental Health' problem every year.

Some people are detained just because they are mentally deficient, others just because they drink or take drugs.

Even children are diagnosed as mentally ill and locked up.

People are detained just because they are epileptic.

People vanish.

The majority of prisoners could do fine at home, maybe with a support worker.

Innocent people are locked up for years on end.

Once a person is legally detained under the Mental Health Act Scotland, they are not even allowed to apply for a change of consultant.

Some of the drugs have appalling side effects, but if you refuse to take your prescription, you are deemed to be a danger to yourself.

The spirit of the law is that a person cannot be detained unless they are genuinely a real danger to themselves or others, but the psychiatrists have set case law, such that anyone who disagrees with their treatment is deemed a 'danger to themselves'.

Even people who are released to 'Supported Accommodation' have their movements and visitors restricted, or aren't allowed a drink, or a cigarette when they want one, so there are effectively lots of little prisons that most people are unaware of. The psychiatrists do not care if people are made homeless, or even driven to suicide.

The shrinks and screws have absolute power, backed up by the police.

Most inmates lose control of their finances, even if they have never been manic with money.

Mental Health service users are not more likely to be violent, they are more likely to be victims of violence.

Mad rich people are called 'eccentric'... Mad poor people are locked up.

Royal Ed - Free the Innocents
Free the Inner Sense

Edwin Zarthrusz
September 2014
Another very serious human rights abuse is in mental health law. All that is needed to place someone into a mental health hospital is a justice of the peace signing a document called a warrant under the Mental Health Act as requested by a psychiatrist and mental health officer (social worker). A person loses all of their rights and must appeal the justice of the peace's warrant after 28 days where they can be treated with god knows what medication against their will in the interim period.

The current system prima facie removes a person's human rights altogether for at least 28 days when it should be necessary for the person to be present and put arguments if they wish when the warrant is issued to send someone to a mental health hospital for treatment. No one should be treated without first having their fundamental human rights asserted in law and a right to a fair hearing should start at day 1 minute 1, not 28 days later. At 28 days an appeal is possible, however, there are abuses of the system whereby an appeal is not done when requested at 28 days (s.44) but a "Compulsory Treatment Order" is sought for a further 6 months and an APPEAL of the CTO is done, thereby abusing a person's human rights to a fair hearing under article 6. That is to say an appeal does not occur of the 28 day detention but the 6 month detention - it should be necessary that article 6 hearings cover both periods of detention - but the system is currently lax at 28 day appeals. Mental Health law is not currently complaint with Human Rights legislation and is open to abuse.

I would recommend that in the situation that a justice of the peace issues a warrant for detention, that the person be escorted by the police back before the justice of the peace to plead their case (especially as there may be causative issues which require the investigation of law per se or the intervention of Citizen Advice Bureau) prior to issuing a detention order. It may be the case that the causative issues need to be dealt with only or it may be the case that the causative issues need to be dealt with and a period of detention be dealt with, or it may be the case that the detention is not necessary having heard the facts.

At the moment detention does not affect the causative issues and a person can be sectioned for 28 days or a further 6 months and still have to face their causative issues when detention is up, or may lose their assets due to detention, because they are not working etc. For those people who are experiencing some form of legal conflict or criminal conflict, at the moment the police refuse to engage where a detention has ensued and may also be the cause of the detention when something is reported to the police who fail to act thus ensuring a complete failure of human rights.

Lesley D McDade

September 2014
A Burns

Public Petitions Committee
The Scottish Parliament
Edinburgh.
EH99 1SP

4th December 2013

Public Petitions Committee, Petition PEO 1494

I have direct experience of the negative consequences of detention under CTO
including the destructive impact of psychiatric drugs, the abhorrent disregard for the
patient's human rights or dignity and the lack of any credible objectivity or
accountability on the part of the mental health tribunals.

My late mother's physical, emotional and mental health and wellbeing were
destroyed while she was detained against her and her family's wishes and given
medication including depot injection which she had made clear from the outset that
she did not want. One of the serious consequences of this continual increase in
medications was that she was left crippled and never again walked independently.
This was something that she loved to do. After she managed to escape from the
hospital and walk to her eldest daughter's home in Perth this 82 year old was taken
back to hospital in a police van. On returning to the ward her medication was
changed to Clopixal and in just 12 days she fell and broke her hip. The cycle of
bowel problems and urinary infections followed by dehydration progressively took its
toll. She was medicated for 1 ½ years right up to days before her death.

Although the clinical team were adamant that the hospital was a safe place, this was
far from the truth. Our late mother had been diagnosed with having a fear of male
sexual interference. To subject her to male personal and intimate care is degrading
and abusive. Our late mother was petrified and distressed when this happened.

With no effective safeguarding or independent scrutiny due to the lack of any robust
objectivity from the MHT this abhorrent level of cruelty will continue. It is such a one
sided process which included a persistent determination on behalf of the clinical
teams to embellish reports with inaccuracies and untruths and included the
vilification of the family. Their claim that our mother responded well to their treatment
regime remains unchallenged because, at this time, there are neither effective
means of scrutinising this nor stopping treatment that does more harm than good.
Vulnerable people deserve, at the very least, the same rights as the accused in a
criminal case.

Yours faithfully

Ms A Burns
Thomas Leonard - The Edinburgh Equality Collective Advocacy Forum

Mental Health (Scotland) Bill

Jorge Araya,
Secretary,
Committee on the Rights of Persons with Disabilities,
Groups in Focus Section,
Human Rights Treaties Division,
Office of the United Nations High Commission for Human Rights

Dear Mr Araya,

EECAF submission to UN

This is a submission to you before the deadline of August 22 on the subject of human rights of the mentally disabled and those with mental health issues. I, James Carter, Chairman, am making the following submission on behalf of The Edinburgh Equality Collective Advocacy Forum [EECAF] – web-site:- WWW.EECAF.ORG  I will also forward a submission from Maurice Frank who is Secretary of EECAF. Maurice's issue - which EECAF also wishes to submit - concerns a historic case of physically intrusive abuse at a Welsh Adolescent Mental Health Unit in the United Kingdom and the subsequent cover-up which involved the threat of being sectioned and detained in an asylum if it was ever raised.

EECAF is an independent collective advocacy group, operating in the Edinburgh area of Scotland, completely independent of the British National Health Service or local or national government, for people who have mental health issues or experience of using mental health services. We are an organisation for present or past mental health service users entirely made up of the same. We are a Scottish Charitable Incorporated Organisation and receive no funding from local or national government. We meet monthly.

We feel very strongly about the deleterious side-effects of medications given to mental health service users and would like the office of the United Nations High Commission for Human Rights to consider the lethal and dangerous nature of these medications, for the side-effects of which we have the statistical evidence and anecdotal references of scores of Scottish mental health service users and in particular interviews researched and catalogued on the psychiatric home-page of the web-site of one of our trustees, www.thomashoskynsleonard.co.uk  Dr Leonard is a world-renowned Bayseian statistician and in his recent interview with Wiley [google “Dr Thomas Hoskyns Leonard” & “interview with Wiley”] he argues the use of both anecdotal and statistical evidence as in his submission to the Scottish Government [also on his web-site] to the conclusion that anti-psychotic medication has universally drastic & catastrophic side-effects.
From these users and from these interviews it is clear that the present state of psychiatry in Scotland abuses human rights. Patients would be far better off receiving proven holistic or alternative therapies to anti-psychotic medication, a finding of our organisation which is borne out by the facts.

We also wish to point out the inhumane and degrading nature of psychiatric sectioning and detention in Scotland, in particular the inadequate tribunal system reviewing the cases, the involuntary prescription of drugs and in certain cases, the involuntary administration of Electro-Convulsive Therapy which has been demonstrably shown to have short-term and long-term adverse effects resulting in memory-loss.

In conclusion, what we would specifically like the Human Rights commission to note are the bullet points below:-


* The poor human rights record in the matters of sectioning, detention & tribunals held in asylums.

* The long-term fatal & universally deleterious nature of medications' side-effects.

* The unequivocal effects of memory-loss caused by compulsory Electro-Convulsive Therapy which shouldn't in any case be compulsory & ought to be downright abolished.

* The lack of provision of proven humane holistic & alternative therapies to anti-psychotic medication.

Yours sincerely,

James L S Carter, MA Hons Oxon, Dip Ed,
Chairperson,
EECAFE

Thomas Leonard - The Edinburgh Equality Collective Advocacy Forum
My responses to the six questions appear below. I have taken part in at least six Mental Health tribunals as well as previous consultation processes, and would like to draw attention to the fact that serious problems are being overlooked by the present proposals, which seem to assume that only relatively minor tinkering is required. Legislators are seemingly unaware of numerous documented complaints of medical and legal abuses of patients, though evidence of these complaints has already been given to a parliamentary body in petition PE01494. These serious complaints are linked and summarised briefly below:


SUMMARY OF INDIVIDUAL COMPLAINTS SUBMITTED TO PETITION PE01494 (see above link for details)

All cases: patients wishes not taken into account, completely ignored.
Almost all cases: family wishes completely ignored.
Almost all cases: patients drugged almost immediately.

There were multiple occurrences of the following complaints:

Misleading evidence given to Tribunals (at least 10 complaints)
Tribunal ignoring or dismissing contrary evidence (at least 10 complaints)
Tribunal accepting innuendo as fact (at least 7 complaints)
Breaking the main provisions of the Act
Apparent errors in law and/or tricks to overcome legitimate challenges Mental Health act
Criteria challenged but not tested
False claims made to Tribunals

The following were all reported at least twice:

Preventing witnesses appearing for patient and named person
Tribunal documents not produced
Denial of symptoms of medication
Reason for section not given, medical reports favourable to patient suppressed or not-admitted to
Diagnosis later contradicted

Other extremely serious complaints included one patient never being examined before being sectioned, yet being unable to get redress afterwards; and a
medical professor warned by his health board that if he presented contrary evidence for a patient, his contract would not be renewed.

Reponses to the consultation questions

Question 1  Do you agree with the general policy direction set by the Bill?

No. The call for written evidence states that the overarching objective of the Bill is “to help people with a mental disorder to access effective treatment quickly and easily”. However, the verb ‘help’ here actually means ‘force’ as the Mental Health Act concerns compulsory treatment, usually involving psychotropic drugs.

The statement of objective refers presumptively to ‘effective treatment’ but there is no reference in the policy or the Bill to any process by which the effectiveness of treatment is evaluated. As psychotropic drugs are the leading cause of death in the mental health system (see the submission by Professor David Healy, a psychiatrist) it is difficult to see how accelerating blindly in this direction can possibly be said to ‘help’ patients. This alone suggests an alarming disconnect between those ‘providing’ forced treatment via mental health legislation and its recipients.

Further evidence of this disconnect can be seen by examining the submissions with the word ‘rights’ in the title and comparing them with the complacent assumptions underpinning the proposed bill. For example, under the ECHR a detained person has an absolute human right to challenge their detention in a process akin to a fair trial. The complaints above indicate that Mental Health Tribunals are far from fair. For example, a recurring complaint that was borne out in the hearings I attended was that the Tribunals regarded as ‘reliable evidence’ whatever the MHO and RMO said - even if it had been factually refuted by patients or their representatives. A court would of course test such disputed matters.

The submission by Hunter Watson details many other respects in which Tribunals breach Human Rights. Issues of such fundamental importance to patients clearly have great difficulty in remaining on the agenda of government bodies, if indeed they ever get there. Rather than address these issues, government and professional bodies appear to be relying on the difficulties that a patient would face in order to bring a case before the EC.

I have no comment to make on Questions 2, 3 and 4.

Question 5 asks about the McManus Report. According to this 2003 report, review of the inclusion of learning disability (and autism) in Mental Health legislation was then 8 years overdue, yet consideration of these disabilities is yet again absent from the proposals. If such consideration is still not planned then it is difficult to see the point of Question 5. The submission by Autism Rights
outlines the problems resulting from the historical inclusion of autism in mental health legislation, and details steps that should be taken to address this glaring gap.

Question 6 Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

(i) In my view, the Committee must acknowledge the evidence of abuses from patients, carers and representatives, as these challenge the claim that mental health tribunals are fair. It should take evidence of some of these abuses in person.
(ii) It should take steps to make RMOs and MHOs responsible (in reality, not just in theory) for any false or misleading statements made in order to section patients.
(iii) If the Parliament is serious about improving the human rights of mental health patients, it should take firm steps to address human rights questions arising from compulsory mental health treatment proactively, in accordance with the ECHR.
(iv) Opposing voices should be invited to address the Health and Sports committee. In particular, Professor Healy should be invited to speak on the substantial and serious downsides to forced psychiatric medication, as these seem to go unacknowledged.
(v) The special situation of patients with autism and learning disabilities should also be acknowledged, and campaigners heard.

Walter Buchanan
Claire Muir

Mental Health (Scotland) Bill Consultation

Firstly I would like to endorse Walter Buchanan’s whole submission but find one paragraph sums the situation up: “The submission by Hunter Watson details many other respects in which Tribunals breach Human Rights. Issues of such fundamental importance to patients clearly have great difficulty in remaining on the agenda of government bodies, if indeed they ever get there. Rather than address these issues, government and professional bodies appear to be relying on the difficulties that a patient would face in order to bring a case before the EC.”

At a meeting with Michael Matheson he insisted that lawyers had confirmed the Act was ECHR compatible. However, this is not the case as confirmed in the letter dated 12 June 2013. “At the point of introduction in the Parliament, the Minister introducing the Bill issues a statement confirm legislative competence. In this case, on 16 September 2002, Malcolm Chisholm MSP and the Presiding Officer both issued statements saying that in their view the provisions of the Bill would be within the legislative competence of the Scottish Parliament.”

When the Scottish government passed mental health legislation they exceeded their powers under the Scotland act as it clearly ignores human rights, unless you can tell me ONE Human Right a sectioned person has. Human rights are like fresh air. You take them for granted normally. But from the moment they are denied – you can think of nothing else until you regain them.

People who are sectioned badly need the same rights as everyone else; sadly, at present there is no official body speaking out in a meaningful way for this category of desperate people. Although the UN do seem to be against the MHA. On you tube you can google “depot injections destroy artist” in which you will see a Jean Cozens who was found hanging on Christmas day after the video was made. What would YOU do in her position? It is a position many people on CTOs are in. We must not turn a blind eye and deaf ear to their plight.

Even the UN it seems are to be ignored when they issued their General Comment No 1 making it quite clear it is torture to be forced to take mind-altering drugs. The Mental Welfare Commission, even under Donald Lyons' watch made clear, not only you don’t get told a reason but there does not even have to be a reason for detention. Yet, straight away you lose all rights.
The Jews had Churchill, the slaves had Martin Luther King. The best I can do is a quote from the latter.

In our own nation another unjust and evil system, known as the mental health system has inflicted the sectioned person with a sense of inferiority, deprived him of his personhood, and denied him his birthright of life, liberty, and the pursuit of happiness. We need to see that as it is illegal it is not an act of law. It is dead. The only question remaining is how costly will be the funeral.

These great changes are not mere political and sociological shifts. They represent the passing of systems that were born in injustice, nurtured in inequality, and reared in exploitation. They represent the inevitable decay of any system based on principles that are not in harmony with the moral laws of the universe. If at times we despair because of the relatively slow progress being made in re asserting our rights and if we become disappointed because of the undue cautiousness shown by the petitions committee let us gain new heart in the fact that history holds an eternal reminder to a generation drunk with power that in the long run of history might does not make right.

I have not even looked at the questions in the consultation as it does not address changes that are needed in the Act as a result of PE01494 which it seems was ignored.

It is noticeable from other responses that those profiting from the mental health act have produced a clear “us” and “them”. The ones paid by forcing people to take drugs think it’s great, those forced into such slavery are against it. May I encourage the committee to urge anyone of “them” to answer two questions. 1. Name one human right a sectioned person has. (Representation at tribunals is not a human right, a fair hearing is. Petitions UKDSVRQHRI³XVFRXOGFRQILUPRUGHQ\ any example 1DPHRQHVDIHJXDUGRIWKHDFWDQGDOORZRQHRI³XV\WRUHIXWH confirm. 2. Name one safeguard of the act and allow one of “us” to refute or confirm.

Okay, that would be to much like a debate which would make the “them” obviously unanswerable. But if it becomes clear to you, dear committee member that there are ZERO human rights and NO safeguards in this act in its current form one should refer to the quote:

"Any law which violates the inalienable rights of man is essentially unjust and tyrannical: it is not a law at all." Maximillien Robespierre

Mrs Claire Muir (Founder member of Psychiatric Rights Scotland)
Further Thoughts on Forced Treatment

In its general comment No 1(2014) on Article 12 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), the UNCRPD Committee stated that “State parties must abolish policies and legislative provisions that allow or perpetrate forced treatment…”. Forced treatment was left undefined but Special Rapporteur Juan Mendez made clear in his report of 1 February 2013 to the UN’s Human Rights Council that it included “forced medication and electroshock procedures”. It is to be hoped that it can be agreed that “forced medication” includes all situations in which individuals are administered medication against their will and not only situations where actual force is used. At present individuals are being coerced by psychiatrists into taking medication by being told that if they do not take it then they will be sectioned or, if they have already been sectioned, that they will be held down and injected with the drug if they refuse to take it orally. It is also to be hoped that it can be agreed that forced ECT gives more cause for concern than forced medication. One reason for this is that forced ECT appears to fall more obviously into the definition of inhuman or degrading treatment than does forced medication. Another reason is that the World Health Organisation (WHO) has stated that “If ECT is used, it should only be administered after obtaining informed consent”. However, the WHO has not recommended that psychiatric drugs should only be administered after obtaining informed consent. Clearly the WHO is more concerned about forced ECT than about forced medication.

In my paper entitled “Human Rights Implications of Forced Treatment” I made clear that I was not of the opinion that there should be an absolute ban on all forced treatment but that there might be exceptional circumstances where forced treatment should be permitted. The exceptional circumstances which I had in mind included those where young women with anorexia do not realise that death is a likely consequence if they do not change their eating habits. Coincidentally, since writing that paper I attended a meeting of the Cross Party Group Meeting on Human Rights. There I met a young woman who told me that she would not be alive today if she had not been force fed: she is of the opinion that the force feeding of anorexia patients should not be banned. It might be worth discussing whether it should be permitted and, if so, whether it should only be permitted with the agreement of a court at which the individual receives a fair hearing.

At the Cross Party Group Meeting to which I made reference above a man with an autistic son alleged that mental health professionals had told lies at mental health tribunals. That certainly happened at tribunals at which a Dumbarton woman appeared: the evidence is contained within the tribunal transcripts in my possession. In addition, within submissions supportive of petition PE01494 there were allegations that mental health professionals had given false evidence at other tribunals. The fact is that in Scotland it is not
necessary to torture mental health patients to get them to confess to having made statements indicative of a serious mental illness: mental health professionals can and have given mental health tribunals fabricated accounts of interviews with patients. They can do this with impunity because they are not required to give evidence on oath.

The Government’s position is that it does not comment on individual cases. That is a defensible position. However, it would not be acceptable for the Government to fail to take due note of repeated complaints that the 2003 Act is not being implemented as expected. The Health and Sport Committee should consider carefully whether the complaints about the implementation of the 2003 Act imply that significant amendments to it are required. It is particularly disappointing that the Government is not even prepared to amend the Act so that witnesses are required to give evidence on oath at mental health tribunals.

It is possible that the MSPs who passed the 2003 Mental Health Act assumed that patients would not be detained under that Act unless they suffered from a mental disorder that justified detention. It is also possible that MSPs assumed that the compulsory treatment provided after detention would invariably benefit those involuntary patients. The evidence submitted in support of petition PE01494 makes clear that any MSP who made those assumptions was mistaken. However, the 2003 Act is clearly based on the false premise that each of those assumptions is true. Given this fact together with the General Comment made by the UNCRPD Committee, it is now time to challenge the apparent assumption that the detention in psychiatric institutions of mental health patients followed by the routine provision of compulsory treatment does not require the prior approval of a court as recommended by the Council of Europe.

In its written evidence to the Health and Sport Committee about the current Mental Health (Scotland) Bill, Inclusion Scotland suggested that “The Health and Sport Committee may wish to ask the Scottish Government how it intends to review existing mental health policy in light of the UNCRPD General Comment”. It is to be hoped that the Health and Sport Committee will do this and also that it will also vigorously challenge the Government if its response appears to be unsatisfactory.

W. Hunter Watson
W. Hunter Watson

Mental Health Scotland Bill

Emergency Detention

For a variety of reasons the 2003 Mental Health Act makes it too easy for an individual to be detained in hospital. One reason is that the Act permits any GP to grant an emergency detention certificate if he or she considers it is likely “that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient”. Note that the 2003 Act is based on the premise that after a consultation which might last only a few minutes any GP is able to determine whether medical treatment for a patient’s supposed mental disorder is required and, if so, whether it is urgently required.

The 2003 Act requires the GP to have regard to “the present and past wishes and feelings of the patient” and to the views of various others such as the patient’s named person, carer and welfare attorney. Regrettably, when it comes to mental health matters some GPs and others ignore those basic principles which are meant to underpin the 2003 Act. Obviously when a GP grants an emergency detention certificate the patient’s wishes and feelings are being ignored. It should not be taken for granted that this action on the part of a GP can always be justified. The 2003 Act gives too much power not only to psychiatrists; it also gives too much power to GPs. The Health and Sport Committee should acknowledge that inevitably some mistakes are made when individuals are detained but that the 2003 Act provides no remedy for those who are wrongly detained: they are wrongly stigmatised for life as having had a detainable mental disorder. This is quite apart from the effect on them of the unpleasant and potentially harmful forced treatment to which they are liable to be subjected. (The press reported recently on the fact that the ombudsman has upheld a complaint that a young man was ill-treated while a patient in a mental health facility in Fife. I could provide other examples of mental health patients being ill-treated.)

Another case that was reported in the press recently should also provide grounds for concern. According to the reports, an anorexic teenager, Miss X, was sectioned by her GP even though she was reported as claiming that “I’ve never been this healthy” and even though her father made it clear that he was totally opposed to her being detained in hospital.

The reason for the GP deciding to section Miss X has not been reported; it may have been for no more than the GP being aware that Miss X was anorexic and being of the opinion that her weight was below what is considered desirable. However, given the statements made by Miss X and her father it seems certain that her mental condition posed no immediate significant risk either to herself or to anyone else. Thus it seems certain that there was no valid reason for a court not determining prior to her detention whether it was necessary to detain Miss X in a mental health hospital,
something that would have happened had Scotland adopted the Council of Europe Recommendation, Rec (2004) 10, concerning the human rights and dignity of persons with mental disorder. The Health and Sport Committee should consider whether, in order to minimise the risk of an individual being unnecessarily detained as Miss X might have been, this part at least of the Recommendation should be incorporated into Scottish mental health legislation.

The Council of Europe Recommendation does allow for the emergency detention of a person with a mental disorder. However, emergency detention is to be "for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others". By contrast, in the 2003 Act emergency detention is for a period of 72 hours and there is an assumption that the patient’s mental disorder will be such that it is a matter of determining “what” rather than “whether” medical treatment is necessary. The Health and Sport Committee should consider carefully whether the section on emergency detention in the 2003 Act should be amended to take account of the Council of Europe Recommendation.

As far as forced treatment is concerned, patients with a mental disorder are treated differently from patients with a physical disorder. For example, although the actress Lynda Bellingham has announced that she intends to stop having chemotherapy for her cancer, there is no possibility that she will be detained in hospital and given chemotherapy against her will. The difference between the treatment of patients with a mental disorder and the treatment of patients with a physical disorder is yet another matter which the Health and Sport Committee should discuss during its consideration of the Mental Health (Scotland) Bill. If it does so then it should take account of Article 14 ECHR. This prohibits discrimination on any ground and hence would seem to imply that people with a mental disorder should have the same rights relating to consent as do people with a physical disorder. Even although the UK has ratified the UN Convention on the Rights of Persons with Disabilities and even though Article 12 of this legally binding international treaty guarantees people with disabilities equal recognition before the law, people with a mental disorder obviously do not have the same rights as do those with a physical disorder. However, the SHRC, in its submission, stresses that “…it is clear that the requirement for genuine and demonstrable respect for the autonomy of all individuals, whether or not they are subject to compulsion, is paramount”. The Health and Sport Committee should not ignore this requirement nor the evidence that, in reality, there is no genuine respect for the autonomy of mental health patients. The Committee should ensure that Parliament does more than minor tinkering when it amends the 2003 Act, something that Walter Buchanan called for in his informative and thoughtful submission.

W. Hunter Watson
October 2014
Mental Health Scotland Bill
Chrys Muirhead

A Plea: Fair and Just Treatment for All People in Psychiatric Settings

"The overarching objective of the Bill is stated in the policy memorandum as: to help people with a mental disorder to access effective treatment quickly and easily."

I am looking for more than this. As a mother and carer of two sons with mental disorder labels I want to see:

- The Mental Health Act implemented properly and monitored effectively in every Scottish Health Board area, including Fife where I live
- Mental Health Act safeguards that are safe: in my family’s experience we have found that advance statements were overruled, named persons (myself) were uninformed, Mental Health Tribunals were weighted in favour of “professionals”, Mental Health Officers behaved unprofessionally and the Mental Welfare Commission were wise after the event and had no power to influence health boards to improve buildings that they had declared “unfit for purpose”
- Carers, and mothers, respected by all mental health professionals, including Scottish Government civil servants and Healthcare Improvement Scotland
- Patients not subject to dehumanising treatment and a denial of their basic human rights when locked up and locked in Scottish psychiatric units.

On 29 September 2014 I received a decision letter from SPSO informing me that my complaint against NHS Fife Health Board (submitted to the Ombudsman on 17 September 2013) had been upheld. I had originally wanted the judgement to be about “human rights abuses and dehumanising treatment” but I was told by the SPSO adviser in September that the most I could hope for was “unreasonable treatment”. Human rights abuses would have to go before a criminal court.

Here are the reasons given by the Ombudsman Complaints Reviewer as to why my complaint was upheld:

“It was inappropriate to transfer your son to the IPCU in his underwear and without shoes (I had observed this happening when standing in the car park
outside the acute psychiatric ward). In addition, I do not consider that the observation of your son in the seclusion room was adequate or that there is evidence of a plan to ensure that your son had appropriate access to food, fluids and a toilet during his period of seclusion. This is not acceptable."

I am not satisfied with this decision as I had listed a range of complaints, including injuries untreated, intimidating behaviour and psychiatric abuse. Therefore I have made a Review Request, detailing a large number of inaccuracies in the written report within the letter, by NHS Fife Health Board, and the conclusions that were reached. I have also asked for a copy of all the evidence sent by NHS Fife Health Board to the Ombudsman because I am not confident that all my complaints and FOI requests made at the time were handed over to SPSO. The investigation I contend was not a “level playing field”.

I am concerned that there is a two-tier treatment regime in Scotland’s psychiatric system and that this is reinforced by Scottish Government’s Mental Health Strategy which differentiates between “common mental health problems” and “severe and enduring mental illness”. And for those of us in the latter category it can lead to stigma and discrimination, to unreasonable treatment, to disabling mental and physical conditions and to a much shorter life span. This is unfair and unjust.

I was/am one of those labelled with a mental disorder, Schizoaffective, in 2002 after being coercively treated in a psychiatric ward with an antipsychotic when experiencing a menopausal psychosis, which lead to further drugs being prescribed, an antidepressant venlafaxine, maximum doses, and a “mood stabiliser”. Finally I was told that I had a “lifelong mental illness” and could not expect to recover or to come off the “mood stabiliser” lithium. Fortunately I am a skeptic and didn’t believe it.

I made a full recovery by 2004, under my own steam, although I had a serious leg break in March 2005 aged 53, resulting in 3 fractures to my fibula when only walking down a stair, after a library job interview. Research now tells us that venlafaxine in maximum doses given to older people can result in bone loss. That explains my leg break and 6 inch metal plate which is now welded to my fibula and causes me arthritic pain and cramp.

I believe that my “lived experience” of recovery from coercive psychiatric drug treatment and stigmatising mental disorder labels has benefitted my family members, 8 of us in 3 generations, who have engaged with psychiatry and got the “severe and enduring mental illness” because of experiencing psychoses or altered mind states at times of life transitions. And because the drugs didn’t cure anything. I was able to advocate for my family in psychiatric circumstances and give mentoring support for those who decided to taper and come off psychiatric drugs/medication.
I am now a writer, activist and campaigner in mental health matters because of personal circumstances and having to stand with family members, to support and protect them in psychiatric settings. But I shouldn’t have to.

The Mental Health Act for Scotland should be protecting the rights of people who have been given a mental disorder diagnosis. Scottish Government civil servants should be supporting mothers and campaigners who are influencing positive change. Scottish Government Ministers should be overseeing the civil servants and the mental health law so that mothers, carers and campaigners are being given their place and respected.

I hope that the Health and Sport Committee will consider my Plea.

Chrys Muirhead
October 2014
Anne Greig

Mental Health Act (Scotland) 2003

I write concerning the circumstances of my sectioning on the 5 September 2000 during which a number of unlawful breaches of the various acts and codes of practice took place from 1 May 2000 onwards.

I was not detained as a result of an assessment as stated in my medical records. I was not offered an assessment before being detained. During this detainment, based on false information without any evidence provided to Dr H by my ex-husband and our adult son, I was judged to be “paranoid against my husband.”

My mental condition was not assessed by any doctor or psychiatrist prior to my detention. I sincerely hope you will agree that the act of detaining me was unlawful, breaching all related codes of practice. I was subjected to a brutal abduction that falls within the definition of torture and inhumane degrading treatment.

Unbeknown to me, throughout the summer months preceding my sectioning on 5 September 2000, NHS staff, police and social workers had been alerted by Dr H who circulated, without evidence and without meeting me, my ex-husband’s and our adult son’s false allegations.

Under the 1984 Mental Health Emergency Act I was detained and drugged without examination or my consent.

On the 25 August 2000, 10 days prior to being sectioned, I accompanied our Down Syndrome daughter to the police station to make a complaint as she had just revealed to me further information relating to a serious complaint she had made on the 18 May 2000 concerning her brother (our son) and my ex-husband.

A section 117 was applied for and there is evidence in my medical records that the MHO SP met with a JP and made a Statement of Truth on the morning of 5 September 2000, and an order was granted. I have on several occasions since tried to obtain a copy of the Order and the said statement only to be ignored and refused on all occasions. I was detained under a section 24 emergency certificate issued by a GP who had never examined me, neither had the MHO SP, whom I had never even met. The same MHO gave a sworn statement on the 5 September at 12 noon to the JP, JL this led to a section 117 Order being issued. This Order authorises a mental health officer or a medical commissioner or a constable to enter a premises and remove the individual named in the Order. I have to date, not been permitted a copy of the said 117 Order and hope that The Committee will agree that this is also an unsatisfactory situation which subverts all human rights.

The way in which I was detained was completely criminal. I hope that the Committee will see that it is unacceptable to forcibly inject a person with
excessive drugs namely 5mg of Droperidol AND 2mg of Lorazepan, one of which was double the recommended dose and dangerous impacting on the cardiac system. As a result it was withdrawn in January 2001 by the manufacturer and black listed by the FDA because it had caused the deaths of many people. I was treated as though I was a wild animal.

The drugs used to sedate me posed grave risks to my health and I hope that the Committee will agree that I should not have been injected with the said drugs because of their inherent risks. (Please see attachments with a copied extract of my hospital notes specifying the drugs used. In these attachments are also two articles describing the dangerous effects of Droperidol as well as information relating to effects of Lorazapan.)

After 3 DAYS detention (the maximum time authorised by a 117 Order and section 24 Order) I was released from Cornhill Hospital having had advice from my solicitor. However, the consultant, Dr P, had during my detainment personally threatened me, informing me that I would be brought back into Cornhill Hospital if I did not take the drug Respiredol which he had prescribed upon my release. I hope that the Committee will agree that a consultant psychiatrist should not be allowed to issue such threats.

As a consequence of having been sectioned I have been, and still am being, seriously stigmatised and defamed. This stigmatisation continues to be used in attempts to deprive me of my liberty and to silence me to this day. I hope that the Committee will agree that the greater care should be taken before either a GP, or a psychiatrist, is allowed to decide to section an individual, to prevent the risk that individuals are often wrongly stigmatised by unproven false allegations. No one person should be permitted such powers.

With reference Article 5 ECHR. My detention was unlawful because I was not detained in accordance with the procedure prescribed by the Mental Health Act and Human Rights Act: there was a failure to consult my nearest named relative, my cousin, named by me, although it would have been quite possible for them to have done so, instead of maintaining contact with my ex-husband and our adult son who were both the initiators of false information leading to my sectioning. The nearest relative is the named person unless someone different has been named which my cousin was.

The Law Society, by drawing attention to Article 8 ECHR, helpfully pointed out that "a patient can only be treated involuntarily provided there is a lawful and proportionate justification for this (namely, protection of health) under article 8(2) ECHR, failing which there is a violation of the individual's right to private life/autonomy under article 8(1) ECHR. If a patient is treated in violation of article 8(1) it might amount to inhuman or degrading treatment."

Although I was sectioned before the passage of the Mental Health Act 2003, nothing has changed in the way a person is sectioned. In fact, it is now worse, it amounts to inhumane and degrading treatment allowing for abuse within the system.
I therefore urge the Committee to pay serious attention to the Human Rights Act and change the current 2003 Mental Health Act (Scotland), to make stringent amendments to prevent such abuse and criminal treatment as I have experienced.

Whilst some health professionals adhere to the regulations it would appear from my experience that not one of them, under the present law, is accountable for their OPINION based actions, making it possible for the first unsuspecting, perhaps gullible, health professional in receipt of false information, accepted without evidence, to pass on as fact forever as truth, down endless years to a limitless circle of national health professionals and others in authority.

The public needs to be protected from the covert actions of some unscrupulous professionals and others, who may have ulterior motives. I want to ensure that what happened to me can be permanently prevented from ever happening to others. The criminal abusers of the Mental Health Act must be held to account and the victims of such abuse must be afforded redress in a court of law. Unless the Committee can see its way to making the necessary critical changes to the Mental Act, tyranny will continue to be enacted with impunity.

I hope and trust that the Health and Safety Committee will accept my plea.

Anne Greig
October 2014
Second submission.
I attach four documents to show how the act is abused.

1. Please find attached an assurance from Shona Robison that the tribunal see evidence of mental illness before a CTO is extended. This is simply not true. A tribunal do not see the patient until after weeks of being drugged up. It is during these drugged up weeks that evidence for the tribunal is collated.

How one behaves during these weeks is not indicative of a mental illness but that of one who has no human rights, is drugged against their will and is arbitrarily held prisoner without knowing why.

2. (x2) Dr X’s concerns about the human right to know why one is detained.

3. Page 403 of my medical notes which makes clear the assessment upon which the tribunal accepted an extension to a CTO was a falsification. S318 offence for which I am currently pursuing with the police. Surely this is incongruous with Shona’s assurance. They just take Dr Y’s word for it that he did the assessment honestly and would be able to prove it in what should, according to my human rights, be the equivalent of a court.

4. Acceptance letter from the MHTS clearly showing they will just take Dr Y’s word for it. Again proving the assurances of Shona’s letter are simply not founded.

I am submitting this as an example of how the act works in practice. Kafkaesque.

Mrs Claire Muir
Written answer dated 16 April 2010 to Nicol Stephen MSP from Shona Robison

Nicol Stephen: To ask the Scottish Executive whether it plans to require a court or tribunal to determine whether there is valid and reliable evidence of the existence of a detainable mental disorder before a person is detained and subjected to involuntary treatment under mental health legislation.

(S3W-32648)

Shona Robison: The Mental Health (Care and Treatment) (Scotland) Act 2003 already provides for a court or tribunal to be satisfied on the evidence as to whether persons are suffering from a mental disorder before detention and compulsory treatment are permitted.

There are limited exceptions to this. Firstly, a certificate by a medical practitioner authorising emergency detention in a hospital for up to 72 hours is permitted, although it should be noted that in this period no compulsory treatment may be given. Secondly, a short term detention certificate for up to 28 days sanctioned by a medical practitioner with specialist experience in the diagnosis and treatment of mental disorder permits treatment. In both of these cases there must be a significant risk to the health and safety of the patient or the safety of others. Thirdly, the Scottish Ministers can, by means of a direction under the act, transfer a prisoner to hospital for treatment on the basis of reports from two medical practitioners who confirm that the prisoner has a mental disorder, and again that there is significant risk to the health, safety or welfare of the prisoner or to the safety of any other person if medical treatment is not provided.

In the cases of short term detention and any transfer to hospital for treatment of a prisoner, both the patient and their named person can apply to the Mental Health Tribunal for revocation of the power to detain and treat.
Subject: MWC – know reason for detention
From: Andrew Muir
To: claire.muir@
Co:
Date: Friday, 16 August 2013, 19:41


We were contacted by a solicitor who was helping a man who wanted to appeal against a short-term detention certificate. The patient had not seen the certificate. The Act does not require that the patient is given the certificate. It does not even require that he is informed of the grounds for it to be granted. He may have needed to wait for hospital managers to grant a "subject access request" to see his own records. Without knowing the grounds for his detention, how could he mount an appeal?

Human rights legislation says that anyone deprived of liberty must be able to appeal the detention (article five of the European Convention on Human Rights) and that there must be a fair legal process (article six). We agreed with the patient's solicitor that it was unfair and possibly a breach of his human rights that he did not at least know the grounds for his detention. We made the mental health law team at the Scottish Government aware of this. They agreed with us and are considering amending the Act.

Our interpretation of article six is that the patient must be given an explanation of the grounds for detention in order that he can challenge them. The best way to do this is to give the patient the grounds in writing and explain them to him. He could be given the full certificate but hospital managers may need to check it urgently for third party information (e.g. information from the named person or a relative) that could be harmful.
It was discussed that I have applied for extending Miss Ailin's Community Treatment Order without carrying out a formal application because she has refused to be seen. I last saw her at Kendal Health Visitor and had ample opportunity to show her she was paranoid and delusional. Her GP Dr. McFadden forced her to attend and there was tentative indication that her mental state was deteriorating and that medication was reduced to 500mg daily. 2 days later in the Hospital she cut herself. 

It was decided at the meeting that:

1) No further application for extending Miss Ailin's Community Treatment Order.

2) Dr. Cooper, as an independent medical practitioner, will assess Miss Ailin on Monday 24/5/97, formally to decide whether the Section should be extended.

3) If she does not attend for assessment, she will be recalled to Hospital for up to 72 hours for assessment.

4) Concern was expressed regarding her paranoid delusional behaviour. He is writing threatening letters to the team and myself. There are concerns about her general health, possible "folie a deux", and there is growing concern about her overall safety and that she is being looked after by two mentally unstable patients.

5) It was agreed that Mr. Lyall write to the Manager of Child Protection Team regarding this incident.
16 May 2007

Vale of Leven District General Hospital
North Main Street
Alexandria
Dunbartonshire
G83 0UA

Case Reference:

Dear Dr

The Mental Health Tribunal for Scotland has received a Section 86 determination to extend the Compulsory Treatment Order (CTO) for patient Mrs Claire Muir, DoB 30 Jan 1962, CHI Number 3001625325 on 16 May 2007. After reviewing this determination, with reference to Section 101 of Mental Health (Care and Treatment) (Scotland) 2003 Act, the Mental Health Tribunal for Scotland will not be reviewing this determination. We have updated our records with the CTO extension.

Please contact the Mental Health Tribunal, quoting the case reference number above, if you require any further information.

Yours sincerely,
W. Hunter Watson

Mental Health Scotland Bill

An Inadequate Bill

Both the Scottish Human Rights Commission (SHRC) and the Mental Welfare Commission for Scotland (MWC) make clear in their submissions to the Health and Sport Committee that the Mental Health (Scotland) Bill does not go far enough as far as amending the 2003 Mental Health Act is concerned.

The SHRC in its submission stated that it “believes that the Bill could go further to implement a number of the recommendations of the McManus review”. One of those recommendations is that there should be a review of the inclusion of learning disability in the 2003 Act. Given that the forced administration of psychiatric medication is unlikely to ameliorate either learning disability or autism, which is deemed to be a learning disability, this is a matter to which the Health and Sport Committee should give serious consideration. Oral evidence should be taken about this issue.

The MWC notes that at present there are three routes to non-consensual treatment and that there might shortly be a fourth. In its submission, it stated that “in our view, it is now time to review the overall framework for non-consensual care and treatment, to make it clearer, more consistent, and compatible with human rights norms”. The MWC, therefore, appears to be recommending that new incapacity legislation be formulated and that this should subsume the 2000 Adults with Incapacity Act, the 2003 Mental Health Act, the 2007 Adult Support and Protection Act and any new Act that might be enacted following proposals expected to emerge soon from the Scottish Law Commission. That recommendation is worthy of serious consideration but such a major piece of legislation is unlikely to be ready to present to Parliament in the near future. It is important, therefore, that the Health and Sport Committee presses ahead and amends the 2003 Act taking due account of Article 12 of the UN Convention on the Rights of Persons with Disabilities together with the General Comment on that Article. Both the MWC and the SHRC agree that this is important as do, indeed, several others who have made submissions to the Health and Sport Committee.

In her submission to the Health and Sport Committee Anne Greig makes clear that she was detained for 72 hours in a psychiatric facility as a consequence of a warrant issued by a justice of the peace under section 117 of the 1984 Mental Health Act. That section authorised detention for a period not exceeding 72 hours. It should be noticed that the corresponding section in the 2003 Act (s 35) authorises detention for a period of only 3 hours “for the purposes of enabling a medical examination of the person to be carried out by the medical practitioner specified in the warrant”. This fact should be noted when the Health and Sport Committee consider whether a GP should be able to grant an emergency detention certificate which authorises detention for up to 72 hours to determine what (!) treatment should be provided to the patient whom he or she has sectioned. As I suggested in a previous paper, 72 hours
would appear to be an unnecessarily long period to determine whether an individual has a serious mental disorder which might benefit from treatment. The Health and Sport Committee should also take an interest in sections 33 and 34 of the 2003 Act together with the corresponding sections of the 2007 Adult Protection Act. The Committee should notice that by virtue of s 51 of the 2007 Act no appeal is competent against the granting of a removal order by a sheriff following an application by a council officer and that justices of the peace may also grant a removal order. I have had representations made to me from a young man in Macduff with Asperger’s syndrome. He is concerned that he will be removed from his home as a result of an application from the Aberdeenshire council. In a letter to me he referred to a “shrink” who lives locally. He expressed the fear that the opinion of that person together with the opinion of Aberdeenshire social services would be accepted as the truth. While I do not know what the truth is, I am clear that this case is another example of Scottish mental health legislation making it too easy for people to be deprived of their liberty. Neither the 2003 Act nor the related 2007 Act requires the evidence to be tested in court prior to the forcible removal of an individual from his or her home; neither even requires the justice of the peace or the sheriff to give the adult allegedly at risk an opportunity to refute the allegations made. There appears to be the unwarranted assumption that, if given on oath, the allegations made by a mental health professional to a sheriff or a justice of the peace will always be factually accurate.

The Health and Sport Committee should recognise that much of what is in the 2003 Act is there because of advice received from psychiatrists, particularly from those in the MWC. In general, it seems that psychiatrists are in favour of legislation that makes it easy to detain non-compliant patients so that those patients can be treated in ways that the psychiatrists imagine, often wrongly, to be in their best interests. The Health and Sport Committee should amend the 2003 Act in ways that reduces the risk of an individual being wrongly deprived of his or her liberty and then subjected to unwanted, unpleasant and potentially harmful treatment.

W. Hunter Watson
Chrys Muirhead

Mental Health (Scotland) Bill

“Sometimes, when people are unwell, they may have to be detained in hospital or have treatment against their will. But they still have rights. We all have human rights, and mental health law contains special rights and safeguards to protect people.” Mental Welfare Commission for Scotland

Unfortunately it was my family’s experience in February 2012 that the safeguards contained in the Mental Health (Care and Treatment) (Scotland) Act 2003 weren’t safe.

A family member who became an inpatient of an hospital’s IPCU on 1 February 2012 knew the Act well as they were studying it for a BSc honours sociology 4th year dissertation at University, and therefore knew their rights (they graduated this summer 2014). As primary carer and named person I also knew what their rights and mine were. However our knowledge and experience carried little weight when they were detained under the Act in a locked seclusion room with no toilet or water to drink, for hours at a time, medicated with Midazolam.

The Mental Health Act is based on a set of 10 Principles and at number 7:

“Respect for carers - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account”

I contend that I was not accorded the respect as prescribed in the Act and was not given timely or appropriate information. For example on 1 February 2012 they received a serious hand injury and I wasn’t told about it until 3 February on a phone call. I then had to ask a doctor in the IPCU to examine it on Saturday 4 February, after attempts by nurses to keep me from visiting until Monday 6 February. I had to ask the ward Junior Doctor to examine my relative’s hand and then asked him to arrange an X-ray at St Andrews Hospital which I also attended, on 6 February where it was confirmed that they had breaks to their right hand at the joints. (my relative is a pianist)

I contend that I was bullied and intimidated by 5 nurses in the dining room of the IPCU on Saturday 4 February 2012 at around 2pm for trying to see them and photograph the hand injury and bruising. The nurses refused to let me see my relative and said they didn’t want to see me yet when I got home later there was a message on my phone from my relative asking me to visit, so I went back up at 6pm as the nurses wouldn’t let me in until then. I was not allowed to take a photo of their swollen broken hand and bruising to their face and arms, when I eventually saw them at 6pm 4 February 2012. The bruising was due to restrained face-down on 1 February 2012 in the ward by 3 nurses.

My relative is asthmatic and has had 3 collapsed lungs in the past so this procedure was very risky to their health and then they transported them in
only their bare feet and underwear, escorted by 2 porters into a minibus and up to the IPCU. I witnessed this and was told by the Mental Welfare Commission, on the phone, that there were no complaints about the IPCU. Therefore I assumed this meant that they were in a safe place. I didn’t know they used a locked seclusion room and had never heard of this before in Scotland’s psychiatric system of which I have over 40yrs experience. I was shocked and started making enquiries around the country, phoning other psychiatric hospitals to ask if they used locked seclusion rooms. I never found another place that did use them.

Furthermore regarding “Respect for carers”, I informed Fife Council social work managers about the issues in the IPCU and later found out that the Adult Protection Investigation focused more on me rather than on the nurses’ behaviour. I was accused of causing “psychological harm” when my relative was having their human rights abused in the IPCU. The Fife Council Mental Health Officer leading the Adult Protection Investigation questioned a psychiatrist and a CPN about my character while my relative was a locked-in patient of the IPCU. I was accorded little respect from any of the statutory agencies and made complaints to all of them, including to the Fife Police who were involved in the investigation. To which I received an apology, that it was a “learning point”. I got a similar response from Fife Council social work services. It seemed that disrespecting a relative and carer was a matter of not having enough learning or education.

**Named Person**

I was primary carer and Named Person for my relative when they were an inpatient of the IPCU yet the RMO, a consultant forensic psychiatrist, waited a week before meeting with me to discuss my relative’s treatment in the IPCU. At this first meeting the RMO told me that “people without capacity don’t require advocacy”. I told him that he was mistaken. Firstly my relative had capacity although they were mentally distressed and required caring treatment. Secondly all patients detained under the MH Act are entitled to advocacy, more so if they lack capacity. That first meeting with the RMO set the scene for the rest of our engagement. My relative asked me to advocate for them at clinical meetings in the ward and so I had face-to-face engagement with the RMO at close quarters.

It wasn’t pleasant and on one occasion he mentioned a medium secure unit in Edinburgh, and the State Hospital at Carstairs, both hospitals that he had worked at. This seemed like a veiled threat, that if my relative didn’t comply or conform then he may end up in either of these institutions. (I knew of other patients who had ended up there from the hospital) Threats don’t work with me and this made me more determined to advocate for my relative and align myself with their wishes, regardless of what I thought might be best. For the best advocacy is independent advocacy. Unfortunately in Fife the advocacy isn’t independent because the service is managed by an English learning disability service provider.
Mental Health Tribunal
My relative appealed their 28 day detention. They had been put straight on to the 28 day section on 1 February and wasn’t informed about this until 2 February. By the time their appeal was heard at the Tribunal they were back in the open acute Ward, under a different psychiatrist and they were appealing a CTO. They had been forcibly medicated when in the IPCU with Haloperidol, 25mgs, firstly by injection in the locked seclusion room, which caused them to fall over and have agitation, restlessness. I had to instruct the nurses to give them Procyclidine for side effects. Therefore when my relative got to the Tribunal they were sedated and had been traumatised by the abusive treatment in the IPCU. I advocated for them at the Tribunal and they also had a solicitor present who unfortunately was not experienced and kept referring to a reference book regarding procedures.

The Tribunal psychiatrist instructed my relative’s psychiatrist to give them a diagnosis/disorder label because up to that point there was no psychiatric “label” in their notes. The point being that if a person has been detained and forcibly treated then they should have had a mental disorder diagnosis for this to happen. Otherwise for what reason would an RMO be authorising the locking in of his patient in a seclusion room with no toilet or water to drink? What sort of treatment is that, for a person who is mentally distressed and has had suicidal thoughts? Is this appropriate professional practice? With no mental disorder diagnosis in the notes I wonder how the use of force can be justified. (in fact I contend that this sort of treatment is dehumanising and can never be justified, mental disorder diagnosis or not)

My relative’s appeal was not upheld and they were put on a CTO then given a bipolar disorder diagnosis. However the CTO was revoked by their psychiatrist approximately 2-3 months later as they had been discharged at the beginning of April 2012 into my care. They live with me. And the Haloperidol drug/medication was tapered over a five month period with agreement by the psychiatrist and with my support. They got off all the psychiatric drugs by August 2012. However the flashbacks from the dehumanising treatment in the IPCU continued for quite some time and even now to think on what was done to them was not pleasant. They have been disabled by the psychiatric treatment and is not able to do paid work.

Independent Advocacy
I have touched on this already and would add that it was difficult for them to access an advocate in the IPCU when they needed one. They weren’t always available and if they were then it might not be the same person twice which wasn’t helpful having to repeat the story. They have made attempts in the first week or two of being in the IPCU to speak to the police about an assault they claims were made on them by a nurse in the Ward on 1 February 2012 but the appointments were cancelled by the psychiatrist on more than one occasion. They also spoke out about other abuses and these have still to be investigated properly. Now that my complaint against NHS Fife, in respect of the seclusion room and the transfer in bare feet and underpants, has been upheld by the Scottish Public Services Ombudsman it means that we can consider how to proceed with criminal matters.
In 2009 the local Fife independent advocacy services lost out at a tendering process to the English learning disability service provider. I campaigned at the time with the local groups at Scottish Parliament and still believe it was a mistake on the part of Fife Council and NHS Fife to award the advocacy contract to a service provider, moreover based in England. The Scottish Independent Advocacy Alliance does not recognise the Fife advocacy project as being “independent”. I contend that it has further disempowered the mental health service user voice, and that of carers, resulting in more risks to psychiatric inpatients and less accountability in terms of implementation of the MH Act, and its effective monitoring. If patients and carers are being silenced and disrespected then the result will be human rights abuses and targeting of whistleblowers.

Advance Statement
My relative had an advance statement written down prior to becoming a detained inpatient of the IPCU. They have a more detailed one now and so do I, in which we both have written that we don’t want, under any circumstance, to be treated in the future in Hospital. It would be far too risky for either of us. In February 2012 their advance statement was not adhered to and the RMO told me that he preferred Haloperidol to Risperidone as a drug of choice. There was no consultation and the decision was his. Haloperidol is an older antipsychotic which is harsh in its side effects. They were forcibly injected with it after their dirty protest and what the nurses did to them afterwards. They were forced until they would take the drug orally and voluntarily. Which eventually they did when they had made them conform. On 28 February 2012 they got out of the IPCU and into the Ward. I felt that they had broken their spirit and it meant I had to keep a close eye on them in the open ward.

I continued to raise complaints whenever I witnessed unprofessional nursing behaviour or anything untoward. I was bullied by 3 different male nurses in the Ward during March 2012. One shut a door in my face, it was the male nurse who my relative alleged assaulted them on 1 February 2012. Another came up close and leaned over me where I stood and I had to tell him to move back. Yet another confronted me on one occasion, was aggressive in manner, and I later found out that he was one of the male nurses who had cornered my relative in a back room of the Ward on 1 February 2012 when my relative’s hand got broken. Even later on I heard that this nurse had emigrated.

I witnessed other issues in Ward in March 2012 which I complained about in Emails to senior NHS Fife mental health managers, copied in to Mental Welfare Commission staff and Scottish Government mental health division senior civil servants.

Mental Welfare Commission for Scotland
I phoned the MWC on 1 February 2012, twice from the Ward after I had been put in a side room by a nurse and left there. This was after seeing my relative face down on the floor being restrained after I’d come back into the ward having made a complaint about a male nurse who had behaved inappropriately with me that morning. That same male nurse was the one who my relative alleged assaulted them when I was out of the ward collecting a
holdall of clothes from our house, about a half a mile from the hospital. The
timing of this is as follows: the male staff nurse at about 10am had put his arm
around me without my permission in front of my relative and others. It was
inappropriate behaviour as I didn’t know the man and it was over-familiar. It
concerned me and so I decided to bring it to the attention of the clinical
services manager who I knew. I told her about the incident at about 12.15pm
up at her office which was in another building on the grounds. Then I went
home to pick up the holdall. I’d told them I was coming back at 2pm. They
hadn’t been admitted at this point to the Ward as a patient because the
assessment with the Junior Doctor hadn’t been completed.

When I came back at 2pm I entered the Ward with the Junior Doctor who also
was coming back in to see a female patient, he said, who had the police in
with her in the ward. And we both saw my relative face down on the ground, 3
nurses holding them down. I was put in a side room and left there. When I’d
left the ward earlier my relative had been sitting resting in the patio area. Later
I got the full story from them. The nurses tell a different story. I believe my
relative.

I phoned the MWC from the room I was put in, spoke to the Fife worker who I
knew, telling him what had happened and that I’d been left/abandoned in a
side room. Not long after a doctor and a nurse came in to speak to me. Then
later in the afternoon I again spoke to the same MWC worker after hearing
that my relative was getting transferred to the IPCU and was told by them that
there was no negative feedback from patients or carers. I then saw them
getting taken out in their underwear and bare feet, drugged up, at about 4pm
on 1 February 2012, I thought they were going to a better ward environment. I
trusted that they would be well looked after. I didn’t know their hand was
broken or about other issues at that point because no-one told me.

By the 4 February 2012, after being bullied by 5 nurses in the IPCU dining
room I realised that something was far wrong. The fact that there was no
negative feedback at the MWC was no indicator of good practice or of caring
treatment. From that moment on I was on my own, it seemed, and they were at
risk. I didn’t know about the seclusion room until the 8 February and hearing
about the dirty protest. Fortunately I had a good friend who shared the visiting
with me. She is a pastoral visitor at Cupar Baptist Church and has known my
family since 1990. She stood with me and I stood with my relative.

I realised after my relative’s IPCU inpatient stay in February 2012 that the
Mental Welfare Commission for Scotland is not there for patients and carers
who are being subject to bullying and intimidating treatment in psychiatric
settings. Their helpline was of no use to me and on occasion the phone was
put down on me when I asked for help. I would describe the MWC as “wise
after the event”. I was looking for help during the event. But I was on my own
and had to rely on family and friends to stand with me. At times it was a
desperate situation, as a mother, to be in. I wouldn’t wish it on anyone. The
feelings of powerlessness and of injustice at times was unbearable.
**Conclusion**
I want to see Mental Health Act safeguards that are safe, and which work to protect patients in psychiatric settings so that they are free from unreasonable treatment and human rights abuses.

I want to see carers, and mothers, respected for the person they are and the role they have in the patient’s life.

I want to see NHS health boards being held accountable for what happens in psychiatric settings behind closed doors.

System failure is not the fault of patients, carers or families.

**Chrys Muirhead**
Essential Changes
People are having their human rights violated by being detained under the 2003 Mental Health Act and then subjected to forced treatment. All are deprived of their right to liberty and their right to respect for private and family life. Most seem to be deprived of their right to a fair hearing. Many are deprived of their right not to be subjected to inhuman or degrading treatment and some are even deprived of their right to life. Those of us who have been campaigning on behalf of mental health patients are disappointed that the Health and Sport Committee has invited organisations that are not pressing for significant changes to be made to the 2003 Mental Health Act to give oral evidence about the Mental Health (Scotland) Bill but has not invited any of us. It may be that the Committee is of the opinion that none of us would have anything useful to contribute. If that is the case then it would appear that the Committee has no intention of recommending to Parliament that the 2003 Act be amended to take due account the UN Convention on the Rights of Persons with Disabilities (UN CRPD) even though this is a legally binding international treaty which the Scottish Ministers must observe and implement. In April of this year the UN CRPD Committee issued a General Comment (authoritative interpretation) which stressed the importance of not acting as though persons with mental health problems lacked legal capacity. Although organisations are acknowledging that account should be taken of this General Comment, none is proposing specific changes to the 2003 Act that will protect the rights of all mental health patients. These organisations seem to be content to leave it to the Scottish Government to decide what changes are necessary. Unfortunately the Scottish Government has made it clear that it is not prepared to make any significant changes to the 2003 Act. However, if no changes are made the consequence will be that the powers that psychiatrists currently have to detain and treat unwilling patients will remain undiminished and hence patients will continue to have their human rights violated.

This paper contains proposals for a few easily made changes to the 2003 Act, changes which would help to bring it into line with the General Comment of the UN CRPD Committee. These include proposals relating to short-term detention should it be decided that the Act should continue to provide for this rather than adopt the Recommendation of the Council of Europe (see submission MH045). As has been pointed out previously, the 2003 Act does not allow for the possibility that mistakes will sometimes be made when short-term detention certificates are granted and hence some people can be stigmatised by being wrongly sectioned: a successful appeal against detention does nothing to remove the stigma because of the nature of the remit of the Tribunal.

Forced ECT
The feelings of terror and distress caused by forced ECT are such that it clearly falls within the definition of inhuman or degrading treatment, something prohibited in all circumstances (see submission MHB045). The 2003 Act
should be amended, therefore, so that Scottish mental health legislation no longer permits ECT to be given to any patient who “resists or objects to the treatment”. This could be achieved by deleting s239 of the Act, a section which authorises a designated medical practitioner to declare that a patient lacks the legal capacity to make a decision regarding ECT. When considering whether to delete this section, account should account be taken of the fact that a 2009 ruling of the European Court of Human Rights seems to imply that only a court can deprive an individual of his or her legal capacity (see submission MHB045). Those rulings of the European Court are legally binding in the UK and hence in Scotland. There should be no assumption, therefore, that a designated medical practitioner can deprive an individual of his or her legal capacity to make a treatment decision.

**Forced treatment before an appeal**
Subsection 44(4)(c)(ii) of the 2003 Act should be deleted so that the Act no longer authorises the giving of forced treatment to a mental health patient unless, at a minimum, it has been properly established that the patient lacks legal capacity.

**On a related matter,** subsection 242(4) of the 2003 Act refers to a patient who is capable of consenting to the treatment but does not consent. However, if the responsible medical officer is of the opinion that it is in the patient’s best interests that the treatment be given then, it appears that by virtue of this subsection, the treatment may be given against the patient’s will! This appears to be contrary both to common law and to the General Comment issued by the UN CRPD Committee. Section 242(4) of the 2003 Act should, therefore, also be deleted.

**Lack of fair hearings**
Given what is known to have happened in practice, it can hardly be denied that many individuals did not receive a fair hearing when they appealed against their detention or forced treatment. In part this is because witnesses are not required to give evidence on oath so that mental health professionals can give false evidence with virtual impunity. When an individual’s liberty is at stake witnesses should be required to give evidence on oath. This should be specified in Schedule 2, subsection 12(2) of the Act. Consideration should also be given to the following points:

1. A mental health tribunal is required to determine whether the conditions which would justify detention “continue to be met”. That phrase should be deleted from subsection 50(4)(a) of the Act. The fact that the 2003 Act makes no allowance for the fact that inevitably mistakes will sometimes occur when psychiatrists assess patients is a major failing of the 2003 Act. The Tribunal, therefore, should be required to determine whether a mistake was made when an individual was sectioned. If it finds that a mistake was made then it should not only uphold the individual’s appeal against detention, but it should also acknowledge that the individual should not have been sectioned in the first place. This would go
some way towards avoiding the unfortunate situation of individuals being wrongly stigmatised.

2. It is known that the standard of legal representation at mental health tribunals is generally poor. For example, a study of tribunal transcripts has revealed that the performance of one particular solicitor was such that she appeared to be acting on behalf of the responsible medical officer rather than on behalf of her client. That solicitor actually made statements designed to lead the Tribunal to believe that her client had suffered from a mental disorder prior to her detention in hospital even though that could not be deduced from her client’s medical records! That solicitor also failed to draw attention to contradictions in the evidence presented to the Tribunal by the mental health professionals.

It may be that the best way to ensure that the quality of legal representation is improved would be to require that the appeal be heard in public unless the mental health patient requests that it be held in private. At a public hearing solicitors might feel under greater pressure to properly represent their clients. It should be noted that Article 6 ECHR states that “everyone is entitled to a fair and **public** hearing”. Further, the Act does not require that tribunal hearings be held in private: Schedule 2, section 10 merely states that the Scottish Ministers may make rules “enabling hearings to be held in private”.

3. Yet another matter which might militate against a fair hearing is that the grounds for appeal against tribunal decisions are too narrow: section 324 (2) (d) of the Act should be amended because as it stands it can be interpreted to mean that no appeal is permitted against a tribunal decision which the Tribunal found to have been supported by facts that it had established. This section should be amended to allow for an appeal on the grounds that the tribunal had failed to take full account of all the facts presented to it. An appeal should also be allowed on the grounds that the Tribunal had not been in possession of all the facts when it made its decision. (A study of tribunal transcripts has made it clear to me that appeals on those grounds should be permitted. The standard of proof at the tribunals in question was abysmal.)

Concluding remarks
Some of those who have been involuntary patients are of the opinion that Scotland should adopt the General Comment of the UN CRPD Committee in its entirety and hence not permit any forced treatment. If the Health and Sport Committee is not prepared to accept that such a major amendment to the 2003 Act is desirable then it should at least do its utmost to have the 2003 Act amended in a way which ensures that the number of people subjected to forced treatment is drastically reduced. Current mental health legislation makes it too easy for psychiatrists to have individuals detained in hospital and/or treated against their will. Apart from anything else, this means that
there are unnecessary demands on the NHS budget. NHS expenditure could, in fact, be greatly reduced and fewer patients harmed if doctors adhered to the first piece of advice provided in the British National Formulary: “Medicines should be prescribed only when they are necessary, and in all cases the benefit of administering the medicine should be considered in relation to the risk involved”. Few doctors and psychiatrists seem to act in accordance with this advice: there is a vast over-prescription of both psychiatric and other drugs. This has a clear implication for legislation relating to forced treatment. In his submission MHB017, the internationally respected psychiatrist professor David Healy stated that “psychotropic drugs are the leading cause of death in the mental health system”. Also a major piece of research carried out by professor Pirmohamed and others between November 2001 and April 2002 estimated that adverse drug reactions causing hospital admission could be responsible for over 10,000 deaths of patients per year in England. While the drugs in question were not psychiatric drugs it should be noted that, according to Pirmohamed, “Most reactions were either definitely or possibly preventable”. The point is that the side-effects of drugs can harm patients and that doctors commonly do not take sufficient care when prescribing. The Health and Sport Committee should take account of such facts and endeavour to have the 2003 Act amended so that forced treatment occurs only in exceptional circumstances. If the Act is not so amended then the Scottish Ministers will not have observed and implemented the provisions of the UN Convention on the Rights of persons with Disabilities as they are required to do. The production of more guidelines or recommendations would be insufficient since past experience makes clear that these any such guidelines or recommendations are likely to be ignored. It is essential that changes are made to the 2003 Act that greatly reduces the power of psychiatrists to detain individuals and then to subject them to forced treatment.

W. Hunter Watson
Having read the submissions of various authorities to the Public Petitions Committee with regard to Petition PEO1494 I have been impressed by their almost consistent assertion that the Mental Health (Care and Treatment) (Scotland) Act 2003 is, if not absolutely perfect in all respects, an adequate vehicle to ensure the mental wellbeing and uphold the human rights of individuals in Scotland suffering mental health problems. Therefore it is considered compliant with the European Court of Human Rights, ECHR.

“Psychiatrists are regulated by the General Medical Council and abide by the standards laid out in Good Medical Practice. These standards are upheld through Clinical Governance by Health Boards, regular appraisal of individual performance and more recently revalidation by the General Medical Council. As psychiatrists we strive to uphold excellent standards and to provide the best treatment in the interests of patients and their families.” Dr Alex Cook. Royal College of Psychiatrists in Scotland.

“When a person is made subject to a Short Term Detention Certificate (STDC), the patient or the patient’s named person may apply to the Tribunal under section 50 of the 2003 Act for revocation of the STDC. The Scottish Tribunals Service (STS) which provides administrative support to the Tribunal, has a Key Performance Indicator (KPI) requiring it to schedule a hearing within 5 days of receipt of application.” Mental Health Tribunal for Scotland.

The Mental Health Tribunal also states that the ECHR “has held that the term ‘a person of unsound mind………cannot be taken to permit the detention of someone simply because his/her views or behaviour deviate from established norms.’”

“The 2003 Act contains various “safeguards” to protect patients. Patients can have a Named Person/Welfare Attorney/Guardian to look after their interests; recourse to the Mental Health Tribunal, the Mental Welfare Commission (MWC), free access to independent advocacy services and a Mental Health Officer, MHO who must give consent before certain orders can be granted.” Kirsty McGrath. Head of Protection of Rights and Mental Health Unit

When we read medical notes, accessible only after our son’s death, we were appalled by the low standard of the consultant psychiatrist’s records. They contained contradictions, assumptions, inconsistencies and much misinformation. Correct, honest record keeping is an essential ingredient of “Good Medical Practice” and the “excellent standards” necessary to “provide the best treatment in the interests of patients and their families.”
Our son was admitted to hospital on 29th August 2008. He had declared his intention to fast for 8 days. The CPN, Community Practice Nurse, called an out of hours GP we did not know, and an MHO, to our house in Scotland where our son lived with us. The GP and CPN offended our son by their attitude to his religious views. He wrote in a letter to the MWC dated 3rd Sept, that “The MHO, when he arrived, was much more aware and listened to what I had to say. He said it was very hard to section someone who was clearly in a rational state of mind.” But the MHO was overruled by other medical staff.

(We found an undated letter which refers to the 8th Sept. I think it was a rough copy of a further letter which he meant to send since he had had no reply from the MWC. The MWC sent me a copy of the letter which was sent. It is dated 3rd Sept 2008).

On Sunday Aug.31st our son had a “heated discussion” with the consultant, who put him on a STDC. He was angry that his religious reasons for fasting, described as “self-starvation”, were dismissed. Thoughts our son had had, some months back, about low flying aircraft (we lived near Molesworth when he was small) and had not been considered a problem by the consultant, were now used as an excuse for the STDC. Because he refused medication in hospital he was said to “lack insight” into his “illness.” In a letter to the GP about our son’s admission to hospital the consultant wrote “Neither the duty doctor nor the MHO could find hard evidence of mental disorder.”

Our son was seen at 9.30 a.m. on 31st Aug. By 10.30 a.m. the MHO, a different one, had granted the STDC. The consultant wrote on the form that it had been impracticable to call us. His reason, “I phoned the home number and left a message for Mr G. to call back.” Yet three days may elapse between the examination of a patient and granting a SDTC.

On 1st Sept our son saw a representative from the advocacy service who suggested he should pursue his case through a solicitor but that it would take “a week or so” to get the case going. Our son writes, “in distress and sorrow I tried leaving the ward, thinking that if the police came for me there would be a legal means I could pursue.” He writes, “This ended with me voluntarily getting into a member of staff’s car and returning to the hospital. After a struggle, when medication was mentioned, I ended up being forcibly injected against my will ‘to relieve my distress.’” Least restrictive?

The consultant describes this incident as follows, “he was brought back to the ward and was “given” (no mention of a struggle or forced injection) IM Haloperidol and IM Lorazepam because of his ‘agitation and distress’.” The irony of this “compassion” for his “distress” is that it caused greater distress as our son says in his letter.

The consultant wrote, in his letter to the GP that, by the 8th Sept, (our son) “was much improved, played chess with other patients and was sleeping well at night.” The consultant goes on, “I reviewed him on the 8th Sept. I explained to him, on that date, that we would be starting regular IM Risperidal Consta. He was given 25mgs of Risperidal on that day”. In the undated letter our son says he was forcefully injected on the 8th Sept.
By the 12th Sept he was “much brighter”. Perhaps it was because his Tribunal was to be held on the 18th. On the 18th he was “more tense, more perplexed and more angry about the whole detention process.” His Tribunal had been postponed to the 25th September.

He ran away to London to his brother’s house on 22nd of September. That was the day appointed for his next IM injection and he had been told that the RMO and MHO would be applying for a section 63 CTO on 25th September. He is now called “absconder”.

The consultant reports in a letter to the GP, dated 14th Oct 2008, that our son is in London at his brother’s house. He writes “I have made it very clear to (our son) and his family that in my opinion he suffers from schizophrenia. I think that he would benefit from being on regular antipsychotic medication. However it must be emphasised that this diagnosis is still somewhat tentative in that he has only ever described one specific psychotic symptom (a delusional memory) that his body was affected by a low flying aircraft many years ago. All the rest of his behaviour can certainly be described as odd and idiosyncratic (because he was reading the Bible and the Koran? The ECHR warns against such judgements) but it’s clearly not psychotic. There has never been any evidence that he suffers from hallucinations. He does not appear to have any other paranoid thinking or any other form of delusional thinking.” He concludes, “If he returns to Scotland, I would certainly be keen to establish him on antipsychotic medication once again but I do not feel that we can be actively pursuing him at this point.”

Please note that we obtained medical notes and letters only after our son’s death. When I had expressed doubts about the diagnosis of schizophrenia I was told that I had “no insight”. Our GP had diagnosed depression but then agreed with the consultant, even after receiving the above letter. I was vilified to some extent and “my views” ignored.

An independent psychiatric wrote a report after our son’s death in which he claimed there was no evidence to support the diagnosis. All authorities we have since complained to, including the COPFS, who commissioned the report, have ignored his finding.

The MHO is not a “safeguard”. The first one who came to our house was honest but he was overruled. The second MHO, in hospital, agreed with the RMO and granted a short term detention certificate within an hour. The third MHO agreed with everything the RMO said, kept inaccurate and misleading records, and interfered when it was not in her remit. I complained but was just told “she is very professional”.

The MWC, in our experience is not a safeguard. Our son wrote to the MWC for help. His letter was articulate, described events and his distress. It was never answered, we discovered after our son’s death, because the person responsible had been on sick leave.

The Tribunal system is not a “safeguard”. KPI requires that a tribunal be scheduled “within 5 days of the receipt of application”. However the time required to present an “application” is lengthy. It took from the 1st Sept 2008 to 25th Sept. 2008 to arrange our son’s tribunal. First a solicitor has to be found, then he has to interview the patient and various other people have to be consulted and supply reports, (RMO, MHO etc.). An
independent psychiatrist has to be found to examine the patient and make a report. In our case a psychiatrist agreed to do this, then declined and another had to be found. However, the 2003 Act empowers the consultant to force medication on the patient before he/she can appeal. The frustration must be unbearable.

Kirsty McGrath has written, with regard to Tribunals, that S318 of the 2003 Act creates an offence of knowingly making a false entry or statement in any “relevant document”.

The RMO and MHO both made false statements in hospital and tribunal reports. Whether “knowingly” or simply carelessly we do not know, but carelessness is not acceptable. The RMO claimed he had known our son for several years. He only met him in person in Sept. 2007. He and the MHO accuse our son of “sleeping rough”. We know this was untrue. The solicitor notes that our son denies this accusation. The MHO reports that our son was bullied at primary school, that we took him out of school and “home educated”. Their accusations appeared to be an attempt to suggest that he was isolated and odd. He actually had a glowing report at primary school, “an intelligent, athletic, popular and caring” boy. The independent psychiatrist noted this in his report after our son’s death.

In the report of a tribunal held on 10th Feb.2009, which my husband and I attended, it was noted “Both parents also expressed clear objections to what they stated were factual inaccuracies in the previous decision, 25th Sept. 2008. But nothing was changed.

Our son went to hospital for the last time on Oct 9th 2009 because of misunderstandings and bad practice on the part of the police and the (same) consultant. Our son called home to express concerns about his treatment, the re-introduction of medication, and I informed the hospital of his call and our concerns. I was promised that the consultant would call me back. He is supposed to “consult” the views of carers. He ignored us. The next day, less than 24 hours later, our son was given a 2 hour unescorted pass. We were not informed or “consulted”. He died of hypothermia in the hills eight days later.

We learnt from the hospital notes, acquired through FOI, that no symptoms of schizophrenia had been evident on his admission to hospital but our son had still been given medication. Was it forced? We don’t know. When he left the hospital he would have known that, if he returned home or to hospital he would be put on a STDC and forced to take medication which he did not want and for which there was no justification.

“Excellent standards” and the “best treatment in the interest of patients and their families”.

Our son was misdiagnosed, held down and forcibly injected and is dead.

The Health Board, the COPFS, the MWC and the SPSO found “no failings”.

Mrs Judith Gilliland
Advance Statements and Advocacy

It has been suggested that the right of mental health patients not to be subjected to forced treatment, as per the General Comment of the UN Committee on the Rights of Persons with Disabilities, could be protected by placing more emphasis on advance statements and independent advocacy. While this might give some additional protection to mental health patients it would be inadequate. As the Health and Sport Committee would learn if it were prepared to take oral evidence from former mental health patients or their representatives, individuals can be unexpectedly detained. Such individuals would have no cause to consider making an advance statement.

As far as independent advocacy is concerned, there are two points that can be made. One is that the standard of independent advocacy seems to be too low at present and there is no guarantee that this standard could be raised to an adequate level. It should be noted that a 2009 report of research commissioned by the then Scottish Executive was critical of the poor standard of legal representation provided to mental health patients and there seems to be no evidence that this has improved. The situation regarding independent advocacy might be no different. There is, however, a more substantial point: many patients do not lack capacity and hence it should be sufficient for them to withhold consent to treatment. Unfortunately, even in cases where such patients know their rights they are quite unable to uphold them: many psychiatrists clearly believe that the law permits them to subject their patients to forced treatment without first establishing that they lack the capacity to make a treatment decision. Psychiatrists should make no such assumption: the GMC consent guidance makes it clear that there must be a presumption that a patient has capacity and the guidance also draws attention to case law which has established that a patient with capacity has the right to refuse treatment even though death might be the likely consequence. Scottish mental health legislation should be amended to reflect this fact: it should not authorise forced treatment until it has been properly established that, as a minimum, the patient lacks capacity. In addition, Scottish mental health legislation should allow for an appeal to a court against a decision as to incapacity and no forced treatment should be permitted unless a court has heard and has not upheld that appeal. (The Adults with Incapacity Act at section 14 provides for such an appeal.)

A study of the Claire Muir case, which I have written about at length elsewhere, illustrates well what is wrong with the 2003 Mental Health Act. Briefly, Claire Muir was sectioned on 11 September 2006 by a locum consultant who had never met her previously and to whom she had not been referred by either a GP or a psychiatrist. On 1 July 2006 a midwife had expressed concern that, following the diagnosis of a failed pregnancy, Claire
Muir sounded psychotic and possibly suicidal. She was quickly referred to a psychiatrist who found her neither psychotic nor suicidal. Matters might have rested there had Claire Muir not complained about her miscarriage treatment. It may have been no coincidence that shortly thereafter a midwife attempted to give the impression that Claire Muir was delusional. That midwife spoke to a health visitor who in her turn expressed concerns to a community psychiatric nurse who then contacted Claire Muir’s GP. The GP declined to refer Claire Muir to an approved medical practitioner. The community psychiatric nurse then took it upon himself to refer Claire Muir to the locum who interviewed and then sectioned her several weeks after the referral. That Bulgarian locum failed to make any enquiries before granting a short-term detention certificate with respect to Claire Muir and so mistakenly imagined that she had been speaking literally when she had said to the midwife on 21 July 2006 that her daughter was invisible in nursery. (She had only meant that her daughter was not being included in activities at nursery. As can be verified from her medical records, Claire Muir explained that to her GP on 27 July 2006.)

Claire Muir remained on a section until she was put into the care of a different consultant in October 2007. Since he found “no identifiable psychiatric disorder” he took her off the section. Claire Muir was formally discharged from the mental health services on 14 December 2007. Although the locum who sectioned her seemed to imagine that she had a severe and enduring mental illness - he had put her on the Care Programme Approach - she has had no need of mental health services since.

In 2008 attempts were made by Claire Muir and her husband to have some of their complaints properly investigated. When those attempts failed Claire Muir raised actions against the employers of those responsible for her ordeal. She was unable to find a lawyer to represent her in court but, since the actions had been raised under the summary cause procedure, she could be represented by a lay representative at the initial hearings. From the documentation that was available the facts could be easily established, so I was pleased to act as that lay representative. Unfortunately, the sheriff was persuaded by the defendants to remit Claire Muir’s actions to the ordinary cause procedure. Hence the actions raised under the summary cause procedure did not proceed to proof, the stage at which the evidence would have been tested.

One effect of remitting the actions to the ordinary cause procedure was that Claire Muir had to start all over again. She was still unable to get a lawyer to represent her so she had to represent herself since a lay representative cannot represent a litigant at a hearing held under the ordinary cause procedure. Claire Muir successfully represented herself at the initial hearings but the cases did not then immediately go to proof as they would have done under the summary cause procedure. Under the ordinary cause procedure before a case goes to proof it can go to debate at which stage the defendants can attempt to have a case dismissed on technical grounds. In each of the three actions which Claire Muir raised under the ordinary cause procedure the sheriff was persuaded to permit the action to go to debate and in each case the action was dismissed on technical grounds. It has been alleged that this means that Claire Muir’s complaints were fully investigated and no evidence
found to support them. That is clearly false, not only because none of the actions went to proof but also because Claire Muir had grounds to appeal. Appeals were out of the question, however, because Claire Muir was not eligible for legal aid and did not have unlimited resources. Further, any claim that Claire Muir’s complaints had been fully investigated and no evidence has been found to support any is obviously false since the police are currently investigating one of Claire Muir’s complaints, the one in which it is easiest to establish that a mental health professional had committed an offence.

Much can be learned from the Claire Muir affair. She had no reason to fear that she might be sectioned and hence had no reason to make an advance statement. Also there was absolutely no evidence that she lacked capacity. Indeed the evidence is lacking that Claire Muir suffered from a mental illness. Beyond reasonable doubt she should not have been detained. Her detention led to her having what she has described as a “nightmarish experience”. It has also led to her being wrongly stigmatised, something that she can do nothing about now that her court actions have failed. The fact is that the 2003 Act makes no allowance for the possibility that the “professional judgment” (i.e. the opinion) of a psychiatrist might occasionally be in error when he or she considers it likely that the necessary criteria have been met to justify subjecting an individual to compulsory measures. Unsurprisingly mistakes are sometimes made as is evidenced by the Claire Muir case and also by others known to me.

There is another matter which is, perhaps, worthy of consideration. A psychiatrist is currently a member of the Health and Sport Committee. In my opinion, there should not be a psychiatrist on that committee when it discusses changes to Scottish mental health legislation since a psychiatrist is unlikely to be impartial when the desirability of reducing the powers of psychiatrists is being discussed. There would appear to be a case, therefore, for that psychiatrist withdrawing from the Health and Sport Committee for the time being so that he can be replaced by an MSP who would be more likely to be capable of taking an objective view. Ideally any replacement would have some knowledge of and an interest in both mental health matters and human rights. It would not be difficult to find such a replacement.

W. Hunter Watson
Electro – Convulsive Therapy

The 2003 Mental Health Act is an unsatisfactory piece of legislation not least because it permits electro-convulsive therapy (ECT) to be given to a patient who “resists or objects to the treatment”. It should be noted that in 2005 the World Health Organisation recommended that “If ECT is used, it should only be administered after obtaining informed consent. It should also be noted that on 1 February 2013 Juan E. Mendez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, submitted a report to the Human Rights Council of the General Assembly of the United Nations. His report focussed on certain forms of abuse in health-care settings including psychiatric institutions. He observed that “The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock” (Electroshock = ECT). His report helped to influence the UN Committee on the Rights of Persons with Disabilities. In April 2014 that Committee issued a General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. That Convention is an international treaty that is legally binding on states that have ratified it. (The UK is one of those states.) The General Comment requires parties to the treaty to “abolish policies and legislative provisions that allow or perpetrate forced treatment”. However, although Scotland must observe and implement treaties into which the UK has entered, the Scottish Government has indicated that it is not prepared to abolish the legislative provisions which permit psychiatrists to subject unwilling patients to ECT.

A definition of inhuman and degrading treatment was provided by the European Court of Human Rights in the 2002 case of Pretty v UK (para 52): “ [...] “ill treatment” that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering [...] Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 [...]”.

Given the evidence from the survivors of psychiatry and the families of those who did not survive (see the submissions about the Mental Health (Scotland) Bill to the Health and Sport Committee) it is not surprising that the Special Rapporteur drew attention to “non-consensual treatment, such as forced medication and electroshock ” in psychiatric institutions. It is to be regretted that the Minister for Health and Sport has insisted that no significant changes to the 2003 Mental Health Act are necessary. However, from the information provided below, it should be clear that involuntary ECT falls within the definition of inhuman or degrading treatment. Given that such treatment is
prohibited in all circumstances the Minister’s defence of the current position, namely that involuntary ECT can only be given with the approval of a second opinion doctor, is totally inadequate. (The American psychiatrist, Dr Peter Breggin, in his paper entitled “ECT Resources Center”, states that the giving of ECT against the expressed wishes of a patient is “an extreme civil rights abuse”.)

I have obtained information about ECT from a variety of sources including the transcript of the relevant part of the debate that preceded the passage of the 2003 Mental Health Act. That transcript is well worth studying. Shona Robison (SNP) proposed two amendments “to prevent ECT being given to patients who are incapable of consenting to treatment, or who resist or object to its being administered. The only exception would arise in urgent situations, where the treatment could be given under the urgent treatment provisions in section 171”. She stated that “One of my constituents had ECT when he was 16 years old. … He now regrets the treatment very much, because it completely wiped out all his primary school learning. …” (A woman I know told me that she had been screaming when she was given ECT against her will. She also told me that it did not cure her depression but it did deprive her of her childhood memories.)

Ms Robison also quoted from an appraisal consultation document on ECT from the National Institute of Clinical Excellence (NICE): “… Whilst some patients consider ECT to be a beneficial and lifesaving treatment, others report feelings of terror, shame and distress, and find it positively harmful and an abusive invasion of personal autonomy.”

Clearly, patients in the latter group, by virtue of the definition of inhuman or degrading treatment, had been subjected to treatment in that prohibited category. Unfortunately, no MSP drew attention to that possibility. Margaret Smith (LD) stated that “SAMH is concerned about anybody being given ECT treatment who has not consented fully to it.” (SAMH = Scottish Association for Mental Health.) However, she added “On the other side of the argument, we must take on board the comments that the Mental Welfare Commission for Scotland made to the Committee. It said that if we go down the route that SAMH advocates, we might prevent people from getting treatment that, in some cases, might help them.” The then Labour/Lib Dem Executive chose to accept what it supposed to be expert advice and pushed through the section on ECT against SNP opposition. Now that the SNP form the Scottish Government, it is opposed to amending the 2003 Act in line with its position in 2003. This suggests that officials are dictating to Ministers what the Scottish Government’s policy on mental health legislation should be.

The following is a summary of what happens when a patient is given electro-convulsive therapy: he or she is injected with an anaesthetic to block out pain, and also with a muscle-paralysing agent to shut down muscular activity and hence prevent spinal fractures. Electrodes are then placed on his or her head and a high current is passed through the brain. This constitutes a single treatment. A course of ECT consists of several such treatments. According to
information obtained by Alison McInnes, MSP, the median number of treatments per course in 2012 was 8, with the majority of patients receiving two treatments per week. (She was also informed that in 2012 362 patients in Scotland were given between them 434 courses of ECT, 32% of those given ECT had not consented to it and 23% of the patients who lacked capacity showed no improvement!) It should not take much imagination to appreciate how terrifying it must be to be forcibly taken twice a week for several weeks to the room where the ECT procedure is carried out. The procedure will be particularly distressing to anyone who knows that ECT is not always effective, that it can cause permanent memory loss and even result in death. (Statistics from Texas suggest that the death rate among the elderly receiving ECT is one in 200. In Scotland during the period 2005-2011 there were recorded 6 deaths among patients aged over 65 who were receiving ECT.)

Alison McInnes has kindly asked several questions on my behalf relating to the 2003 Mental Health Act. I am concerned about the number of evasive, misleading or untruthful answers provided by the Minister for Health and Sport. It seems reasonable to assume that those answers were formulated by officials who wished to ensure that the Minister did not provide information which might draw attention to the unsatisfactory nature of the 2003 Act. For example, in his response to a question about ECT, the Minister claimed that “there is no evidence of permanent memory loss”. That is untrue as can be verified by noting what Shona Robison reported about one of her constituents or by going to the internet (google risks and side effects of ECT). Anyone who uses the internet to research ECT will find that the Minister was also being disingenuous when he advised Alison McInnes that ECT is “a safe and effective treatment for severe mental illness” though, to be fair to the Minister, that false statement is likely to be traceable to a psychiatrist.

It is to be hoped that MSPs will now accept that involuntary ECT is inhuman or degrading and must, therefore, be ended. If it is not ended then the NHS might have to pay compensation to victims that could amount in total to well over £1 billion. It should be noted that in 2004 a judge ruled that “slopping out” in jails amounted to degrading treatment. He observed that this had damaged the human dignity of the prisoner who had raised the action and had caused him to have feelings of anxiety, anguish, inferiority and humiliation. Clearly the judge had based his ruling on the definition of degrading treatment referred to above. The judge awarded the prisoner only £2400 compensation but since then other prisoners have been awarded similar compensation. According to the Scottish Prison Service, the total amount of compensation that has been paid out to individuals who were forced to slop out when they were prisoners in Scottish jails has risen to £11,313,500! It seems safe to assume that if one mental patient who had been given involuntary ECT could establish in court that this action constituted inhuman or degrading treatment then there would be an award of compensation of very much more than £2400. If that happened then it would be a near certainty that others who had been similarly treated would receive similar compensation. If an ECT case did come to court then the plaintiff could refer to successful ECT actions raised elsewhere. In an action raised in the USA in 2005, one in which Dr Breggin was the medical
expert, there was an award of £635,000. (Following that case, a state Court of Appeals confirmed Dr Breggin’s testimony about the harm done by ECT.) More recently Dr Breggin was the expert in a malpractice suit against an ECT doctor that resulted in a settlement of over $1 million. The position of the Scottish Government seems to be that it need not seriously examine the possibility that involuntary ECT constitutes inhuman or degrading treatment unless a court rules that is the case. It is to be hoped that MSPs will realise that it would be prudent to amend Scottish mental health legislation before that happens and a Scottish court awards substantial compensation to the victim. If there were such a judgment then other victims would be likely to claim and be awarded similar compensation: according to a 2009 STV report, in 2007 the House of Lords ruled that prisoners who brought human rights claims under the Scotland Act (sic) did not have to do so within a one year time limit. (There is such a limit in the Human Rights Act.) Also, according to a 2011 report in the Telegraph, judges in Scotland’s highest court overturned a ruling that three former prisoners had been too late to submit their compensation claims for being forced to use chamber pots in their cells. Given this precedent and the fact that the infliction of inhuman or degrading treatment on an individual is such a serious matter, it seems likely that if involuntary ECT were ruled to fall into that category then all who had been subjected to it would be eligible for compensation and that the total to be paid out would be horrific. In such situation it would ultimately be the taxpayers who would have to pay up. It might, therefore, be worthwhile having a public debate on this issue before there is a vote on the Bill that is currently before Parliament.

W. Hunter Watson
Antipsychotic Drugs

Individuals detained under mental health legislation are frequently forced to take antipsychotic drugs. A high proportion of care home residents are also given those drugs. They have many serious side-effects to which the elderly are particularly susceptible. Because of this the British National Formulary (BNF) advises that “Antipsychotic drugs should not be used in elderly patients to treat mild to moderate psychotic symptoms”.

One little publicised side-effect of antipsychotics is known as tardive dyskinesia (rhythmic, involuntary movements of tongue, face and jaw). According to the BNF, “It is of particular concern because it may be irreversible on withdrawing therapy and treatment is usually ineffective”.

The BNF notes that “Tardive dyskinesia occurs fairly frequently, especially in the elderly”. Regrettably many elderly care home residents and elderly mental health patients are given antipsychotics. It is known that elderly mental health patients are not given antipsychotics only when they have severe psychotic symptoms and it would be disingenuous to claim that in care homes antipsychotics are only prescribed when those symptoms are present.

The Health Committee at Westminster observed that medication was “in many cases, being used simply as a tool for the easier management of residents” (Elder Abuse. Second Report of Session 2003-04, para 65). Also a joint report by the Scottish Care and Mental Welfare Commissions stated that “We also found evidence of GPs prescribing medication (to manage challenging behaviour) without having seen the person” (Remember, I’m still me; May 2009). That is reprehensible as is the fact that the Scottish Care Standards for Care Homes for Older People permit “sedative or tranquilising (sic) drugs” to be used “for the symptomatic treatment of restless or agitated behaviour”. Given what is now known about those drugs and also about ways of caring for elderly people with dementia, it would be unforgivable if those Care Standards are not suitably amended. It would also be unforgiveable if mental health legislation is not suitably amended to ensure that psychiatrists cannot administer antipsychotics to patients against their will. Perhaps legislators should now note that in the USA there was a $1.5 million jury award in a tardive dyskinesia case in February 2014 and a £700,000 settlement in May 2014. In each case Dr Peter Breggin was the medical expert. It would be obviously imprudent to permit doctors and psychiatrists to continue to prescribe antipsychotic drugs to patients without their informed consent or the approval of a court since that could lead to punitive damages being awarded. These could amount in total to billions of pounds if all of those who developed tardive dyskinesia were awarded damages.

W. Hunter Watson
Dear Sirs and Mesdames

MENTAL HEALTH (SCOTLAND) BILL

I am grateful to the Committee for the opportunity it gave me to give evidence on 30 September 2014 for the Mental Health Tribunal for Scotland (“the Tribunal”).

In the course of answering questions on the issue of named persons, Dr Richard Simpson asked me if the Tribunal had, or wished to have, a power to require a person who had made a declaration not to have a named person to have an advocate. I undertook to consider that matter, to discuss it with Mr Colin McKay (Chief Executive of the Mental Welfare Commission for Scotland (“the Commission”)) and to respond to the Committee on that matter in writing.

At the moment the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) allows a person to nominate a named person and, in the event that no such nomination is made, section 251 of the 2003 Act will operate to identify a “default” named person (essentially, the person’s primary carer or nearest relative). A named person is a party to any case before the Tribunal concerning the person whose named person they are. Accordingly, the named person is automatically provided with all case papers, which may contain information that the named person does not wish to know and which the person who is the subject of the case before the Tribunal did not wish the named person to have.

The Scottish Government’s stated policy is “… that an individual should only have a named person if they choose to have one” (paragraph 90 of the Policy Memorandum). That policy is in line with recommendation 4.1 of the Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report that “A service user should only have a named person if he or she has appointed one”.

7 October 2014
The Tribunal and the Commission both support the policy objective that a person should have a named person only if the person has chosen to have a named person. (In passing I note that the Tribunal and the Commission both have concerns that the provisions of the Bill as they stand do not actually deliver that policy objective).

I have discussed Dr Simpson’s question with Colin McKay. It appears to the Tribunal and to the Commission that the issues of whether a person who is the subject of a case before the Tribunal has a named person or has an advocate are – and should remain – separate. The issue of the named person is whether a person should have a named person only if the person chooses to have one, or if section 251 of the 2003 Act should be allowed to continue to operate to identify a “default” named person where no named person has been nominated. The Tribunal and the Commission are clear that a person should have a named person only if the person has chosen to have one.

The issue of advocacy concerns patient participation in Tribunal hearings. A patient is entitled to have an advocate in Tribunal hearings and is entitled to be represented by a solicitor in Tribunal hearings. However, no one can require a patient to have an advocate or to be represented by a solicitor. Those are matters, rightly, for the patient. Accordingly, it appears to the Tribunal and to the Commission that, irrespective of whether or not a patient has a named person, the decision as to whether a patient should have an advocate (or a solicitor) in Tribunal hearings is, and should remain, a matter for the patient.

In our discussion on Dr Simpson’s question, Colin McKay and I went on to consider whether the Tribunal should have a power to appoint a named person in the case of a patient who has not chosen to have one. The Tribunal and the Commission are of the view that where a person has not chosen to have a named person that should be the end of the matter. Where a person has not chosen to have a named person it appears to the Tribunal and to the Commission that to give a power to the Tribunal to appoint one in proceedings before the Tribunal would override the autonomy of the patient. Further, it would put the Tribunal in the position of deciding whether a family member should become a named person and so a party to the Tribunal’s proceedings and so required to be provided with information which the patient may not wish the family member to have.

Simply for the sake of completeness the Tribunal and the Commission note that the 2003 Act provides various layers of protection for patients in terms of Tribunal hearings. Mental health officers (MHOs) and responsible medical officers (RMOs) are subject to various statutory duties in addition to their professional responsibilities; a patient may have a named person; a patient is entitled to have access to advocacy services; a patient is entitled to be legally represented in Tribunal hearings (for which a form of non means tested legal aid is available); Tribunal panels themselves are independent and comprise general and medical members and are convened by a legal member; where a patient does not have the capacity to instruct a solicitor the Tribunal appoints a curator ad litem from a list of solicitors to take a view on the case, to instruct a medical report if the curator so wishes and to ask such questions and to make such submissions as the curator considers appropriate; Tribunal panels are semi-inquisitorial, which means that they do not simply hear evidence and legal argument and then make a decision but have power to ask questions, require the production of documents and even to instruct their own reports.
Accordingly, even if a Tribunal panel is faced with a case in which a patient who is capable of instructing a solicitor does not do so, who declines to have an advocate, chooses not to have a named person and decides not to attend any Tribunal hearings, the Tribunal itself is able to obtain documents, instruct reports and test the evidence of MHOs and RMOs by questioning before making a decision. Finally, decisions of the Tribunal are subject to review on appeal to the superior courts.

From all of the foregoing it appears to the Tribunal and to the Commission that decisions as to whether to choose to have a named person, whether to choose to have an advocate, whether to choose to be legally represented and to choose to what extent a person wishes to participate in any case concerning that person before the Tribunal are decisions best left to the patient.

The Tribunal and the Commission recognise the importance of the involvement of close relatives and carers in the lives of service users. However, the Tribunal and the Commission are of the view that appointing a “default” named person is not the best route to secure such involvement.

I trust that the Committee finds this response helpful. If the Committee requires clarification of anything in this letter or wishes any further information from the Tribunal please do not hesitate to contact me.

Mr Colin McKay has had sight of the text of this letter and I copy this letter to Mr McKay for his information.

Yours faithfully

Dr J J Morrow
President
29 October 2014

Dear Rebecca,

I write to provide further information, as requested, on the role of Healthcare Improvement Scotland in relation to scrutinising services that review and report incidents of suicide or homicide by people with mental illness.

This was discussed by the Committee on 7 October and I would firstly like to correct a statement which was made during that evidence session. It was stated that Healthcare Improvement Scotland ‘has developed a robust process through which incidents of suicide or homicide by persons within mental health services must be robustly reviewed and reported on’. We do not, in fact, have any role in relation to incidents of homicide by people who have been in contact with mental health services, and I would be grateful if this correction could be formally recorded. These events should be reported through NHS board processes for managing adverse events and should also be reported to the Mental Welfare Commission.

Healthcare Improvement Scotland does lead on the National Approach to Learning from Adverse Events. This provides an overarching framework to support NHS boards to standardise processes for managing adverse events. It covers all adverse events and we are supporting NHS boards to openly share the learning points and improvements that have resulted following reviews.

As part of this programme, we manage the Suicide Reporting and Learning System (SRLS). The SRLS supports NHS boards to improve the way that suicide reviews are carried out in mental health services and to help to reduce risk. NHS boards use suicide reviews to understand what happened to a person who has been in contact with its Mental Health service who complete suicide, and to recognise what can be done to make services safer for other people at risk. The SRLS analyses suicide review reports to provide feedback to NHS boards on effectiveness of the review process and aggregates mental health services learning themes to drive national improvement. If the analysis of the suicide review report indicates that there may be issues relating to individual service user care or welfare issues then the SRLS will liaise with the NHS board and the Mental Welfare Commission to ensure the latter is notified, as set out in the Mental Welfare Commission notification process.

Learning from the reviews is shared through the Suicide Reviews Community of Practice website and through a 6-monthly briefing paper which makes recommendations for action on current service improvement issues.

Healthcare Improvement Scotland also leads the Scottish Patient Safety Programme – Mental Health, which is committed to reducing harm and supporting NHS boards to make services safer for patients. The programme aims to systematically reduce harm experienced by people using

www.healthcareimprovementscotland.org
mental health services in Scotland by empowering staff to work with service users and carers to identify opportunities for improvement, to test and reliably implement interventions, and to then spread successful changes across their NHS Board area. The work will be delivered through a four-year programme, running from September 2012 to September 2016.

The Scottish Patient Safety Programme for Mental Health and the Suicide Reporting and Learning system are working with Scottish Government to deliver Commitment 6 of the Scottish Government's Suicide Prevention Strategy:

I hope that the above information will be of assistance. Please do not hesitate to get in touch if you require any further information.

Yours sincerely,

Robbie Pearson
Director of Scrutiny & Assurance
Dear Rebecca

HEALTH AND SPORT COMMITTEE MEETING ON 2 DECEMBER 2014
MENTAL HEALTH (SCOTLAND) BILL

As you are aware, at the Health and Sport Committee’s meeting on 2 December, Dr Richard Simpson indicated that it would be helpful for the Committee’s consideration of the Bill and specifically Part 1, Section 1 (Measures until application determined) to have some idea of the precise reasons why there might be more than one Tribunal hearing before the Mental Health Tribunal is in a position to determine an application for a Compulsory Treatment Order.

I am grateful for the work undertaken by my colleagues in the Mental Health Tribunal Unit within the Scottish Tribunal Service which has enabled me to provide this information (Annex A). The information provided covers the last two financial years (2012-13 and 2013-14) and has been derived by interrogating the requisite computer system.

I do hope the Committee Members find this information is helpful to their consideration of matters. Please do not hesitate to contact me if there is any additional information the Committee might wish and we will endeavour to provide this.

Yours sincerely

Carol Sibbald

CAROL SIBBALD
REASONS WHY A FURTHER HEARING MAY BE REQUIRED BEFORE A CTO IS DETERMINED

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of instances</th>
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</thead>
<tbody>
<tr>
<td>A report needs to be provided (a required report relating to the CTO application has yet to be submitted)</td>
<td>32</td>
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<tr>
<td>Applicant requires additional time</td>
<td>19</td>
</tr>
<tr>
<td>Appointment of Curator ad Litem</td>
<td>67</td>
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<td>Commission Person of Skill</td>
<td>6</td>
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<td>Failure of parties to attend</td>
<td>75</td>
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<tr>
<td>Independent medical report</td>
<td>306</td>
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<td>Other (i.e. not one of the defined reasons outlined)</td>
<td>27</td>
</tr>
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<td>Other party required</td>
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<tr>
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<td>278</td>
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<td>Failure of parties to attend</td>
<td>65</td>
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<td>Independent medical report</td>
<td>254</td>
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<td>Report to be provided (Tribunal may call for a specific report to aid their consideration)</td>
<td>17</td>
</tr>
<tr>
<td>Respondent requires additional time</td>
<td>266</td>
</tr>
</tbody>
</table>

Points to note

- The “Applicant” in this scenario is the Mental Health Officer who is the person who submits the CTO application;
- The “Respondent” in this scenario is the individual who will be subject to the CTO;
- Commission Person of Skill – this is where the Tribunal is unsure whether the individual might benefit from having for example a Curator ad Litem appointed. In such cases the Tribunal asks for an appropriate person to assess the individual and reach a view.
- A case can have more than one reason for requiring a further hearing to be held.
Dear Rebecca

HEALTH AND SPORT COMMITTEE MEETING ON 2 DECEMBER 2014
MENTAL HEALTH (SCOTLAND) BILL

Further to my letter of 12 January and our subsequent telephone conversations I am pleased to be able to say I have some further information which I hope will prove helpful to Committee members.

I attach – Annex A – some additional information relating to the number of section 63 compulsory treatment order applications which required more than one Tribunal hearing before the Mental Health Tribunal was in a position to determine the application in 2012-13 and 2013-14. I am grateful for the work undertaken by my colleagues in the Mental Health Tribunal Unit within the Scottish Tribunal Service which has enabled me to provide this additional information.

I do hope the Committee Members find this information is helpful to their consideration of matters. Please do not hesitate to contact me if there is any further information Committee members might wish and we will endeavour to provide this.

Yours sincerely

Carol Sibbald

CAROL SIBBALD
Financial Year 2012-13

There were a total of 1,819 section 63 (application for a compulsory treatment order) cases. 657 (36.11%) cases required a further hearing. Table 1 below provides information outlining the reasons why a further hearing was required and the number of instances each reason occurred during the year. A case can have more than one reason for requiring a further hearing to be held. This is evidenced by the fact that whilst there were 657 hearings which required a further hearing there were 832 instances of the reasons for having a further hearing.

<table>
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<td>278</td>
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<td><strong>Total</strong></td>
<td><strong>832</strong></td>
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Financial Year 2013-14

There were a total of 1,831 section 63 (application for a compulsory treatment order) cases. 600 (32.76%) cases required a further hearing. Table 2 below provides information outlining the reasons why a further hearing was required and the number of instances each reason occurred during the year. A case can have more than one reason for requiring a further hearing to be held. This is evidenced by the fact that whilst there were 600 hearings which
required a further hearing there were 743 instances of the reasons for having a further hearing.

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Delegated Powers and Law Reform Committee

61st Report, 2014 (Session 4)

Mental Health (Scotland) Bill at stage 1

Published by the Scottish Parliament on 29 October 2014
Delegated Powers and Law Reform Committee

Remit and membership

Remit:

1. The remit of the Delegated Powers and Law Reform Committee is to consider and report on—
   (a) any—
      (i) subordinate legislation laid before the Parliament or requiring the consent of the Parliament under section 9 of the Public Bodies Act 2011;
      (ii) [deleted]
      (iii) pension or grants motion as described in Rule 8.11A.1; and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;
   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;
   (c) general questions relating to powers to make subordinate legislation;
   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation;
   (e) any failure to lay an instrument in accordance with section 28(2), 30(2) or 31 of the 2010 Act; and
   (f) proposed changes to the procedure to which subordinate legislation laid before the Parliament is subject.
   (g) any Scottish Law Commission Bill as defined in Rule 9.17A.1; and
   (h) any draft proposal for a Scottish Law Commission Bill as defined in that Rule.

Membership:

Richard Baker
Nigel Don (Convener)
Mike MacKenzie
Margaret McCulloch
Stuart McMillan (Deputy Convener)
John Scott
Stewart Stevenson
Committee Clerking Team:

Clerk to the Committee
Euan Donald

Assistant Clerk
Elizabeth Anderson

Support Manager
Daren Pratt
Delegated Powers and Law Reform Committee

61st Report, 2014 (Session 4)

Mental Health (Scotland) Bill at stage 1

The Committee reports to the Parliament as follows—

1. At its meetings on 5 August and 7 and 28 October the Delegated Powers and Law Reform Committee considered the delegated powers provisions in the Mental Health (Scotland) Bill at stage 1 ("the Bill")\(^1\). The Committee submits this report to the lead committee for the Bill under Rule 9.6.2 of Standing Orders.

2. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill ("the DPM")\(^2\).

3. In this report the following expressions bear the following meanings:

   “the Bill” means the Mental Health (Scotland) Bill;
   “DPM” means the Scottish Government’s Delegated Powers Memorandum;
   “the Tribunal” means the Mental Health Tribunal for Scotland;
   “the 1995 Act” means the Criminal Justice (Scotland) Act 1995;
   “the 2003 Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003; and
   “the CJ Act 2003” means the Criminal Justice (Scotland) Act 2003.

OVERVIEW OF BILL

4. The Bill was introduced by the Scottish Government on 19 June 2014. The lead Committee is the Health and Sport Committee.

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\(^1\) Mental Health (Scotland) Bill [as introduced] available here: 
http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/b53s4-introd-bookmarked.pdf

\(^2\) Mental Health (Scotland) Bill Delegated Powers Memorandum available here: 
http://www.scottish.parliament.uk/S4_Bills/Mental_Health_DPM.pdf
5. The Bill makes provision in relation to mental health. In particular, the Bill makes a large number of technical amendments to the 1995 Act, the 2003 Act and the CJ Act 2003.

6. Part 1 of the Bill amends various aspects of the 2003 Act including the provisions of that Act concerning compulsory treatment of patients, emergency and short-term detention, suspension of detention, removal of patients and levels of security. Part 1 also makes provision in relation to the cross-border transfer of patients within the mental health system and for absconding patients. The principal changes in that regard are to the powers of the Scottish Ministers to make regulations in respect of transferring patients.

7. Part 1 of the Bill also makes a number of amendments to the 2003 Act to enable references to a hospital to be read as references to a particular unit within a hospital (similar changes are made to the 1995 Act by Part 2 of the Bill). These changes are designed to reflect experience in practice whereby it may be appropriate to transfer a patient to a different part of the hospital in which he or she is already being treated, as opposed to transferring the patient to another hospital altogether.

8. Part 2 of the Bill makes amendments to the 1995 Act. The majority of these amendments are technical in nature and are designed to give greater clarity of meaning to, and to improve the operational efficiency of, the mental health provisions in that Act. Many of the changes made by Part 2 amend provisions in the 1995 Act concerning the timescales for assessment and treatment orders for mentally disordered offenders. The amendments are intended to align the provisions on timescales with the practice of the criminal courts more generally.

9. Part 3 of the Bill creates a notification scheme for the victims of mentally disordered offenders. The CJ Act 2003 as amended by the Victims and Witnesses (Scotland) Act 2014 already provides a notification scheme for victims of offenders who do not have a mental disorder. The scheme allows victims to receive specific information from the Scottish Ministers about the offender, such as information about the offender’s release from prison, unless there are exceptional reasons why the disclosure of such information would be inappropriate.

10. The Bill extends the notification scheme to victims of mentally disordered offenders. It creates new categories of information that may be disclosed in respect of offenders subject to detention in hospital by virtue of a hospital direction or a transfer for treatment direction. In particular, it entitles the victims of mentally disordered offenders to be informed when a certificate suspending the offender’s detention without supervision has been granted; of the fact that such a certificate has been revoked; and when an offender is unlawfully at large.
11. The Committee considered each of the delegated powers in the Bill. At its first consideration of the Bill, the Committee determined that it did not need to draw the attention of the Parliament to the following delegated powers:

- Section 19(2) – Consent to being a named person
- Section 24 – Cross-border transfer of patients
- Section 25(3) – Dealing with absconding patients
- Section 25(4) – Dealing with absconding patients
- Section 50 – Commencement

12. At its meeting of 5 August, the Committee agreed to write to the Scottish Government to raise questions on the remaining delegated powers in the Bill. This correspondence is reproduced at the Annex.

13. In light of the written responses received, the Committee agreed that it was content with the following delegated powers and did not need to comment on them further:

- Section 12(3) – Qualifying non-state hospitals and units
- Section 12(3) – Power to make further provision about the operation of sections 268-271
- Section 43(3)(b) – Right to information: offender imprisoned
- Section 48 – Power to make modifications

Recommendations

14. The Committee’s comments, and where appropriate, recommendations on the remaining delegated powers in the Bill are detailed below.

Section 45(2) – Right to make representations

Power conferred on: the Scottish Ministers
Power exercisable by: guidance
Parliamentary procedure: none

Provision

15. Section 45(2) of the Bill inserts new sections 17B-D into the CJ Act 2003. The new section 17B affords a person who is to be given information by virtue of the new victim notification scheme a right to make representations before certain decisions are taken in respect of the offender. Those representations must be about how the decision in question might affect the victim or the victim’s family.
16. The new section 17C(2) of the CJ Act 2003 obliges the Scottish Ministers to issue guidance as to how written representations made under the new section 17B are to be framed and how oral representations are to be made.

17. The Committee considered at its meeting on 5 August that the power to issue guidance under the new section 17C(2) of the CJ Act 2003 was acceptable in principle. The Committee was also content that the guidance was not to be subject to any parliamentary procedure. The Committee agreed, however, to ask the Scottish Government whether it considered it necessary to include a requirement on the face of the Bill that the guidance issued in exercise of this power be published.

18. In response to the Committee’s question, the Scottish Government explained that guidance issued under the new section 17C of the CJ Act 2003 will be published. The Scottish Government does not consider it necessary, however, to include a requirement that the guidance be published on the face of the Bill. In that regard, the Government draws a parallel between this provision and the existing provision in section 17(4) of the CJ Act 2003. Section 17(4) provides that the Scottish Ministers are to issue guidance as to the manner in which representations made under section 17(1) (release on licence) are to be framed. There is no requirement on the face of section 17 that such guidance be published.

19. The Committee notes the Scottish Government’s response to its written question and absence of a requirement to publish guidance issued under the parallel power that exists at section 17(4) of the CJ Act 2003. The Committee considers, however, that the absence of a requirement to publish the guidance issued under section 17(4) is not in and of itself a reason not to include such a requirement in respect of the new section 17C(2) of that Act as inserted by section 45(2) of the Bill.

20. The Committee considers that, as a matter of general principle, where guidance is to be issued, it should be published, and a requirement to publish the guidance should be included on the face of the legislation conferring the power. The guidance to be issued under the new section 17C of the CJ Act 2003 will be used by members of the public in order to assist them in framing representations that they wish to make in respect of decisions that may affect them. The Committee considers it to be important that such guidance is made publicly available in order that it can serve that purpose and that, as such, there should be a requirement on the face of the Bill that the guidance be published.

21. The Committee draws the power in section 45(2) of the Bill to the attention of the Parliament. The Committee recommends that section 45(2) be amended at Stage 2 so as to include a requirement that guidance issued under the new section 17C(2) of the Criminal Justice (Scotland) Act 2003 be published.
ANNEX

Correspondence with the Scottish Government—

On 5 August 2014, the Delegated Powers and Law Reform Committee wrote to the Scottish Government as follows:

Section 12(3) – Qualifying non-state hospitals and units

Power conferred on: the Scottish Ministers
Power exercisable by: regulations
Parliamentary procedure: affirmative procedure

1. Section 268 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) provides a right of appeal against detention in conditions of excessive security to patients held in hospitals other than a state hospital. Such a right is available to “qualifying patients” in a “qualifying hospital”, however the meaning of each of those terms is left to be defined in regulations made by Scottish Ministers under sections 268(11) and (12).

2. Section 11 of the Bill makes a number of amendments to section 268 of the 2003 Act. Together with section 12, the Bill reformulates the right of appeal against detention in conditions of excessive security for patients other than those held in a state hospital. The 2003 Act continues to provide that the right of appeal is available to patients in a “qualifying hospital”, but section 12(3) of the Bill inserts a new section 272A into the 2003 Act which provides that a “qualifying hospital” is a hospital other than a state hospital which falls within such further meaning (if any) as is given to that expression by regulations. The right of appeal therefore appears to be conferred upon patients in all hospitals other than a state hospital, with the possibility that regulations could be made which restrict that right by further defining the expression “qualifying hospital”.

3. The Committee asks the Scottish Government:

- To clarify the intended use of this power. In particular, the Committee asks the Scottish Government to explain whether it is intended that, in the event that regulations giving further meaning to the expression “qualifying hospital” are not made by the Scottish Ministers, the effect of the new section 272A(1) is that the right of appeal will be available to patients detained in all hospitals other than a state hospital?

- Why, if the Scottish Government agrees with that interpretation of the power, it is considered appropriate as a matter of principle to qualify the application of the right of appeal provided for in the new section 272A(1) of the 2003 Act in subordinate legislation, as opposed to specifying on the face of the Bill those patients to whom the right will (and will not) apply?

4. Section 272A(3) provides that regulations may make further provision as to the operation of sections 268 to 271 of the 2003 Act in particular circumstances.
5. The Committee asks the Scottish Government:

- Whether it can provide examples of the “particular circumstances” in respect of which regulations made in exercise of the power in the new section 272A(3) of the 2003 Act (as inserted by section 12(3) of the Bill) may apply?

Section 43(3)(b) – Right to information: offender imprisoned

- Power conferred on: the Scottish Ministers
- Power exercisable by: order
- Parliamentary procedure: affirmative procedure

Section 48 – Power to make modifications

- Power conferred on: the Scottish Ministers
- Power exercisable by: order
- Parliamentary procedure: affirmative procedure

6. Section 43(3)(b) of the Bill amends section 16 of the Criminal Justice (Scotland) Act 2003. Section 48(2) of the Bill inserts a new section 18B into that Act. Section 16 as amended and the power in the new section 18B(1)(c) both permit the modification of the new section 18A of the Criminal Justice (Scotland) Act 2003 (as inserted by section 47(2) of the Bill).

7. The Committee asks the Scottish Government:

- Why it is considered necessary to take two separate powers to modify section 18A of the Criminal Justice (Scotland) Act 2003: the power in section 43(3)(b) and the power in the new section 18B(1)(c) as inserted by section 48(2) of the Bill?
- Whether the Scottish Government considers that it would be clearer to consolidate these two provisions into a single provision?

Section 45(2) – Right to make representations

- Power conferred on: the Scottish Ministers
- Power exercisable by: guidance
- Parliamentary procedure: none

8. The new section 17B of the Criminal Justice (Scotland) Act 2003 (as inserted by Section 45 of the Bill) affords a victim who is to be given information by virtue of the victim notification scheme a right to make representations before certain decisions are taken in respect of the offender.

9. The new section 17C(2) of the Criminal Justice (Scotland) Act 2003 obliges Scottish Ministers to issue guidance as to how written and oral representations which are made by victims or their families under the new section 17B are to be made. The guidance will be published on the websites of both the Scottish Government and the Scottish Courts and Tribunals Service. However, there is no
requirement for publication of the guidance that is issued on the face of the Bill, but simply a statement to that effect in the Delegated Powers Memorandum.

10. The Committee asks the Scottish Government whether it considers it necessary to include a requirement that the guidance issued in exercise of this power is published on the face of the Bill?

On 19 August 2014, the Scottish Government responded as follows:

Section 12(3) – Qualifying non-state hospitals and units
Power conferred on: the Scottish Ministers
Power exercisable by: regulations
Parliamentary procedure: affirmative procedure

Committee question:

To clarify the intended use of this power. In particular, the Committee asks the Scottish Government to explain whether it is intended that, in the event that regulations giving further meaning to the expression “qualifying hospital” are not made by the Scottish Ministers, the effect of the new section 272A(1) is that the right of appeal will be available to patients detained in all hospitals other than a state hospital?

Why, if the Scottish Government agrees with that interpretation of the power, it is considered appropriate as a matter of principle to qualify the application of the right of appeal provided for in the new section 272A(1) of the 2003 Act in subordinate legislation, as opposed to specifying on the face of the Bill those patients to whom the right will (and will not) apply?

Scottish Government response:

The Scottish Ministers policy is to make provision for those patients held within a medium secure setting. The power in section 12 (3) is intended to enable regulations to be made by Scottish Ministers which will cover a wide variety of situations and conditions that do not fit easily within a definition referring to a particular level of security. This reflects the position that what constitutes medium security within a particular hospital is not consistent in all locations across the mental health estate in Scotland. The conditions of security in which a patient is held may also alter to reflect the needs of individual patients.

The Scottish Ministers intention is that the regulations will define qualifying hospitals by name (there are currently three units which offer “medium secure” settings). In addition the regulations will define a set of restrictions to which a patient within such a unit may be subject.

In the absence of such regulations it is correct that the section would operate to give a right of appeal to all patients who are not detained within the state hospital, although the Scottish Government is planning to make regulations using this new power, and a draft of these will be made available in early course. It is intended that the right of appeal will be afforded to patients within the medium secure units of “qualifying hospitals” which will be defined in regulations. As discussed in
paragraphs 62 and 63 of the policy memorandum the policy is not intended to extend to patients detained in “low secure” units.

It was thought appropriate to take this power, instead of specifying on the face of the bill those patients to whom the right to appeal will and will not apply because the description of what constitutes a medium level of security within the mental health estate will vary amongst establishments and parts of establishments and determining what constitutes an appropriate level of security is complex and better set out in regulations. In addition taking a power will allow the legislation to adapt as the provision within the hospital estate changes in future.

Paragraph 66 of the policy memorandum also sets out an alternative approach which was considered but rejected on the basis that it would cause delay. The approach taken in the bill allows the creation of an effective appeal within a shorter timescale.

Committee question:

Whether it can provide examples of the “particular circumstances” in respect of which regulations made in exercise of the power in the new section 272A(3) of the 2003 Act (as inserted by section 12(3) of the Bill) may apply?

Scottish Government response:

It is intended that subsections (11) – (14) of section 268 will be repealed by the bill (see section 11(2)(f) of the bill. Inserted section 272A replaces those provisions of section 268 which it was thought note fit for purpose in the context of the mental health estate within Scotland.

This is a complex area and the Scottish Government intend to undertake further discussion with stakeholders to help inform secondary legislation in this area. The consultation on the excessive security provisions undertaken last year made it clear that there is currently no consensus on the way forward, but it was clear that the existing provisions were deemed not to be fit for purpose (see policy memorandum paragraph 65).

Section 272A(3) is designed to ensure that there are no gaps left in the new provisions made under section 272A (2) and (4) and is necessarily wide since it purpose is to ensure that the existing provisions of the Act can be made to work in the wide variety of circumstances within the medium secure estate.

In particular the power is necessary to ensure that any circumstances or arrangements which are not in current contemplation can be provided for as appropriate. It is anticipated that such issues will emerge in greater detail during the development of the draft regulations mentioned above.
Power conferred on: the Scottish Ministers  
Power exercisable by: order  
Parliamentary procedure: affirmative procedure

Section 48 – Power to make modifications

Power conferred on: the Scottish Ministers  
Power exercisable by: order  
Parliamentary procedure: affirmative procedure

Committee question:

Why it is considered necessary to take two separate powers to modify section 18A of the Criminal Justice (Scotland) Act 2003: the power in section 43(3)(b) and the power in the new section 18B(1)(c) as inserted by section 48(2) of the Bill?

Whether the Scottish Government considers that it would be clearer to consolidate these two provisions into a single provision?

Scottish Government response:

Legislative propositions can always be expressed in a variety of ways. The Scottish Government takes the view that the drafting approach taken by the bill is the clearest way to present the powers being conferred.

The power to modify section 18A to add or remove definitions is an adjunct to the powers to amend sections 16, 16A, 16C and 17B of the Criminal Justice Act.

Section 18A will be amended either because a clause has been added to one of those sections which uses a word or expression that needs to be defined, or because one of those sections has been amended so that it no longer uses a term defined in section 18A thereby rendering the definition redundant.

The Government takes the view that it would be artificial to present the power to amend section 18A as a single freestanding power in its own section. It would, moreover, mean that anyone amending section 16, 16A, 16C or 17B would have to know to look at two sections (i.e. the section conferring the power to make the principal amendment and the section conferring the power to amend section 18A) rather than one.

Section 45(2) – Right to make representations

Power conferred on: the Scottish Ministers  
Power exercisable by: guidance  
Parliamentary procedure: none

Committee question:

To ask the Scottish Government whether it considers it necessary to include a requirement that the guidance issued in exercise of this power is published on the face of the Bill?
Scottish Government response:

The Government does not consider it necessary to impose a statutory requirement to publish guidance issued in exercise of proposed section 17C(2) of the Criminal Justice Act. The policy aim of issuing guidance would be to encourage people to make their representations in the manner suggested in the guidance and the Scottish Government therefore intends to publish the guidance to enable this to happen.

There is direct parallel in this case with section 17(4) of the Criminal Justice (Scotland) Act 2003, which requires the Government to issue guidance about the way that victims should make representations to the Parole Board. That provision was recently amended by the Parliament through the Victims and Witnesses (Scotland) Act 2014. There is no statutory requirement for guidance issued under section 17(4) to be published. The provision which the Scottish Government has taken in this bill makes is therefore symmetrical with the equivalent provisions in the victims and witnesses provisions.
Mr Nigel Don  
Convener  
Delegated Powers and Law Reform Committee  
Scottish Parliament  

By email: DPLR.Committee@scottish.parliament.uk  

DELEGATED POWERS AND LAW REFORM COMMITTEE 61RST REPORT  
MENTAL HEALTH (SCOTLAND) BILL  

The Scottish Government welcomes the Delegated Powers and Law Reform Committee’s Report on the Delegated Powers Memorandum that accompanies the Mental Health (Scotland) Bill (“the Bill”). The Government would like to thank the Committee’s members for their thorough scrutiny of the delegated powers contained within the Bill. 

The Government offers the following response to the recommendation made in the Committee’s report (which relates to a power to issue guidance in section 45(2) of the Bill). 

The Committee’s report states the following at paragraph 20:- 

“The Committee considers that, as a matter of general principle, where guidance is to be issued, it should be published, and a requirement to publish the guidance should be included on the face of the legislation conferring the power.” 

At paragraph 21 of its report the Committee continues:- 

“The Committee draws the power in section 45(2) (that is the guidance making power) of the Bill to the attention of the Parliament. The Committee recommends that section 45(2) be amended at Stage 2 so as to include a requirement that guidance issued under the new section 17C(2) of the Criminal Justice (Scotland) Act 2003 be published.”
The Government notes the comments made by the Committee, but the Government’s position remains as set out in the letter the Government sent to the Committee on 19 August. Namely, the Government does not consider it necessary to impose a statutory requirement to publish guidance issued in exercise of proposed section 17C(2) of the Criminal Justice Act.

The Government does not agree with the Committee’s view that “as a matter of general principle” a requirement to publish guidance should always be included on the face of legislation. The Government considers that legislation should always be drafted in a way that takes account of context.

The context, in this case, is that the Government is being empowered to produce guidance about the making of representations under the victim representations’ scheme which is to be established by the Bill. The guidance will only achieve its purpose of helping victims to put their representations into proper form if it is published, in the sense of being made available to victims who wish to make representations. So naturally having made guidance for that purpose, the Government will make it available to victims.

The Government’s letter to the Committee of 19 August made the point that a directly parallel guidance-making power already contained in section 17(4) of the Criminal Justice Act is not accompanied by a statutory duty to publish the guidance made under it. The Committee remarks at paragraph 19 of its report that the absence of a publication duty in relation to section 17(4) is not, of itself, a reason not to include such a duty in relation to new section 17C(2). The Government agrees. It is perhaps worth clarifying that the point being made in the letter of 19 August is that in relation to section 17(4) it was not thought problematic that there was no duty to publish the guidance, because it was appreciated that the policy goal behind making the guidance could only be served if any guidance made was appropriately publicised.

I hope the Committee finds this information helpful.

Yours sincerely

Carol Sibbald
Dear Carol

Thank you for your letter of 9 December 2014, responding to the Delegated Powers and Law Reform Committee’s report on the Mental Health (Scotland) Bill at stage 1. The Committee considered the response at its meeting of 16 December and agreed to write to the Scottish Government to seek clarification on a certain matter.

The Committee’s report recommended that section 45(2) of the Bill be amended at Stage 2 so as to include a requirement that guidance issued under the new section 17C(2) of the Criminal Justice (Scotland) Act 2003 be published.

In its response to the report, the Government explained that whilst it intends to publish any guidance issued under section 17C(2), it does not consider that there should be a statutory requirement for such guidance to be published.

The response goes on to clarify that the guidance will only achieve its intended purpose if it is made available to victims who wish to make representation under the new victim representations scheme to be established by the Bill.

However, the Committee would welcome further clarification as to why the Government does not consider it appropriate for there to be a requirement for guidance issued under section 17C(2) to be published.

For information, I include a link to the Official Report of the Committee’s meeting of 16 December at which this matter was discussed. The relevant discussion can be found at columns 25-27.

I would be grateful of a response by 3 February.
Liz Anderson
Assistant Clerk to the Delegated Powers and Law Reform Committee
Mental Health (Scotland) Bill

10:40

The Convener: Agenda item 7 is consideration of the Scottish Government’s response to the committee’s stage 1 report on the Mental Health (Scotland) Bill. Members will have seen the briefing paper and the response from the Scottish Government. Are there any comments?

Stewart Stevenson: I am still not very comfortable with the Government’s response. Although it has restated its intention to publish guidance made under new section 17C(2) of the Criminal Justice (Scotland) Act 2003, which section 45 of the bill seeks to insert, it still contends that there is no requirement for the guidance to be published. That is fine as far as it goes, except that it goes on to say that the guidance will achieve its intended purpose only if it is made available to victims who wish to make representations under the new victim representations scheme. It seems rather strange that the Government asserts that the guidance will achieve its objective only if it is made available to people while simultaneously asserting that it does not wish to make it a legal requirement for the guidance to be published. I find myself unable to reconcile those two points.

The Convener: As I understand it, I think that is probably acceptable. It is a principle of law that we do not write down anything that we do not need to write down. As a car cannot operate if it does not have an engine, we do not need to say that it has to have an engine; in the same way, if something cannot operate unless it is published, it does not need to be said in law that it must be published. I wonder whether our legal advisers would care to comment on that. Was that a fair interpretation of the principle?

John Scott: I absolutely—and perhaps unusually—agree with Stewart Stevenson. Earlier this morning, we heard a Government minister make the case for introducing framework legislation, as I think it was wonderfully called, when there is apparently no reason for introducing it at all. The fact that there are different sets of standards operating within Government in itself poses questions.

As I have said, I agree entirely with Stewart Stevenson, and we as a committee should adhere to our position, which is that the guidance should be published. If any committee in Parliament is about openness and transparency, it has to be this one. Let us stick with our position.

The Convener: I merely reflect that the Government says that it is going to publish the guidance, simply because it must.

John Mason: Perhaps I am not understanding this, but just for clarification, is the Government drawing a distinction between, on the one hand, publishing the guidance and, on the other, making it available to victims? Are those two separate things?

The Convener: Yes. Let us be clear: the Government is not suggesting that the guidance will not be available. It will operate only if it is available.

John Mason: But it is suggesting that the guidance can be available without being published.

The Convener: The Government is arguing that there is no need to say that it must be published, because it has no existence if it is not published. It cannot operate if it is not published, in exactly the way in which cars cannot operate if they do not have an engine; in the same way, if guidance cannot operate unless it is published, it is no good it being written to the effect that it must be published.
same way that a car without a motor is not a car, but a go-kart.

**Margaret McCulloch:** Again, I apologise if this is a stupid question, convener, but if the guidance is not published, how do victims know that it is there for them to access?

**The Convener:** That is precisely the point. As I understand it—and I am arguing its corner here—the Government is saying that as a matter of policy the guidance will have to be made available and therefore will have to be published. As a result, there is no need to say that it must be published, because, actually, it must be published.

**Margaret McCulloch:** On the back of that, then, why is there a problem for the Government in not wanting to publish it?

**The Convener:** I would argue that that comes back to the legal principle that we do not write something that is redundant, in exactly the same way as we do not write something twice. We do not want something twice in statute; after all, we complain if a provision can be found in two different places. As a matter of drafting practice—as I understand it; I am speaking now as a non-lawyer, never mind as a drafter—we would not write it down if it was a logical imperative. We would simply not write it down, because it is a logical imperative.

**Stewart Stevenson:** Convener, you have offered to write the Government in light of this discussion. I think that your offer is a helpful one.

**The Convener:** If the committee will allow me to do that, I will do so. The point has been very well made and will be extensively reviewed in the *Official Report*.

Let me come back to wherever on earth I had got to. The question was, “Do members have any comments?” and the answer is, “Yes, quite a few.” On the question whether we want to note the response, I think that the answer is yes, and we are agreed that I will write to the Government to seek clarification on that point. Are we content with everything else?

**Members indicated agreement.**
Dear Liz

On January 5, the Committee wrote to the Government probing whether there ought to be an express statutory requirement to publish guidance issued under what will become section 17C of the Criminal Justice (Scotland) Act 2003 (that section will be inserted into the 2003 Act by section 45 of the Mental Health Bill that is presently before the Parliament if it is passed in its present form).

The Government has read the report of the Committee’s discussion of the matter on December 16 last year. What the Convener said on that occasion reflects the Government’s position perfectly. In short, well-drafted legislation should say neither more nor less than it needs to. Having stated that the Scottish Ministers are to issue guidance to help victims frame their representations under the proposed victim-representation scheme, it would be saying more than is necessary to go on to say that any guidance issued should also be published.

Saying more than is necessary in legislation can lead to unintended consequences, because quite properly the courts will seek to give legal effect to every word that Parliament has chosen to enact. Section 17C(2) already states that guidance must be “issued”, of the definitions given for that word in the Oxford English Dictionary the one most apposite in the immediate context is: “[t]o give or send out authoritatively or officially; to send forth or deal out in a formal or public manner; to publish; to emit …” Imposing a duty to “publish” in addition to the duty to “issue” guidance, would put the Government under a legal obligation to do more than what issuing entails. It is not clear from the record of the Committee’s discussion what more those members of the Committee who favour including a requirement to “publish” section 17C(2) guidance want the Government to be legally obliged to do.

It might be suggested that if the words “issue” and “publish” can be regarded as synonyms, or near-synonyms, a compromise position might be to reframe section 17C(2) as a requirement to publish rather than issue guidance. The difficulty with that approach, however, is that the existing section 17(4) of the 2003 Act requires the Scottish Ministers to “issue” guidance. Section 17(4) is directly cognate to section 17C(2) — the former relates to...
the representation scheme for the victims of imprisoned offenders, while the latter (if enacted) will relate to the representation scheme for the victims of offenders who are in a hospital due to mental disorder. The usual rule of statutory interpretation is that by using different words in two or more sections which operate in a similar context, Parliament is signalling that the legal effect of each section should be different. It is not obvious from the record of the Committee’s discussion whether those members who favour expressly requiring section 17C(2) guidance to be published intend that section 17C(2) guidance should be disseminated differently from guidance under the existing section 17(4). That is certainly not the Government’s policy intention, and wording the two sections differently would therefore not best reflect the Government’s policy intention.

Having warned against saying more than is necessary, it may nevertheless be helpful to add a few final lines to allay a concern that seemed to underlie at least some of the Committee’s discussion: namely that unless the Government publishes guidance under section 17C(2), the victim-representation scheme which the Mental Health Bill aims to establish will be fundamentally undermined. There is no cause for concern on that account. The sections which the Mental Health Bill (if passed) will insert into the 2003 Act to establish the victim-representation scheme, do not say that victims can only make representations in accordance with guidance issued by the Scottish Ministers. This is quite deliberate. The purpose of issuing guidance is purely to provide victims with some assistance in articulating their position. The operation of the victim-representation scheme is not contingent on guidance being issued. If guidance were not produced for some reason, victims would miss out on whatever assistance they might have gleaned from it (and Ministers would be in breach of their clear statutory duty to issue guidance), but the Ministers’ failure would in no way stop victims from making representations under the scheme.

I hope that the information provided has addressed the Committee’s concerns but please contact us if we can be of any further help.

Nicola Paterson
Protection of Rights Unit
Mental Health (Scotland) Bill: Financial Memorandum

Dear Duncan,

The deadline for the Finance Committee’s call for evidence on the Mental Health (Scotland) Bill’s Financial Memorandum passed recently and a total of 14 responses were received. These are available on the Committee’s web page via the following link: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/79985.aspx.

A number of respondents drew attention to the potential impact of the Bill on Mental Health Officers and the related financial implications for local authorities.

These concerns were summarised in supplementary written evidence submitted by COSLA which suggested that there were discrepancies between the Explanatory Notes and Financial Memorandum—

“Specifically, the Bill explanatory notes (page 5, paragraph 13) which deal with section 2 of the Bill regarding hearings relating to compulsory treatment orders, suggest that an MHO report will be required in any of three different circumstances – where there is a change of diagnosis, where the MHO disagrees with the determination, or when the tribunal has not [received] the compulsory treatment order within a certain timeframe. However the financial memorandum (page 34, paragraph 32) suggests a report will only be required in one of those circumstances – where the MHO disagrees with the determination. It estimates this to occur in about 20 cases per year, and goes on to give estimates of costs based on that incorrect narrower scope.
The same discrepancy exists in respect of section 41 of the Bill, which would introduce a requirement for an MHO report in relation to compulsion or compulsion and restriction order hearings. The FM estimates these to be ‘less than 20’ per annum. Again, the financial memorandum estimates are based on a narrower set of duties than described within the Bill.”

Aberdeen City Council made the same point, stating—

“The Bill does have financial implications for our organisation which have not been accurately reflected in the Financial Memorandum. Reports under S87A and S153A – the FM refers only to S101 (2) (a) and S165 (2) (a) whereas it is clear from the Bill that S101 (2) (b) and S165 (2) (b) are also included. This has a significant impact on the estimated number of reports which will be required – instead of 20 it will be more like 600 across Scotland in any given year.”

COSLA’s supplementary submission suggested that the total number of hearings requiring a report could be in the region of 593 as opposed to between 20 and 40 as stated in the FM. As the FM estimates a cost of £475 per report this suggests an overall annual cost to local authorities of over £281,000 instead of the £18,000 noted in the FM.

However, COSLA also suggested that the estimated cost of £475 per report does not take full consideration of the potential for additional costs including those relating to travel, the differential complexity of cases and year-on-year fluctuations.

COSLA and a number of other respondents also sought clarity as to who would be expected to bear the costs of a MHO having to visit a prisoner as a result of the Bill (i.e. would the costs fall on the prisoner’s “home” local authority area or that in which the prison was located?).

In conclusion, COSLA stated that it has “significant concerns” about the increased workload for MHOs and the apparent discrepancies between the accompanying documents regarding the scope of new MHO duties. COSLA therefore recommended that “the resulting financial burdens on local authorities must be properly understood and funded in full by the Scottish Government.”

Your committee may wish to consider the above information along with the attached submissions in its evidence session with the Minster in charge of the Bill.

Yours sincerely

Kenneth Gibson MSP
Convener
WRITTEN EVIDENCE TO THE FINANCE COMMITTEE

Aberdeen City Council
City of Edinburgh Council
Comhairle Nan Eilean Siar
COSLA
COSLA supplementary submission
East Ayrshire Council
Fife Council
Law Society of Scotland
NHS Orkney
NHS Western Isles
Orkney Island Council
Shetland Island Council
South Ayrshire Council
South Lanarkshire Council
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM ABERDEEN CITY COUNCIL

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Aberdeen City Council’s Social Care and Wellbeing service did return a response to the consultation on the Draft Bill in February/March 2014. We commented that the proposed amendments would increase the workload of an already stretched MHO service. The additional duties being around the proposed provisions in relation to Named Persons, reports in relation to extensions, prisoners on Assessment Orders being moved to other hospitals and the travelling time involved for MHOs. Costs of training in the new provisions was also highlighted along with the need for updated local information leaflets for service providers and so on.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. The Bill as it has been introduced differs from the Draft we commented on and it now places fewer duties on MHOs. Even taking this in to account however the Financial Memorandum seriously underestimates the numbers of reports that will be required under S87A and S153A. The Financial Memorandum indeed contains inaccurate and misleading information about the legislation – both the 2003 Act and the Bill.

Did you have sufficient time to contribute to the consultation exercise?
3. If this refers to the consultation on the Draft Bill then yes, sufficient time was given. In relation to the Financial Memorandum and the Bill as introduced then no, there been very little time available. The consultation and the response to the Financial Memorandum has produced a fair degree of confusion.

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. The Bill does have financial implications for our organisation which have not been accurately reflected in the Financial Memorandum. Reports under S87A and S153A – the FM refers only to S101 (2) (a) and S165 (2) (a) whereas it is clear from the Bill that S101 (2) (b) and S165 (2) (b) are also included. This has a significant impact on the estimated number of reports which will be required – instead of 20 it will be more like 600 across Scotland in any given year.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. The estimated costs on local authorities are not accurate and are significantly underestimated.
If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?

6. The Bill will require a significant increase in the numbers of statutory reports from MHOs both as a result of S87A and S153A. Given that the current numbers of MHOs are currently failing to meet their statutory duties in relation to Social Circumstances Reports it is reasonable to surmise that an increase in the number of MHOs will be required. The training, recruitment and retention of MHOs within local authorities also requires to be reviewed. The costs of the above should be met by the Scottish Government as implementers of the legislation.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?

7. No comment.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?

8. I think it is reasonable to expect that there will be increased costs associated with the need for MHOs to give consent to Transfer for Treatment Orders. The proposals relating to application to the Tribunal for extension of Suspension from 200 to 300 days will result in the Tribunal calling for MHO reports to accompany such applications. The Tribunal will require to have relevant information to hand as to the reasons for such extensions as opposed to variations. Requiring MHOs to send their report to the MHTS, the patient, their Named Person, RMO and the MWC potentially could incur costs particularly where short notice of intention to extend is given by the RMO. Special delivery or even courier costs may be necessary.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

9. As above, it is not possible to quantify these costs at present.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM CITY OF EDINBURGH COUNCIL

Consultation

Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?

1. Yes. The City of Edinburgh broadly welcomed the amendments. We considered that the additional proposed duties and responsibilities placed on Mental Health Officers (MHO) reflected good practice, addressed some of the shortfalls in current legislation and strengthened safeguarding functions.

While we highlighted that there would be financial implications we did not detail actual costs.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?

2. The FM infers that the Scottish Government considers that the proposed legislative changes will result only in minimal costs for local authorities. The FM prepared for the Bill appears to be inaccurate when detailing the costs to local authorities.

The paper does not appear to take into account costs associated with amendments in Part 1 of the Bill. The FM appears to duplicate the cost implications only for the additional responsibility of providing MHO reports in respect of COs; and within that costing does not take into account all circumstances which would necessitate the preparation of a report (see paras 32 and 47 of the FM).

The city of Edinburgh Council considers that there will be substantial financial implications for the MHO workforce. Edinburgh would not be in a position to meet the statutory requirements of MHOs as set out in the Bill without an increase in the current capacity of the MHO Service.

Did you have sufficient time to contribute to the consultation exercise?

3. Yes - satisfactory.

Costs

If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.

4. As for 2 above the estimated costs do not appear to take into account the full cost to local authorities.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?

5. FM appears to predict that there will be no significant costs to other services as many of the changes associated with the Bill will be offset by other small scale efficiencies and different practices being adopted. However, it's not evident that changes will offset other costs.
The amendment relating to a transfer for treatment direction whereby a direction may be made only if a MHO has agreed to the making of it will increase pressure on MHO services. If the position is taken that the MHO service in the area where the prison is situated respond to assessment requests then areas affected will see increased demands on local authority MHO services. Edinburgh would be one area affected. It is considered that it would be impractical for local authorities to respond to requests for home authorities to carry out the assessments within reasonable timescales.

*If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?*

6. There would be significant financial implications for the MHO service in Edinburgh if the additional statutory duties were to be met and best practice upheld. It is anticipated that the additional duties could not be met by the current MHO workforce. Additional funding would be necessary to implement the amendments. It is not foreseen that efficiencies in other areas of the service would offset additional costs associated with increase in workloads.

**Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?**

7. The reference to suggested costs to local authorities do not appear to accurately reflect the additional work the amendments will necessitate, particularly in respect of section 87 reports by MHOs.

**Wider Issues**

*Do you believe that the FM reasonably captures any costs associated with the Bill? If no, which other costs might be incurred and by whom?*

8. No. Not only are the costs to the MHO service not accurately reflected, there will be administrative costs associated with the additional responsibilities that are not accounted for.

**Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?**

9. Under section 22 of the Bill there is likely to be increased pressure on translation and interpreting services; extending duties around the provision of accommodation and services for mothers would also have to be reviewed and may necessitate an increase in resource.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM COMHAIRLE NAN EILEAN SIAR

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. No

If applicable, do you believe that your comments on the financial assumptions have been accurately reflected in the FM?
2. Not applicable

Did you have sufficient time to contribute to the consultation exercise?
3. Not applicable

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. Yes

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. Yes

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. Yes, as the Bill is currently drafted

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would expect to arise?
7. Yes, as the Bill is currently drafted

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. Yes, as the Bill is currently drafted

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?
9. There may be but it is not possible to predict in the absence of more specific information.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM COSLA

Introduction
1. COSLA is the representative body for all 32 Councils in Scotland. Local authorities are responsible for securing social care and support (e.g. housing, day care services etc) in the community and providing mainstream services to support recovery for people with mental health problems. A key role is played by mental health officers (MHOs), who are social workers with additional training, employed by local authorities. The Bill introduces some additional statutory duties on local authority MHOs, and these extra duties are reflected in the FM.

2. COSLA welcomes the opportunity to provide written evidence to the Finance Committee on the Financial Memorandum produced for the Mental Health (Scotland) Bill (‘the Bill’). We are aware that Social Work Scotland (formerly the Association of Directors of Social Work (ADSW)), and some individual councils, responded to the consultation on the Bill to highlight some issues of technical or professional import, but expressing general support for the broad policy direction proposed overall. COSLA would generally concur with these positions and so have focused on issues of political or financial impact for our members.

3. Having considered the final draft Bill and supporting documents, including the Financial Memorandum (FM), we believe that the exact scope of new duties, and resulting financial implications, need to be clarified. Specifically, there is a discrepancy between scope of MHO duties set out in the Bill explanatory notes, versus in the financial memorandum. This has a resulting impact on work to estimate the costs to Councils that will arise from the Bill. Further detail is provided in the ‘Resource Implications’ section of our response below.

Policy context
4. Our initial perspective is that many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, and improving assessment options for individual councils and professional associations.

5. However, the introduction of new statutory duties on local authority MHOs to prepare reports for a tribunal hearing places another burden on an already overstretched and limited resource. There is a risk that proposals to require these reports, while welcome in policy terms, will result in an increased burden on local authorities.

6. The Bill proposals in relation to additional duties on Mental Health Officers (MHOs) are not clear, and as a result, nor are the financial implications. Specifically, the Bill explanatory notes (page 5, paragraph 13) suggest that an MHO report will be required in any of three different circumstances – where there is a change of diagnosis, where the MHO disagrees with the determination, or when the tribunal has not the compulsory treatment order within a certain timeframe. However the financial memorandum (page 34, paragraph 32) suggests a report will only be required in one of those circumstances – where the MHO disagrees with the determination.

7. These discrepancies require to be resolved before the financial implications of the Bill proposals can be properly considered. COSLA will undertake further work to attempt
to determine the potential impact of the different proposals on Councils’ finances; however, this will require additional work and COSLA is therefore seeking further time in the parliamentary process for this Bill to allow for this.

**Resource requirements**

8. Despite a degree of comfort with the policy proposals, the introduction of new statutory duties on local authority Mental Health Officers (MHOs) to prepare a report for a tribunal hearing places another burden on an already overstretched and limited resource. There is a risk that proposals to require these reports, while welcome in policy terms, will result in an increased burden on local authorities COSLA is of the view that this extra burden and financial cost for local authorities is not adequately reflected in the FM.

9. The FM published with the Bill estimates 20 such reports across the whole of Scotland, at a cost of £475 each, giving an additional cost of £9500 per annum (we would highlight that the FM erroneously gives the total cost as £9000). The estimated cost of £475 per report was verified by the then ADSW. However the number of such reports is challenged by Social Work Scotland: by drawing on figures from the Mental Welfare Commission for 2012/13, SWS estimates that this new duty will result in an additional 1789 reports per annum. Working out potential costs for all Councils from a top down approach, and using the unit cost for a report of £475, the 1789 reports would amount to an additional cost to local authorities of approximately £850k per annum.

10. In considering the Social Work Scotland estimates further, it has become apparent that the Bill documentation itself is not clear on the scope of the new duties that are proposed and estimates may need to be revisited. However, given the disparity between the scope of duties considered by the FM, and those described in the Bill explanatory notes, the FM clearly substantially underestimates the costs associated with this new statutory duty, along with the workload implications for MHOs.

11. Initial estimates based on a bottom up approach have produced figures from a limited return from 12 Councils, but shows that the majority of Councils are anticipating the need for extra MHO resource, averaging £45k per local authority; however, these estimates may change once the scope of the duties is clearer and we have a more comprehensive picture across Scotland. Even in the absence of clarification on the extent of the Bill, it is clear that the Financial Memorandum significantly underestimates the costs that will be incurred, along with the workload implications for MHOs.

12. Although many aspects of the Bill are to be welcomed, the introduction of new statutory duties on local authority MHOs places a significant burden on a workforce which is already reporting capacity problems. Therefore, a more comprehensive review of MHO services is necessary to ensure that local authorities are sufficiently resourced to enable them to fulfil their statutory functions.

**Summary**

13. Although many of the policy intentions contained in the Bill are broadly welcomed, there is concern about the burden these will place on an already overstretched and limited resource. COSLA is concerned that the scope of new duties on MHOs is unclear at this stage. However, that point notwithstanding, it is clear that the additional cost set out in the FM is an underestimation of the costs associated with the measures described in the Bill explanatory notes. COSLA will undertake further work to attempt to determine the potential impact of the different proposals on Councils’ finances; however, this will require additional work and Councils will need time to estimate the additional costs they will incur.
14. Given that the introduction of the new statutory duties on local authority MHOs places a significant burden on a workforce which is already reporting capacity problems, COSLA is requesting a more comprehensive review of MHO services. This is to ensure that local authorities are sufficiently resourced to enable them to fulfil their statutory functions.

15. COSLA hopes these comments will be useful in the Finance Committee’s deliberations on the Financial Memorandum for the Bill. If you require any further information or clarification please contact Andy Witty, Policy Manager, COSLA on 0131 474 9312 or andy.witty@cosla.gov.uk
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUPPLEMENTARY SUBMISSION FROM COSLA

Introduction
1. COSLA recently participated in a Health and Sport Committee oral evidence session, convened to support scrutiny of the Mental Health (Scotland) Bill 2014. At that session, COSLA raised a number of issues in relation to discrepancies within the Bill documentation and the resulting questions this raises over the accuracy of Financial Memorandum estimates of potential costs to councils. It was agreed COSLA would provide further written detail on potential costs to councils, and this is provided below along with some background information on COSLA’s policy position on the Bill.

Background – pre-existing pressures on the MHO workforce
2. Our initial perspective is that many of the proposed duties and responsibilities are welcome in the interests of good practice, strengthening and extending existing safeguarding functions, and improving assessment options for individual councils and professional associations. However, the introduction of new statutory duties on local authority mental health officers (MHOs) to prepare reports for a tribunal hearing places another burden on an already overstretched and limited resource. There is a risk that proposals to require these reports, while welcome in policy terms, will result in an increased burden on local authorities.

3. New duties need to be considered against the backdrop of historic pressure on MHO capacity arising from the Adults With Incapacity Act, which introduced a demand-led system over which local authorities have no control. Since the Act’s introduction, there has been a year on year increase in MHO workload arising from AWI duties. For example, guardianship applications have been increasing by 10-12% per annum since 2000, and there are questions over whether the funding originally provided was sufficient. This burgeoning demand is occurring within the context of reducing MHO capacity. The Scottish Social Services Council recently published a report which showed that the MHO workforce is shrinking. It reduced by 3.4% between 2012 and 2013, and is now the same size as in 2008 despite increasing demand. Moreover, the workforce is ageing; about three-quarters of MHOs are over 44 years old, and one in three MHOs is 55 or older, meaning many will be retiring and recruitment has not kept pace.

4. Furthermore, the Scottish Law Centre published a report earlier in October which recommends changes to AWI legislation, to ensure compliance with the ECHR, which would significantly increase burdens on MHOs. The report proposes new AWI legislation to ensure compliance with Article 5 of the ECHR on deprivation of liberty. This would require local authorities and health boards to implement formal schemes for the ‘authorisation of significant restriction of liberty’. Such schemes would require increased use of guardianship and so would place a significant additional burden on MHOs in the form of increased guardian applications and new MHO reports.

5. All of these points underpin COSLA’s support for the Mental Welfare Commission’s call for a national strategy on recruitment, training and retention. We are aware that the Scottish Government Chief Social Work Adviser is carrying out work that will consider the role of MHOs as part of wider work on developing future social work strategy. The Committee may wish to reflect on whether the scope of this work will provide sufficient information about current and future resourcing to support the development of a robust strategy going

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forwards. COSLA would assert that any national strategy on recruitment, training and retention must be based on a fundamental review of MHO workload and capacity; this should include consideration of the wider policy and legislative landscape, what this means for longer-term capacity requirements, and how those requirements will be resourced.

6. In the interim, there is a case for the position that there should be no new duties which place an additional burden on MHOs until this work has been carried out and sufficient resources are in place to support change going forwards. Should Parliament nonetheless decide to proceed with new duties, the resulting financial burdens on local authorities must be properly understood and funded in full by the Scottish Government.

Scope of the Bill
7. The Bill proposals in relation to additional duties on Mental Health Officers (MHOs) are not clear due to inconsistencies between the various documents published with the Bill, and as a result, nor are the financial implications. COSLA is seeking clarification from Scottish Government regarding this inconsistency, but irrespective of the response, the Financial Memorandum significantly underestimates the financial implications of the Bill as currently drafted.

8. Specifically, the Bill explanatory notes (page 5, paragraph 13) which deal with section 2 of the Bill regarding hearings relating to compulsory treatment orders, suggest that an MHO report will be required in any of three different circumstances – where there is a change of diagnosis, where the MHO disagrees with the determination, or when the tribunal has not the compulsory treatment order within a certain timeframe. However the financial memorandum (page 34, paragraph 32) suggests a report will only be required in one of those circumstances – where the MHO disagrees with the determination. It estimates this to occur in about 20 cases per year, and goes on to give estimates of costs based on that incorrect narrower scope.

9. The same discrepancy exists in respect of section 41 of the Bill, which would introduce a requirement for an MHO report in relation to compulsion or compulsion and restriction order hearings. The FM estimates these to be ‘less than 20’ per annum. Again, the financial memorandum estimates are based on a narrower set of duties than described within the Bill.

10. Both the Mental Welfare Commission (MWC) and the Mental Health Tribunal for Scotland (MHTS) have also highlighted these discrepancies in their responses to the Health and Sport Committee. The Mental Health Tribunal for Scotland clearly states, in paragraph 16 of its response, that reports will be “triggered more often than is anticipated by the FM, and so the costs involved will be greater than those estimated.”

Resource Implications
11. The financial memorandum uses a unit cost per report of £475, provided by Social Work Scotland, and an estimate of 20 reports per annum to arrive at cost to councils of £9000 – although this would actually give a figure of £9,500. The ‘less than 20’ reports it assumes for s41 are written off as absorbable. As noted by COSLA and others, including the MWC, these figures are based on an incorrect interpretation of the Bill duties.

12. COSLA’s submission to the Finance Committee indicated that the number of additional MHO reports could be as high as 1800, but that additional time was required to conduct further and these figures would need to be re-visited. COSLA has since obtained hearings

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4 Mental Health Tribunal for Scotland evidence submission, paragraph 16. [http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Mental_Health_Tribunal_for_Scotland.pdf)
data, for the financial year 2012/13, from MHTS and these show that the actual number of hearings where a report would be required under s. 2 of the Bill are 493. The provisions under s.41 would add a further 100.\footnote{Mental Health Tribunal for Scotland, case management database information request response, 30/09/2014} This gives a total of 593, not somewhere between 20 and 40 as the financial memorandum states. Assuming a unit cost of £475, this would give a total cost of £281,675.

13. However, even the figure of £281,675 may not be an accurate reflection of the full costs to councils for four main reasons:

i. **Travel costs**
   The unit cost of £475 does not allow for travel costs, which can be considerable in some cases – for example where an MHO is required to carry out visits to a person’s home, a hospital, or a prison, as part of gathering the information needed to be able to prepare a report. These costs will obviously vary a great deal across the country and are likely to be higher in rural areas. Estimates from our members ranged from £575 per report, to £675 (including travel).

ii. **Differential complexity of orders**
   The unit costs of compulsion and restriction orders can be significantly higher than the £475 estimate which the financial memorandum applies to reports across the board. Compulsion and restriction orders are more complex than other types of orders and consequentially can require more MHO time. Estimates from our members ranged from agreement with the £475 figure (excluding travel), to £847 per report.

iii. **Bill measures not considered by the financial memorandum**
   The financial memorandum does not include any estimated costs for new provisions introduced under sections 22 and 26 of the Bill. Section 22 extends the requirement for an appropriate person (often the MHO) to arrange assistance for people with communication difficulties, from not only those who are the subject of certain orders, but also to those who are subject to an application for these orders. Our members have indicated that the costs associated with this are difficult to estimate and further work will be required to estimate costs across Scotland.

   Section 26 introduces a new requirement for an MHO to agree before a transfer for treatment direction can be used (to remove someone from prison to hospital). This will normally require an MHO to visit the relevant prison, sometimes on more than one occasion. Given the distribution of prisons across Scotland, this is likely to require significant travel in many cases. Cost estimates from our members vary due to local circumstances, but the most commonly-reported figure was between £500 and £600. Estimates of the number of cases in each council where this is likely to apply ranged from two to ten, meaning the costs across Scotland could be significantly more than for the other measures which merited inclusion in the financial memorandum.

   Individual members also highlighted a range of other costs that could arise as a result of various measures within the Bill. There is no clear pattern in relation to these costs, with different councils highlighting different issues – for example in relation to removal orders and named person requirements, and including a need
for requirement for additional MHO posts with admin support. This suggests that costs are likely to impact differentially across councils, due to varying local circumstances, and that further work to scope these costs is required.

iv. **Year-on year fluctuations**

All of the additional costs outlined above, will be subject to year-on-year variations and these need to be taken in to account when estimating future costs. The financial memorandum considered a snap-shot of demand, during 2012/13. Looking at the most resource intensive measures – i.e. new duties on MHOs in relation to compulsion and retention orders, reveals a 120% increase from 2012/13 to 2013/14. Similarly, compulsion orders also increased by 30% over the same period. Compulsion and treatment orders have shown a more erratic pattern over recent years, suggesting future sharp increases cannot be ruled out. These fluctuations will have the effect of multiplying the additional costs described above, and there is a need to consider demand in a more robust manner by using a wider range of historical data to arrive at future demand projections.

**Conclusion**

14. In summary, although many of the policy intentions within the Bill are broadly welcomed, COSLA has significant concerns about the burden these will place on an already overstretched and limited resource. As previously noted, many of these concerns are shared by others, including the Mental Health Tribunal for Scotland and the Mental Welfare Commission. COSLA is also concerned that the scope of new duties on MHOs is unclear at this stage, with the financial memorandum and Bill explanatory notes disagreeing on the scope of duties. However, it is clear that the additional cost set out in the financial memorandum is an underestimation of the costs associated with the measures contained in the actual Bill.

15. Given that the introduction of new statutory duties on local authority MHO’s places a significant burden on a workforce which is already facing capacity problems, COSLA is requesting a fundamental review of MHO workload and capacity is carried out. Moreover, this review should include consideration of the wider policy and legislative landscape, what this means for longer-term capacity requirements, and how those requirements will be resourced. Should Parliament then decide to proceed with new duties, the resulting financial burdens on local authorities must be properly understood and funded in full by the Scottish Government.

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6 Mental Health Tribunal for Scotland, case management database information request response, 30/09/2014

MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM EAST AYRSHIRE COUNCIL

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Yes.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. The only other implication which may impact on MHO activity is the proposal for MHO’s to become more involved in activity under section 136 which is the transfer of prisoners for treatment for mental disorder.

This is where an adult held in custody is deemed to require treatment in hospital for mental illness. Again this is not an activity MHO’s would traditionally be involved in but the suggestion again is that this is a relevant event in terms of the legislation and should warrant an MHO report.

In practice this is not a common occurrence but the increase in capacity required to undertake this duty, while numbers within individual council areas may be small, the potential for travel out with area is high and consideration requires to be given to where this MHO provision should come from – either the council where the patient/prisoner currently resides or the originating area.

This could become complex due to the geography of prisons/hospitals. MHO’s from East Ayrshire may require travelling to Prisons at some distance or indeed respond, as MHO for prisoners held within their local authority area –i.e. HMP Kilmarnock.

Did you have sufficient time to contribute to the consultation exercise?
3. Yes.

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. Yes, however, please see comments above at question 2.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. Yes, welcome amendments in reducing multiple tribunal hearings.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. Financial resources should be available, however, concerns over recruitment and retention of MHO’s remain (recognised as a national problem but particularly impacts within East Ayrshire).
Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?

7. Yes, report makes an accurate reflection of uncertainty associated with Bill’s estimated costs and reflects unpredictability at the timescale of changes.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?

8. As per question 2, travel costs and MHO staff cover costs could both have a financial impact on the service.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

9. Difficult to comment at this point. Further details of subordinate legislation will be required to consider at a later date.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM FIFE COUNCIL

Consultation

Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Fife Council has participated in the consultation process to date with a primary focus on the impact of legislative change on service users who experience mental health difficulties and the resultant additional responsibilities to be placed upon mental health officers.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. Fife Council has not provided comment thus far on financial assumptions.

Did you have sufficient time to contribute to the consultation exercise?
3. More time to allow consultation with other local authority partners would have been preferred.

Costs

If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. The FM indicates that there would be few additional costs to local authorities in relation to the changes in the Bill.

There is a lack of detail regarding the new proposed duties for mental health officers which makes it difficult to quantify the financial implications for local authorities and also the additional workload likely for a workforce which is already working to capacity. The suggestion that there would only be 20 hearings per year in respect of the new section 87A appears to be an underestimate and it is suggested that more detailed analysis is required in relation to both section 87A and 153A. Fife Council believes that a comprehensive review of additional professional responsibilities to be placed on the mental health officer including additional travel, additional training required in relation to forms/reports for example needs to be undertaken in order to provide a realistic response to the question of financial implications to local authorities. This will also inform future workforce development, training requirements and associated costs.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. Estimated costs in the FM appear to primarily relate to the Mental Welfare Commission. Table 1 lacks sufficient information to be able to work out whether costs are reasonable and accurate. For example does the £15k relate to a national training programme aimed at mental health officers?

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. Unfortunately, it is not possible to provide a meaningful response until it is clearly known what additional responsibilities will be placed upon mental health officers.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?

7. As Fife Council considers that there may be an underestimation in the costs associated with new responsibilities, at present we would not be able to comment on this other than to say that it does not appear to reflect the margins of uncertainty.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?

8. The answer to this question is ‘no’ on the basis that there is insufficient detail available to quantify costs to local authorities.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

9. It is not possible to quantify any costs associated with future legislation.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM THE LAW SOCIETY OF SCOTLAND

The Law Society of Scotland’s Mental Health and Disability Committee recently considered and responded to the Health and Sport Committees call for written evidence on the Mental Health (Scotland) Bill¹.

In that response, the Society set out the range of potential costs, which may have arisen from the provisions of the draft Bill (see Appendix A). While the present Bill as introduced, does not repeat some of the draft provisions (e.g. the single mental health report for an application under section 63 of the Mental Health (Care and Treatment) (Scotland) Act 2003) there will be potential costs from the existing provisions. In addition to our earlier comments, the Society considers these to include:

Mental Health Officers (MHOs)
The Bill expands the duties of MHOs to include a range of additional responsibilities, which includes the provision of reports. While the Society welcomes this, these additional responsibilities will have to be considered within the context of finite resources of local authorities. The Society would be concerned if this leads to a dilution of the MHOs broader range of responsibilities. It would also be helpful to quantify the numbers of current MHOs and the number of social workers who are applying to become MHOs, to identify if there is likely to be a deficit in the future.

The Mental Health Tribunal
If the Tribunal is to hear applications to extend the 200 (overnight) suspensions to include a further 100 (overnight) suspensions then this may give rise to an increase in hearings. Where a patient is approaching the total of 200 suspensions - and the expiry of the order, if not extended, the RMO may consider it prudent to make an application to extend and vary the order, along with the application for a further 100 suspensions. This could give rise to multiple applications, which may reduce the potential for the Tribunal to hear two cases (different patients) in one hearing day.

General
The Society reiterates that it is essential that legislative changes are not resource driven where individuals’ rights are at stake. The Scottish Government’s obligations in relation to recognition and protection of the rights in the ECHR and other international treaties identifying civil and political rights are therefore emphasised. This was also fully recognised in the Millan Report, which shaped the form and content of the 2003 Act.

If you have any questions in relation to this, then please contact me direct.

Appendix A
(Extract of Society’s response to the Health and Sport Committees call for written evidence on the Mental Health (Scotland) Bill.

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible.

The relevant authorities must be consulted on the actual costs involved. However, the following are likely to involve resourcing considerations:

a) For local authorities as a result of the additional duties required of MHOs in connection with extending CTOs (Question 5) and being consulted in connection with proposed TTDs (Question 11).

b) For local authorities and health boards as a result of the reception and treatment of patients from other jurisdictions.

c) For the Mental Health Tribunal the additional costs that may arise from more interim hearings if more independent reports are ordered as a result of the proposals regarding medical examinations and CTOs (Question 3).

d) The possible multiple hearings identified in relation to Question 2 may also incur costs for the Tribunal, patients and other parties involved.

e) The proposed amendment to section 24 (extending provision of services for certain mothers with post-natal depression to mothers with mental disorder) will also incur costs for health boards.

It is important, however, that legislative changes must not be resource driven where individuals’ rights are at stake. The Scottish Government’s obligations in relation to recognition and protection of the rights in the ECHR and other international treaties identifying civil and political rights are therefore emphasised. This was also fully recognised in the Millan Report, which shaped the form and content of the 2003 Act.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM NHS ORKNEY

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Yes we contributed to the consultation through the Social Work Scotland (ADSW as was) response.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. No – the FM underestimates the additional report workload and also the potential system cost implications of the Bill

Did you have sufficient time to contribute to the consultation exercise?
3. Yes

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. We believe the costs have not been adequately reflected in the FM. The potential additional workload implications for RMOs are not adequately explored and we believe the MWC for Scotland figures on reports / scenarios affected by the Bill are more accurate than the numbers put forward in the FM.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. No, for the reasons given above.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. No, as highlighted above, it is likely that additional RMO work will lead to additional costs for the service delivered which is met by a Service Level Agreement with another NHS Board area where in patient care is provided to our patients. There are also considerable MHO workload and cost implications which have been underestimated in the FM. This is further explored in our partner Local Authority response to the FM.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?
7. The FM has a starting point assumption that we do not believe is realistic therefore all subsequent estimates are also felt to be under.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. In addition to the RMO and MHO workforce implications there are also potential implications re the requirement to have advanced statement available 24/7. There may be IT system and remote / mobile working implications associated with delivery of this elements that has not been accounted for the in the FM. There is no recognition within the FM of technical system requirements to support implementation and, for our area at least, the additional requirements would not be able to be met utilising existing systems.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

9. It is not possible to quantify this at this stage.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM SHETLAND ISLAND COUNCIL

Consultation

Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. We did not take part in any consultation preceding the Bill.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. N/A

Did you have sufficient time to contribute to the consultation exercise?
3. N/A

Costs

If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. We are a small local authority with only a small number of MHO’s. The duties the MHO’s have to carry out varies in volume and frequency so it is difficult to predict exact workloads as they do these duties in addition to an “ordinary” case load. The new provisions in the Bill will undoubtedly create extra work for MHO’s but we envisage being able to pick this up within our existing resource. Our biggest dilemma is in relation to any work we have to do “off island” as this has a considerable cost in terms of finance and time.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. We have been part of other aspects of consultation in relation to this and believe that the estimates provided by the Social Work Scotland Mental Health Sub Group are more realistic.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. Given our context we are content that we can meet any financial cost.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?
7. We believe the Bill underestimates additional duties and the figures provided by the Social Work Scotland Mental Health Sub Group are more realistic.

Wider Issues

Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. Some of the duties in the Bill provides additional responsibilities for MHOs – some of this is explicit, but some is implicit e.g. changes in Named Person
procedures are highly likely to involve MHOs although this is not stated. Such duties will incur additional MHO time and costs.

*Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?*

9. Without knowing what subordinate legislation will impose it is impossible to answer this question.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM NHS WESTERN ISLES

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. No

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. N/A

Did you have sufficient time to contribute to the consultation exercise?
3. N/A

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. Costs are not anticipated to be significant, although they cannot be quantified.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. The logic seems reasonable although there are no estimated figures, so it is not possible to comment on accuracy.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. If the costs are not significant, as indicated in the Financial Memorandum, then NHS Western Isles should be able to meet them. If they should transpire to be significant then representation would be made to Scottish Government.

Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?
7. The FM does indicate areas where there are unquantifiable variables at this stage. Although it is difficult to say whether or not they are accurate they do seem reasonable, as do the timescales.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. The FM does appear to reasonably capture associated costs.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?
9. It is extremely difficult to predict future costs that might be borne out of subordinate legislation – we are not aware of any at this stage.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM

SUBMISSION FROM ORKNEY ISLANDS COUNCIL

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Yes we contributed to the consultation through the Social Work Scotland (ADSW as was) response.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. No – the FM underestimates the MHO workload and also the potential system cost implications of the Bill

Did you have sufficient time to contribute to the consultation exercise?
3. Yes

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. We believe the costs have not been adequately reflected in the FM. The workload implications for MHOs are potentially very significant and we believe the MWC for Scotland figures on reports / scenarios affected by the Bill are more accurate than the numbers put forward in the FM.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. No, for the reasons given above.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. No, as highlighted above, the majority of the additional costs will be in relation to MHO capacity. The Bill needs to be viewed within the context of the national MHO workforce as a whole which is already stretched and workforce analysis shows that the high numbers of MHOs expected to retire in the short term is not being adequately compensated for by new numbers coming forward for training. The Bill therefore creates cost pressures both on individual Local Authorities and on the national training arrangements.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?
7. The FM has a starting point assumption that we do not believe is realistic therefore all subsequent estimates are also felt to be under.

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. In addition to the MHO workforce implications there are also potential implications re the requirement to have advanced statement available 24/7. There may be IT system and remote / mobile working implications associated with delivery of this elements that has not been accounted for in the FM. There is no recognition within the FM of technical system requirements to support implementation and, for our area at least, the additional requirements would not be able to be met utilising existing systems.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

9. It is not possible to quantify this at this stage.
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM SOUTH AYRSHIRE COUNCIL

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. We did not take part in the consultation exercise.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. n/a

Did you have sufficient time to contribute to the consultation exercise?
3. n/a

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. Para 33 accurately reflects the costs for the assumed number of referrals.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. Yes from a local authority point of view.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. We can meet the costs based on a share of 20 referrals. Should the level of referrals increase materially this should be met from additional Scottish Government funding.

Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?
7. Yes

Wider Issues
Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?
8. Yes from a local authority viewpoint.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?
MENTAL HEALTH (SCOTLAND) BILL; FINANCIAL MEMORANDUM
SUBMISSION FROM SOUTH LANARKSHIRE COUNCIL

Consultation
Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?
1. Yes, South Lanarkshire Council did take part in the consultation exercise. It was not however possible to quantify the actual financial impact of the proposals contained in the Bill other than to recognise that costs would increase.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. Refer to the response to question 1 and question 4.

Did you have sufficient time to contribute to the consultation exercise?
3. Yes

Costs
If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
4. Section 2 of the Act introduces a new duty requiring MHO’s to prepare a report. The FM suggests that this will apply to 20 cases throughout Scotland at an additional cost of £9,000. However further information gained from The Mental Welfare Commission and included in the Social Work Scotland Mental Health Sub Group Response states that this will apply to 1789 reports (2012/13) and this would then result in an additional cost of £850,000 across Scotland. It is not possible at this stage to quantify the financial impact on South Lanarkshire Council as a result of the new duty.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
5. Further clarification is required based on the evidence provided by Social Work Scotland. If this evidence is accurate then the Financial memorandum has significantly underestimated both the costs that will be incurred and the MHO workload implications.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
6. The Adult Support and Protection Act, the Mental Health Act and the Adults with Incapacity Act have all greatly extended the protective, monitoring and investigative functions of local authorities. The Bill proposes further increases to the duties and responsibilities of MHO’s, and there is an increasing requirement to review the national MHO workforce and workload capacity. Taking into consideration the financial challenges currently being experienced across the public sector, a significant increase in cost would further add to the budget pressures within Social Work. Consideration should therefore be given to the availability of additional funding.
from the Scottish Government to meet these new cost pressures emanating from the new duty.

*Does the FM accurately reflect the margins of uncertainty associated with the Bill’s estimated costs and with the timescales over which they would be expected to arise?*
7. Please refer to the response to question 1 and question 4.

**Wider Issues**

*Do you believe that the FM reasonably captures any costs associated with the Bill? If no, which other costs might be incurred and by whom?*
8. No. Please refer to the response to question 1 and question 4 specifically the uncertainty in respect of the impact on workloads and the number of reports.

*Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?*
9. This is not known at this stage.
EXTRACT FROM THE MINUTES OF PROCEEDINGS

Vol 4, No. 89 Session 4

Meeting of the Parliament

Thursday 12 March 2015

Note: (DT) signifies a decision taken at Decision Time.

**Mental Health (Scotland) Bill:** The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn) moved S4M-12624—That the Parliament agrees to the general principles of the Mental Health (Scotland) Bill.

After debate, the motion was agreed to ((DT)).

**Mental Health (Scotland) Bill: Financial Resolution:** The Cabinet Secretary for Finance, Constitution and Economy (John Swinney) moved S4M-12285—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Mental Health (Scotland) Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3(b) of the Parliament’s Standing Orders arising in consequence of the Act.

The motion was agreed to (DT).
Mental Health (Scotland) Bill:  
Stage 1

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I am delighted to open this stage 1 debate on the Mental Health (Scotland) Bill, on a motion that the Parliament agrees to the general principles of the bill.

I am pleased that we are debating mental health for the fourth time in this calendar year. That reflects the importance of mental health and the interest that the Parliament has taken in it. I am heartened to hear the Presiding Officer say that we are short of time, as that indicates the number of members who wish to speak and emphasises the great interest that we have in the subject.

We have debated much of the work that we are doing to improve mental health and mental health services, and we have discussed the progress that we have made and the challenges that we face in improving further. Doubtless, we will debate those matters again.

I am pleased to be able to briefly update Parliament about the £15 million of innovation funding that we announced in November and which is part of that work. Demand for mental health services has increased in recent years, so we must ensure that services continue to be effective and of high quality. The additional investment in the next three years will help to drive further improvements in the quality and delivery of mental health services so that people get the help that they need, where and when they need it.

The funding of £5 million in each of the next three years will comprise four key elements. The first is an allocation to national health service boards to be used in partnership with the wider public and third sector to support improved access to child and adolescent mental health services, to support innovative approaches to delivering mental health services and to identify new ways of treating people. Secondly, there will be an allocation to NHS Education for Scotland to further develop the quality of child and adolescent mental
health services through training for staff in evidence-based psychological interventions. Thirdly, there will be an invitation to NHS boards and their partners to work with the Scottish Government on developing innovative approaches to working with people in distress. Finally, there will be an invitation to NHS boards and their partners to submit proposals to develop novel approaches to meeting the needs of people with mental health problems in primary care settings. We will soon write to NHS boards and their partners to set out more details on the fund, and I am happy to update members who are interested, if they would like me to do so.

Today, we are focusing on the Mental Health (Scotland) Bill, which is a key part of our mental health strategy and which looks to strengthen the rights of and protections for service users. The chief aim of parts 1 and 2 is to amend existing legislation so that it works as effectively as possible for service users. The bill seeks to address issues that were raised in the McManus review of 2009 and elsewhere. Part 3 introduces a victim notification scheme for victims of mentally disordered offenders in a way that respects the rights of victims and of vulnerable offenders.

I was pleased to note from the Health and Sport Committee’s stage 1 report that the committee supports the general principles of the bill. I thank that committee, the Finance Committee and the Delegated Powers and Law Reform Committee for their work in considering the bill at stage 1.

I am grateful to the Health and Sport Committee for the manner in which it took evidence at stage 1. It invited a wide range of stakeholders to give evidence, in the spirit of drawing out the changes that will, in line with the aims of the bill, best improve the system for service users.

The evidence and the committee’s report have been invaluable in helping the Government to reflect on whether we have the provisions exactly right, particularly when there is a range of opinions. I look forward to reflecting on members’ comments before responding to the report in due course.

I will now speak about some of the key individual provisions in the bill. Section 1 seeks to benefit service users by giving them more time to prepare for their first tribunal hearing when a compulsory treatment order is applied for. The aim is to cut down on repeat hearings, which can be distressing for service users. I have noted the concerns expressed to the committee that the change could mean that service users are detained for longer before they automatically appear before a tribunal.

Members might have noted the evidence given to the Health and Sport Committee by Dr Joe Morrow, the President of the Mental Health Tribunal for Scotland. Dr Morrow was very clear that the purpose of the proposed changes is to support service users by allowing them more time to prepare for tribunal hearings and to cut down on repeat hearings. I want to bring in changes that will help service users overall. We must balance the benefits that we are confident will result against concerns about extending the period of detention before the tribunal hearing. We are thinking hard about how best to achieve that balance and I will be happy to hear further views on that area.

One area that is raised in the committee’s report is the capacity of the mental health officer workforce. I recognise the incredibly important work done by MHOs and their vital role in safeguarding service users’ rights. As I noted to the committee, the bill does not quite reflect our intention on MHO reports when certain orders are extended. That caused some understandable confusion around costings, which was raised by the Convention of Scottish Local Authorities, and we will propose an amendment at stage 2 on that point.

The bill will introduce a very small number of duties for MHOs, most of which are considered best practice already and relate to only a few cases across Scotland. Although MHO numbers are ultimately a matter for local authorities, I am pleased to have seen an increase in the number of mental health officers who are receiving training. The Government has recently undertaken a scoping exercise to gather evidence about the issue. When the report of that work is available, we will, alongside stakeholders, identify any appropriate actions.

The committee noted comments on changes to suspension of detention. The Government based the provisions closely on recommendations in the McManus report and agrees with that report’s aims that suspension of detention provisions should be flexible to meet patient needs and should also contain safeguards. Suspension of detention should not be used as an alternative to a less-restrictive community-based order, which is why the safeguard of a tribunal hearing is included.

The bill updates provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 on appeals against conditions of excessive security. As I noted at the committee, the framing of the provisions in the 2003 act no longer reflect the nature of the estate, meaning that we were unable to use existing powers, which talk about transfer from hospital to hospital, to bring in an appeals process. We intend to introduce regulations that set out the levels at which appeals can be made at an early stage.
Turning to the nurse’s holding power, we feel that it is useful to clarify that the power to detain is for a maximum of three hours, and that it can be used for the purpose of a medical examination. That is not radically different from the current position; it just means that the period can be extended to three hours. I am very clear that, as now, we expect the power to be used in line with the principle of least restriction, and guidance will reflect that.

I have listened to the concerns about proposed changes to the timescales for appeal on transfer to the state hospital, when unwell patients might need longer than four weeks to lodge an appeal. I want to ensure that we strike the right balance, given other concerns about the effect of the current timescales. We are considering that matter carefully ahead of stage 2.

On named persons, I have been reflecting on whether we have the right balance between ensuring that service users have a named person only if they want one and protecting the most vulnerable. For many service users, the named person role is very important, and it is an important protection at a difficult time. It is therefore vital that we get the balance right, and I will lodge amendments at stage 2 that seek to do that.

One of the major changes in the bill is the introduction of a victim notification scheme for certain mentally disordered offenders, which will sit alongside the existing scheme for other offenders. We are introducing the scheme in response to a European Union directive on the rights of victims, which does not distinguish between the status of offenders. Furthermore, the Scottish Government has consistently shown its support to victims of crime.

We recognise that such offenders are vulnerable themselves. I will seek to ensure that we get the balance right while ensuring that the rights of victims to information are fulfilled. That is fundamentally important.

The committee acknowledged that the bill is intended to be a limited bill and is designed to make the 2003 act work as effectively as possible. I am aware that there are some long-standing issues that some people would have liked the bill to include, such as the issues that the Scottish Law Commission raised on incapacity and calls to bring incapacity and mental health legislation together. Those are very complex issues, but I make it clear that I have heard what people have been saying. There have also been some limited calls for consideration of whether persons with a learning disability on the autistic spectrum should be included within the scope of the 2003 act. I am clear that the bill might not be the best vehicle for those matters, and I want to consider them further before coming back to Parliament, separately from the process around the bill, to update members on my thinking.

I conclude—somewhat ahead of time, I notice—by reiterating that the aim of this amending bill is to improve existing legislation to ensure that the system works as effectively as possible for service users, and to introduce a victim notification scheme for mentally disordered offenders.

I look forward to hearing members’ thoughts on the bill. I hope that the Parliament will support its general aims, and I look forward to working with members of all parties as we continue to take it through Parliament to ensure that we have the most effective system in place for treating mental health disorders across the country.

I move,

That the Parliament agrees to the general principles of the Mental Health (Scotland) Bill.

The Deputy Presiding Officer: Many thanks, minister. Your concluding slightly early might allow me to call all members in the open debate.

I call Duncan McNeil to speak on behalf of the Health and Sport Committee.

15:11

Duncan McNeil (Greenock and Inverclyde) (Lab): Stephen Fry said:

“One in four people ... have a mental health problem. Many more people have a problem with that.”

I ask members here in the chamber, and indeed everyone in the public gallery, to think of a person they know who has a mental health condition. Who is that person—that individual who has popped into your head? Is it a family member, a work colleague or a friend? Or is it you? The reason I ask that question is that we must place at the heart of our consideration of the Mental Health (Scotland) Bill the person with the mental health condition. It is important that we consider the impact that the changes proposed under the bill would have on the individual requiring mental health care.

During the Health and Sport Committee’s scrutiny of the bill, we have been mindful of the importance of the rights of the patient. As the minister said, that of course needs to be balanced against the administrative processes that are in place to deliver mental health treatment. Broadly, the bill has achieved the right balance. However, there are a number of areas, some of which were outlined by the minister in his speech, in which the committee believes there is a need for further clarification from the Scottish Government.

We welcome the minister’s welcome of our stage 1 report. It would be remiss, however, not to express the committee’s disappointment that the
Government’s response to our report was not received in time for the debate. That means that some of my focus will be on areas that the minister has already mentioned. I hope that the minister will be able to offer us some assurances and clarification today on some of the following specific points.

The first area that I want to highlight is the automatic extension to the continuous period of detention that was alluded to by the minister. Thinking again about that from the perspective of the patient, there were positive comments from the Mental Health Tribunal for Scotland—as the minister said. The tribunal felt that the provision was about ensuring that patients were ready and prepared to proceed at their first tribunal hearing, thereby reducing the need for people to attend multiple hearings with all the associated problems.

As a committee, we recognise that it is important that measures are taken to ensure that tribunals do not exacerbate the circumstances and the stress for patients. However, serious concern was raised about that provision by the Scottish Human Rights Commission. The concern was discussed within the context of the European convention on human rights, the issue being whether there was sufficient and proportionate justification for a blanket extension that would apply to all patients.

To ensure that the provision is compliant with the right to ‘liberty and security,’ it is vital that the Government assesses its implementation closely. Therefore I ask the minister to give us further clarification and to respond to the recommendations. First, the committee recommends that the Government provide a detailed plan of the estimates in relation to the reduction in multiple hearings that could be expected as a result of the provision. Secondly, we recommend that there is a clear monitoring regime that records the reasons for delayed, rearranged and repeat tribunals. Finally, we recommend that the Government clarifies how deducting the proposed extension time from the continuous period of detention will be calculated.

To quote once more Mr Stephen Fry, the president of the mental health charity, Mind, “If ignorance is bliss, why aren’t there more happy people in the world?”

I move on to another aspect of the bill that was mentioned by the minister: the provisions relating to placing new duties on mental health officers. There is concern about the capacity of mental health officers to deliver on those duties. They are already under pressure due to an increased workload, an ageing workforce and the clear difficulties in attracting new social workers into the role. In Glasgow City Council, for example, the number of mental health officers has fallen from 120 in 2011 to just 94 in 2013.

It is important that the provisions relating to mental health officers can be delivered effectively. I therefore seek from the minister an assurance that some of the funding that he mentioned might find its way to support mental health officers and ensure that their provision is adequate to deliver what the bill proposes.

Another area of the bill relating to delivery of services by a specific profession is the proposed extension time for nurses to detain a person pending a medical examination. In the committee, Derek Barron of the Royal College of Nursing was frank in his assessment of the provision. He believed that there was no evidence that those changes would have any impact whatsoever.

Again, the issue of patient rights and administrative efficiency raised its head when Derek Barron told the committee:

“Our duty is to protect their human rights, not to make things easier for our workload.”—[Official Report, Health and Sport Committee, 7 October 2014; c 16.]

As a committee, we believe that any provision that restricts a service user’s liberty must be fully justified by robust evidence. I seek assurance from the minister that that is the case. I also ask the minister what steps can be taken to increase the accuracy and detail of the data recorded on the nurse’s holding power.

There are other aspects of the bill where the committee believes that there is a need for the Scottish Government to provide further information on the rationale and evidence that have informed its thinking. That includes the proposal to reduce the appeal period for people transferred from one hospital to another from 12 weeks to 28 days. Carolyn Roberts of the Scottish Association for Mental Health told the committee:

“The argument is that the time for appeal delays treatment that might be required urgently, but we neither understand that nor think that it has any substance.”—[Official Report, Health and Sport Committee, 11 November 2014; c 49.]

Again, the committee recognises the importance of protecting the patient’s rights. I therefore ask the minister to respond to the suggestion that, should a transfer take place before the outcome of an appeal has been determined, the place that the patient has come from should be held until the appeal has been decided. It would be good if that could be offered as a guarantee to the patient.

The Deputy Presiding Officer: The member should begin to close, please.

Duncan McNeil: I will jump to the closing stage on your instruction, Presiding Officer.
In conclusion, I ask members not to forget whom they pictured at the start of my speech when I asked them to think of a person with a mental health condition. If we hold those individuals in our sights during the Parliament’s consideration of the bill, we can ensure that it is a robust and fit-for-purpose piece of mental health legislation.

The Deputy Presiding Officer: I am afraid that, even with the minister generously giving time back, we are still tight for time. I call Richard Simpson, who has a maximum of nine minutes.

15:21

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I refer members to my declaration in the members’ register of interests as a fellow of the Royal College of Psychiatry and honorary professor of psychology.

The new funds to which the minister referred are of course welcome, although I point out that, proportionately, mental health funding is £75 million a year down on what it was in 2009, so there is some way to go to make that up. I hope that some of the new money will be applied to tiers 1 and 2 of the child and adolescent mental health services to support interventions such as perinatal attachment work and groups such as Place2Be in primary schools where there is significant deprivation. That would help to reduce the growing demand on CAMHS at tiers 3 and 4, and support some of the 6,000 children whose referrals were rejected by the specialist CAMHS last year.

I think that we all agree that the bill is fairly modest. It arises from some of the McManus report recommendations, and seeks to address some of the perceived weaknesses that have come to light in the Mental Health (Care and Treatment) (Scotland) Act 2003, the Criminal Procedure (Scotland) Act 1995 and the Criminal Justice (Scotland) Act 2003.

Given that the bill is modest, I say at the outset that Scottish Labour will certainly support the principles at stage 1. However, we believe—as Duncan McNeil indicated—that there is a flaw in the proceedings of this Parliament that makes the debate much less meaningful than it might have been if we had received the Government’s response to the committee’s report. We could then have had a further debate in Parliament. I know that the rules at present do not require that, but I urge the Presiding Officer and the Scottish Parliamentary Corporate Body, along with the Government, to take a close look at that to see whether we can make such debates more meaningful. What we are doing today is asking questions. The minister has indicated today some movement on some of the issues, but we do not really have time to appreciate and understand that. My comments may therefore not be totally pertinent, and for that I apologise.

Before considering the concerns that were raised by the committee and those who gave evidence, I stress that the committee, in taking oral and written evidence, perceived that there was a probable need for a wider review of the Mental Health (Care and Treatment) (Scotland) Act 2003 alongside the Adults with Incapacity (Scotland) Act 2000. Issues around human rights, and the provisions covering them with regard to learning disability and autism in particular, should be examined, and the complex interaction between the two acts with regard to capacity must be revisited. Detention is a very serious business, and we must ensure that we get it right and apply the Millan principle of using the least restrictive option to allow patients who are suffering from mental illness to go through the procedure as easily as possible, and feeling well supported.

I have concerns that some of the issues that were raised in the McManus report are not addressed in the bill. Issues are either not included or not adequately covered, and there are concerns regarding the absence of independent advocacy in the bill. If the minister wants to take a look at that with regard to the cabinet secretary’s view, he might look at the 2002 debates on the 2003 act, in which I participated, and in which Shona Robison said that advocacy should be everyone’s right. The bill does not complete what Shona Robison advocated in Parliament at that time.

There should be more focus, too, on the bit of the McManus report on groups subject to inequalities, such as asylum seekers, refugees and young people, as well as on sections 25 to 31 of the 2003 act, which deal with the obligations of local authorities to promote recovery and access to other services, including employability and education. He felt that those should be revisited, but there is no indication in the bill of any intention to do that. Finally, the report highlighted the expansion of mandated treatment to include psychological care for families where appropriate.

Those are some of the issues that the bill does not cover. Let us take a quick look at the issues that are covered; my colleagues will deal with some of them in more detail.

On the extension of the number of days for a tribunal hearing, the administrative situation is that the number of repeat hearings has been reduced under the current chair, and that is extremely welcome, but we cannot have a blanket extension that is purely for administrative purposes. I will move on this issue at stage 2 if the minister does not. The extension should happen only with the application of the individual to whom the matter
pertains, or with the consent of the individual or their named person in respect of not receiving an adequate report for the tribunal to consider, thereby avoiding repeat hearings. I would like two qualifications in the bill in order to ensure that the rights of the individual are protected and that we do not have a situation in which there is simply a blanket extension and a drift in the number of days in which people can have a hearing.

Duncan McNeil mentioned the new duties on MHOs, which are of considerable concern as workforce planning in that area is not good. We understand from the Government’s response that COSLA got the number of additional reports wrong, but I remain to be completely convinced of that and I would like to see further evidence form the Government in its detailed response.

Jamie Hepburn: Does Richard Simpson recognise that I made it clear in evidence at stage 1 that COSLA got it wrong, but that I accepted that that was my fault?

Dr Simpson: I do, and that is exactly what I said. I am not convinced that either the figures that COSLA had or the figures that the minister has given us were correct, and I would like to see more evidence. Perhaps we can get into that at stage 2.

There is no evidence to justify the extension of the nurse’s holding powers to three hours, and the human rights issue there is important. When the nurses are telling us that they do not think that it should occur, I think that it should be deleted from the bill.

I am concerned about the reduction from 12 weeks to 28 days for the right of appeal against transfer. One of the justifications for that reduction is to bring it into line with other appeals, but it is an area of such overwhelming importance that I would like to see some justification for the change other than an administrative nicety. Will the Government comment in its report on ensuring that, when there is an appeal or a proposed transfer, until the time limit of the appeal is up the bed should be kept open in the existing situation, so that if the appeal is upheld the patient can go back? That is not happening.

My colleague Rhoda Grant will deal with the named person in more detail, but we certainly have considerable concerns about that.

There are concerns from all of us on the underuse of advance statements, but what evidence is there of Government work to improve the uptake of such statements? They are now proposed to be held by the Mental Welfare Commission, which is reasonable, but they must be both secure on the one hand and readily accessible 24/7 on the other. There are concerns about the credibility of advance statements with regard to implementation. There is not a general acceptance out there in the community that advance statements are worth making, and we need more research to understand why that is, before driving forward on the use of statements.

We also need to look at the concerns about currency in advance statements. In other words, they need to be updated, so they should not just be promoted, and there should not just be a requirement on boards or local authorities to promote them.

Mary Scanlon (Highlands and Islands) (Con): Will the member give way?

Dr Simpson: I do not have time, I am afraid. I may give way when I sum up at the end.

On the question of community leave, paragraph 78 of the committee’s report refers to the issues associated with the proposal for extension by 100 days.

The question of detention in a medium-secure unit and transfer reduction is fine, but what about transfers within a hospital rather than to another hospital? I am not sure that that issue has been properly addressed. Then there is the question of the low-secure units, which do not feature at all in the bill, but low-secure units are still secure. Being held in such a unit is still a restriction of liberty, and there should be an appeal against that along with the appeal against medium-secure detention.

On the question of advocacy, I have already mentioned Shona Robison’s speech in 2002, and I hope that at stage 2 the Government will consider reintroducing advocacy.

Presiding Officer, I will conclude early. In my summing up, I will also refer to the part of the bill on victims’ rights. It is excellent, but it fails in one major regard in that the investigation of and reporting on homicides and serious assaults perpetrated by people who are suffering from mental illness is not included in the bill at all. There is a considerable disparity between the dysfunctional, fragmented system in Scotland and the much better system in England. I will return to that in my summing-up speech.

15:30

Nanette Milne (North East Scotland) (Con): We support the general principles of the Mental Health (Scotland) Bill but, as others do, we have a number of concerns that we believe the Government needs to address in the next stage of the parliamentary process. The Health and Sport Committee’s stage 1 report mentions several issues that were raised by witnesses that require either clarification from the minister or amendments to strengthen the bill, although I must say that I find it difficult to address those issues in
a stage 1 speech without having had the Government’s response to the committee’s report ahead of this debate.

The Mental Health (Care and Treatment) (Scotland) Act 2003, which the bill seeks to amend, was an important piece of legislation that aimed to minimise interference in people’s liberty and to maximise service users’ involvement in their treatment by giving them a right to express their views about their care and treatment, a right to independent advocacy, a right to submit an advance statement about how they wish to be treated when they become ill and a right to choose a named person who can act on their behalf when necessary. The bill seeks to build on that by making changes to current practice and procedures to ensure that people who have mental health problems can access effective treatment in good time.

In the limited time that is available to me, I will focus on some issues in part 1 of the bill and a few matters of concern that are not included in the proposed amending legislation.

The new duties that are to be placed on mental health officers have raised the issue of workload for those specialist social workers in the face of an ageing workforce and difficulty in recruiting and retaining new MHOs. Although we accept the minister’s explanation of the discrepancy between the policy memorandum, and the financial memorandum and his assurance that the bill’s provisions will not result in a large increase in the number and cost of reports that are required from MHOs, we agree that there should be a strategic review of MHO provision with a view to improving recruitment, training and retention of that important category of staff.

I want to deal now with four key areas that were highlighted by SAMH and other witnesses, and which they consider require amendment. We agree that there is an urgent need to bring into force a right of appeal against excessive security, and we acknowledge the Government’s proposed action—albeit belated—to introduce regulations on that. However, we see the logic of extending that right of appeal to people in low-secure settings, because there may well be different levels of security within low-secure accommodation. I hope that the Government will reconsider its stance on that.

I welcome the minister’s comment to the committee that the right balance might not have been struck in the provisions on named persons. The bill allows a primary carer or nearest relative to be appointed by default if a named person has not been appointed, whereas the clear policy intention is that an individual should have a named person only if they choose to have one. I hope that that will be rectified at stage 2.

During scrutiny of the Mental Health (Care and Treatment) (Scotland) Bill in 2003, a lot of time was spent on provision of advance statements to encourage the involvement of service users in their mental health treatment. It is disturbing that more than 10 years on from enactment of that legislation, the right to produce such statements is underused and many service users are unaware that they have it. At committee, the Government accepted the need to raise awareness of advance statements, and I support the committee’s recommendation that the minister consider placing on health boards and local authorities a duty to promote advance statements.

With regard to a register of advance statements, privacy and confidentiality are extremely important. I have some sympathy with SAMH’s desire that the Mental Welfare Commission merely hold the information that a statement exists, when it was last updated and where it is kept. However, I also recognise the Government’s position that a central depository would allow speedier access. We need an assurance from the minister that we can strike the right balance between availability and confidentiality.

The right of access to advocacy was raised repeatedly with the committee; there is widespread concern that the bill is silent on it. Although it is provided for in the 2003 act, access to advocacy is still patchy across the country, and where it is available the service is often explicitly targeted at supporting people who are subject to compulsory proceedings, whereas it could be of benefit throughout the system.

We need a proper assessment of advocacy services to establish whether we need to increase provision of and access to independent advocacy, and to ensure that local authorities are delivering on their duty to provide appropriate services. As other committee members have done, I welcome the continuing discussions with the Scottish Government about whether local authority advocacy provision could become part of the Care Inspectorate’s review programme. Beyond that, we also need information on how assessment of advocacy provision in secure settings and hospitals can be ensured.

I want to deal with the concerns of people who have learning disabilities and of people who are on the autism spectrum, who feel strongly that current mental health legislation is inappropriate for them. Steve Robertson of People First Scotland made a powerful plea for learning disability to be defined as an intellectual impairment rather than a mental disorder, and other witnesses asked for a wholesale review of mental health and incapacity legislation because of the increasing knowledge of neurodevelopmental disorders. That clearly is not the intention of the bill, and it is important that an
open dialogue is maintained between the Government, the mental health sector and people with learning disabilities and ASD, with a view to developing future legislation to deal with those issues and to meet the needs of the people concerned.

A strong case was also made in the interests of patients and staff for more clarity regarding use of force, covert medication and restraint, bearing in mind the 2003 act’s underlying principles and human rights standards.

Although we will vote for the bill at stage 1, we share the significant concerns that have been expressed by many witnesses and would like to see the Scottish Government give further consideration to a more comprehensive review of mental health legislation in order to ensure compliance with human rights, and to the development of specific legislation to meet the needs of people who have learning difficulties and ASD. We hope for a positive response from the Government to those concerns, as the bill progresses.

The Deputy Presiding Officer: We turn to the open debate. We are tight for time, so speeches should be a maximum of six minutes.

15:36

Bob Doris (Glasgow) (SNP): I thank all the witnesses who gave evidence to the convener, Duncan McNeil, me and the Health and Sport Committee, including the Scottish Government, whose engagement with us on the bill has been open and is on-going.

The committee took the proceedings seriously, because we are talking about restricting people’s liberty, often against their will, and the very sensitive matter of mental health and how it affects not just the people who have mental health problems but their families and wider society. We took very seriously the section on informing victims of crime involving a mental health disorder, when we looked at it.

In a more positive frame of mind, in relation to mental health more generally, it should not matter whether a person has mental health problems or not; we all have health that we have to nurture and mental health is part of that. We should all take cognisance of that, because but for the grace of God any one of us could have our liberty restricted because of the need to protect society, and because people with mental health disorders have the right to be treated—sometimes against their will, unfortunately.

The minister and our committee convener outlined the main themes that must be covered; I will pick up on one or two of them. The real issue in relation to the named person is whether someone becomes a named person by default. If a person does not have obvious next of kin to choose, another family member may become the named person. The committee heard powerful evidence from people who never chose to be the named person and who had found out things about their family members that, quite frankly, they never wanted to find out. We have to protect the privacy of the person who is allocated a named person and we have to respect their dignity, and consider how much family members wish to know about loved ones who may suffer mental health disorders. A little bit thought is needed on that. When a named person is not a family member, we have to ensure that they are still a conduit for appropriate communication to the family, to let them know what is happening to their loved one. There is a balance to be struck, so I ask the minister to reflect on that.

We have heard about the appeal against excessive security. I would like more information on why people in a low-secure setting will not be able to appeal. A bit more thought should be given to institutions that have different levels of security—that matter might have to be fleshed out. We have heard about going beyond a low-secure setting to a community disposal order of some description. I have concerns about that. What happens to someone who is subjected to a level of security against which they have no right to appeal? A person might have to wait two years until the next tribunal, so perhaps something should be done on how long people will have to wait for their security level to be reviewed.

A variety of things is important. On advance statements, one of the key messages that we got was that they are good things, and people wanted to know how we are seeking to promote and extend their use. SAMH raised privacy concerns with us in relation to how advance statements would be stored. I am not sure that I have any problem with there being central register of them, but I am aware that SAMH spoke about a central register merely signposting where the advance statements are held. I am not necessarily drawn towards that suggestion, but we should take on board the concerns about privacy that SAMH has drawn to our attention.

Another aspect that came up during evidence and which was mentioned by Duncan McNeil concerns application for a compulsory treatment order and extension of the associated period from five days to 10 working days. Dr Joe Morrow is content with that and believes that it would reduce further the need for multiple hearings, so I am fine with the proposal. I add the caveat that I would like to ensure that that does not mean that the responsible professionals see that as simply being an extended deadline for them to work to, but
instead seek to move as expediently and quickly as possible to holding the tribunal on whether there should be a compulsory treatment order. With regard to whether the period of 10 working days would be a blanket approach, I would be interested to know whether professionals currently work to the maximum deadlines. If the five-day period is not currently a blanket and uniform approach, the 10-day period will not be, either. I sound a note of caution about how we proceed.

The error in relation to additional cases for mental health officers turned out to be quite helpful for the committee, because we are now clear about what the additional pressures will be on mental health officers. For reasons of time, I will not read out what those are, but they are much narrower than was first thought. However, that issue gave rise to a positive scoping exercise to map out the pressures and requirements on mental health officers to ensure that local authorities, in partnership with the Scottish Government and the national health service, get that workforce and workload planning right.

The Deputy Presiding Officer: You need to close, I am afraid.

Bob Doris: I am delighted that the minister appears to be responding to those concerns and I look forward to amending the bill constructively at stage 2.

The Deputy Presiding Officer: I am afraid that members cannot go over their time.

15:42

Margaret McDougall (West Scotland) (Lab): Mental health problems can affect any one of us. They are not constrained by class, education or financial status, yet this is an issue that is often overlooked or misunderstood.

In the most recent Scottish social attitudes survey, 26 per cent of people said that they had experienced a mental health problem at some point in their life, 47 per cent said they would not want others knowing if they ran into difficulties and 17 per cent said that they would not want to talk to anyone about it. From those statistics, it is clear that, in Scotland, there is still stigma attached to mental health issues. If we are to overcome that, we need to ensure that people feel comfortable talking about mental health issues and that they get the help and support that they need.

In 2013 in North Ayrshire—which is part of the area that I represent—13 males committed suicide, compared to three females. Those figures are lower than the figures in some areas but, in my view, one death from suicide is one too many. The figures also highlight the need to tackle stigma and ensure that people are able to talk about their mental health as they would any other health issue, and the need to ensure that that they can get support. It is no surprise that the suicide rate is higher among men, given that they are less likely to open up about their feelings, never mind to admit that they have a mental health issue.

It is vital that we in this Parliament get our legislation right by ensuring that it focuses on the individual and is strongly based on a human-rights-centred approach—an approach that banishes stigma and ensures that those who are experiencing issues feel comfortable about coming forward. With that in mind, although I agree with the general principles of the Mental Health (Scotland) Bill, I have a few reservations about it at this stage, some of which I will raise today.

First, the proposed changes to timescales in relation to the right to appeal and detention could be seen as stripping away the individual’s rights. SAMH has said that the current plan to reduce from 12 weeks to 28 days the time to appeal against transfer to the state hospital is excessive, and that sentiment has been echoed by the Mental Welfare Commission. Although I understand that the reasoning behind the provision is to ensure that patients can access treatment quickly, such a reduction is not acceptable for someone who has a mental health condition.

Moreover, increasing the extension to short-term detention certificates from five to 10 working days was, according to the Mental Welfare Commission, designed to tackle an issue that has since been resolved through administration improvements in the Mental Health Tribunal for Scotland. If that change were made, a person could be detained for six weeks before there was any judicial scrutiny, which is completely unacceptable.

There is also a range of privacy concerns to address—specifically, the provisions on named persons and advance statements. With regard to named persons, if the patient has not appointed a named person, a primary carer or nearest relative is automatically appointed. That might be problematic if the patient does not get on with the appointed named person, because that person will receive substantial information and have the right to participate in hearings. I welcome the minister’s indication that the issue will be revisited, and I look forward to seeing amendments at stage 2.

I think that advance statements are a good idea; indeed, their use and availability should be promoted to ensure that more people are aware of the option, so I ask the minister what the Scottish Government is doing to promote them. That said, I am, like SAMH, concerned about the requirement to share a full advance statement with the Mental Welfare Commission. After all, the statement will include highly personal information about the
patient’s mental health, so keeping copies of the full document raises serious privacy concerns. No matter how careful people are, breaches in personal information can occur and mistakes can happen and, given the stigma that already attaches to mental health issues, it would be devastating if advance statements were released in full. With that in mind, I urge the Scottish Government to consider SAMH’s suggestion that the commission’s register simply note that a person has made an advance statement, when it was last updated and where it is kept.

As we have heard, the bill in its current form raises numerous other issues. I sincerely hope that they will be addressed as it progresses through Parliament.

15:48

George Adam (Paisley) (SNP): Although I am no longer a member of the Health and Sport Committee, I have retained an interest in this ongoing issue. As Duncan McNeil pointed out, many of us will both professionally and privately know some of the one in four people in Scotland who will experience a mental health problem this year. In fact, given that we are talking about one in four people, I think that it is mathematically impossible for us not to interact with some of those individuals. That is why, in considering this mental health legislation, we must ensure that people with mental health disorders are able to access effective treatment quickly and easily.

When we politicians talk about mental health, we often talk about stigma and the need to make our communities aware of that, to ensure that we talk about the issue and to ensure that, as my colleague Bob Doris has pointed out, people see physical health and mental health in the same way. The fact is that we can be fit mentally as well as physically and, if we do not look at the issue in that way, the stigma that I have mentioned will continue.

What is it like dealing with mental health issues in Scotland in 2015? To my mind, one of the most important issues is the support mechanisms that are available to people. Today, I spoke to Stephen McLellan, the chief executive officer of Paisley-based Recovery Across Mental Health. He told me that many of his clients have difficulty with isolation and loneliness. They lose touch with family and friends and their support mechanism there. RAMH has to come in and try to replace that support. Stephen McLellan calls it social poverty. People end up at home sitting in the house. His exact words were quite brutal, but they explain the situation. He asked how we can get someone mentally healthy if their only contact with the outside world is “The Jeremy Kyle Show” on television, because they have isolated themselves from the world. That is quite a brutal way of putting it, but it is also quite powerful. We have to make sure that we get out to those people to ensure that they have social interaction, which is a basic human need if they are to get better.

RAMH in Paisley has offered that service for 25 years. Its purpose is to make sure that people with mental ill health are able to build independent, fulfilled lives. It says:

“The earlier we can provide the right services to people who need us, the more likely they are to recover quickly. We need to be able to respond to demand, grow and develop our services”.

Much of that is reflected in the bill and in today’s debate. RAMH has set out six ways that it can do that. It talks about providing immediate support in crisis situations; supporting people in their homes with individualised care; providing drop-in centres in their community; providing counselling to young people in their schools, which effectively is about getting over the idea of stigma; supporting carers, families and friends through education; and raising awareness and pointing out misconceptions about mental health. Those are all extremely important ways of dealing with this issue.

As I have said, the overarching aim of the bill is to ensure that people with mental health disorders are able to access effective treatment quickly and easily. It is welcome that the bill will provide an improved legislative system to help treat and care for people with mental health disorders, but it has to remove unnecessary procedures and make existing processes more effective and efficient for health professionals and, more important, for the patients themselves.

I take on board what many of the committee members have already said with regard to the central register of advance statements, which will improve the control that individuals have over how they wish to be treated or not treated should they become unwell and unable to make decisions for themselves. That issue was brought up by my colleague Bob Doris. Advance statements are documents in which mentally ill patients record how they want to be treated in the event of their losing the capacity to make their own decisions. We have to remember that we are talking about the individual and what we can do to enable them effectively to be part of society again.

The minister mentioned the £15 million that will be invested in mental health services over the next three years. That is welcome although, as other members have said, we have to make sure that it gets to the right people in the right places at the right time, so that we reach the individuals who really need support. When the then Minister for Public Health, Michael Matheson, announced the new funding, he said that it was to make sure that we could get there quickly to offer support when it
is needed. I have probably gone on about this at length, but I will close by saying that the World Health Organization says:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

We need to keep that in mind when we are discussing this issue. We need to remember the individual, who is the one dealing with it on a day-to-day basis.

15:53

Jim Hume (South Scotland) (LD): Lib Dems welcome the general principles of the bill but believe that it should adopt a patient-centred approach to keep within the Millan principles of minimising interference in people’s liberty and maximising the involvement of service users.

Of course there are some concerns. The Mental Welfare Commission for Scotland and the Scottish Association for Mental Health spoke in their evidence to the committee about administrative efficiency being given more weight than the rights of patients. We agree that red tape should be reduced and we need to keep in mind that the bill must have its focus on patients’ rights.

Professionals have concerns about the increasing role and duties that mental health officers must undertake while running on overstretched resources and reduced workforce numbers. MHOs are vital for patients and the NHS in general. The bill could make their job even more difficult.

Jamie Hepburn: I have heard what other members have said about the bill placing additional burdens on mental health officers. The Mental Welfare Commission has confirmed that, from November 2013 to November 2014, there have been only 11 occasions when reports have been required. That hardly seems an excessive burden.

Jim Hume: The minister must realise that, according to SAMH, two thirds of local authorities report a shortfall of MHO resources. There are only 57 MHO trainees, which is down from 108 in 2008, and one in three MHOs are aged 55 or older. There are concerns.

The Government has just cut funding for the mental health officer forum’s annual study and the “Mental Health Officer Newsletter”. The forum was identified by the Scottish Association of Social Workers as providing crucial MHO training and development and updates on tribunals. The Government says that the cut is to prioritise resources on implementing the bill over the next two years, but it is doing so at the expense of some of the same people who will be needed to implement the bill.

A concern that was echoed by many experts is the right of appeal of those kept in secure hospitals. The Government has an obligation to introduce regulations for the purposes of the provisions on that. We have not received the regulations. They are essential in creating a fair system of appeals for patients because, as the Government’s policy memorandum says,

“there is at present ... no provision for an appeal against levels of excessive security for patients other than patients detained within the state hospital”.

SAMH supports the point that appeals should include high, medium and low-secure hospitals, and appeals against low-secure accommodation are not necessarily appeals against detention or a move into the community. We support the principle of applying the least restrictive alternative measures to the care of the users.

The Government should perhaps reconsider its position on the reduction in the time for appeal against hospital transfer to a third of the original time—down from 12 weeks to 28 days—the extension of nurse holding powers by an extra hour, and the impact those two measures would have on the overall safeguarding of patients’ rights and treatment with respect and care. The RCN stated that there is no evidence to support such provision and that

“Our duty is to protect their human rights, not to make things easier for our workload.”—[Official Report, Health and Sport Committee, 7 October 2014; c 16.]

SAMH is concerned that the reduction in appeal time

“appears to be a substantial reduction in rights without proper justification”.

There are serious concerns not just from members of the Opposition parties but from people who are involved in the area day to day.

The Royal College of Psychiatrists and SAMH have concerns about the broad scope of access to patient information. Advance statements are critical in engaging the rights and wishes of the patients and must truly reflect patients’ rights. It is crucial that the use of advance statements is increased but, as experts such as SAMH have pointed out, the scope of people who have access to such personal information must be tightened.

The Lib Dems support the direction of the bill, at least at stage 1. It is a step towards better treatment in the new mental health strategy, but we must also keep in mind the wider reasons why progress must be made: the protection of patients’ rights.

As the bill progresses, I look to ministers for assurances on the concerns that I have raised, as
well as on the provisions for wider education, training in awareness of patients' rights, independent advocacy, and building structures for monitoring compliance. The Lib Dems will support the bill at this stage but will look for assurances as the bill goes through stages 2 and 3.

15:59  
Roderick Campbell (North East Fife) (SNP): I welcome the opportunity to participate in this stage 1 debate on the Mental Health (Scotland) Bill, although I am not a member of the Health and Sport Committee.

As the minister indicated, the aim of the bill is to ensure that people with a mental health disorder are able to access effective treatment quickly and easily. He also stated in his opening remarks that the bill does not deal with all aspects of mental health.

As Duncan McNeil indicated in his opening remarks, one in four people experiences a mental health problem in any given year. That gives us an indication of the importance of effective treatment.

The bill follows on from the 2003 act, of course, and from the McManus review. The very nature of mental health problems and their complexity create extremely difficult circumstances for patients and families, especially if the person is detained due to a compulsory treatment order. It is therefore right and proper that, before such orders are made or extended, adequate time is made available for representations and advice to be obtained.

Accordingly, the provision to increase from five to 10 working days the time by which a period of detention is automatically extended beyond the date at which short-term detention certificates would otherwise expire seems to be a sensible proposal. I hope that the risk of a longer period of pre-detention is more of a theoretical than practical issue and that Joe Morrow's comments can be accepted.

As a member of the Faculty of Advocates, I am happy to endorse the views of my namesake Kenneth Campbell QC, who is no relation, on the question of a blanket extension and his comments on the aim of involving the tribunal in procedure to ensure as far as possible that patients' convention rights are properly addressed. I note that, although the Law Society of Scotland was not in favour of a blanket ban, that was largely on the basis that it did not see any particular benefit to it.

I understand and agree with the committee's view on the need for clarity on the issue of how deducting the proposed extension of time impacts on the continuous period of detention.

On orders regarding levels of security, the fundamental Millan principle of least restriction ought to be a key feature of any mental health strategy, and it is clear that there need to be appropriate opportunities to appeal against orders that detain people in conditions of excessive security. Nevertheless, I agree with the minister's comments on low-security settings and note the committee's comments on that aspect.

On the time for appeal against transfers from one hospital to another or to the state hospital, the reduction in the appeal period from 12 weeks to 28 days is clearly substantial. I understand the difficulties that such a long period causes at the present time, as indicated in the policy memorandum, and I believe that getting an appropriate timescale for an appeal is not an easy task. I note that many stakeholders think that the change is too radical. It probably merits further consideration and certainly justification in respect of the extent of the reduction. However, I certainly agree with the view of others that any transfer that takes place should not impact on or prejudice a right to remain in the original hospital.

The importance of named persons must not be underestimated. The right of people in such vulnerable circumstances to choose someone to fulfil that role is fundamental, but that should be subject to an opt-out provision, as the Scottish Government already recognises. The question is how to make those opt-out provisions effective. Accordingly, I welcome the commitment to look further at those proposals.

I agree with the committee that the right to nominate a named person should be restricted to people over 16. People who are under 16 remain a particularly vulnerable section of the population and they certainly require protection, although I accept that there may well be many who are under 16 with the maturity to make that choice. I also accept that there are other areas of Scots law in which people who are under 16 can enter into certain arrangements on the basis of an acceptance of their maturity and understanding of the situation. Obviously, there are arguments about that.

Dr Jill Stavert of Edinburgh Napier University said that advance statements are

"an important form of supported decision making".—[Official Report, Health and Sport Committee, 18 November 2014; c 31.]

It appears that they are currently not used to quite the level that was originally expected and that there is a requirement for further increased awareness and training on their use. The committee seeks to promote them by considering placing a statutory duty on health boards and local authorities to do so. There is, of course, a difference between encouragement and
requirement. I would certainly favour a lighter touch.

On the care for children under the age of one, the right of a mother who is a patient to care for her child provided that she does not endanger it allows an essential level of normality for her and the child at a very important stage of development. To remove that maternal right would create an intolerable level of stress for a mother who is already suffering from a mental health problem. Therefore, I welcome the proposal to extend that right from the current provision, whereby it applies only to mothers who are suffering from post-natal depression, to other conditions.

I looked briefly at the provisions on cross-border transfers and absconding patients; I think that it is quite a complex area. All that I would say is that patients’ rights should be a priority in that context.

We have recently extended the victim notification provisions in relation to offenders who are to leave prison, and a victim notification scheme for victims of mentally disordered offenders certainly seems appropriate. It is right that victims be fully recognised but, as is the case with other offenders, the notification provisions ought to apply to the more serious situations. I am also slightly concerned about the definition of the “exceptional circumstances” that would justify notification applying to compulsion and restriction orders. Clarification of that would be helpful.

As regards independent advocacy, there is concern in many parts of Scotland about the operation of the existing provisions. I believe that requiring the Care Inspectorate to assess the existing provision by local authorities would be a sensible first step.

The Deputy Presiding Officer (John Scott): You must close, please.

Roderick Campbell: Any strategy must be rights based and, as the Mental Welfare Commission has suggested, must have a strong focus on prevention. As with physical health, prevention is certainly better than cure.

16:06

Rhoda Grant (Highlands and Islands) (Lab): As Richard Simpson indicated, I will concentrate on the named person provisions. I welcome the minister’s statement that he is keen to strike the right balance, but we do not have any detail on what he is considering. I hope that the comments that I make will be taken into account as he reassesses the bill.

As many members have said, a patient can appoint a named person to act on their behalf. If they do not have the capacity to do that and have not previously done so, their next of kin takes on that role. That person becomes the patient’s advocate, who will represent them at hearings. They will have a duty of care for the patient and they will even take decisions about their treatment. They will have full access to the patient’s records to allow them to carry out that role.

The Health and Sport Committee heard of huge swathes of paperwork dropping on people’s doormats, which they are supposed to read, understand and act on in the patient’s best interests. The job is extremely difficult. Sometimes, the arrival of that paperwork is the first indication that people receive that they have been given that role.

Some patients would prefer not to have a named person, because there is no one whom they would trust with such extremely personal information. The bill will allow them to declare that they do not wish to have a named person. That is a step in the right direction but, if someone has not nominated a named person and has not indicated that they do not wish to have a named person, the position will revert to the one that was previously in place, whereby their next of kin will automatically take on the role.

We heard evidence from patients and carers organisations that that should not be the case. When a person has not nominated a named person, one should not be appointed on their behalf. That is because it is reasonably common for the trigger for someone’s mental ill health to be something that happened as a result of close family problems. For example, if someone was abused by a parent, that same parent could have access to all the discussions about that abuse in the person’s case notes. If they were abused by another family member, their next of kin might learn of that for the first time when the state appointed them as a named person. That cannot be right; it destroys family relationships and breaches a patient’s confidentiality. It also means that a patient might not disclose information to professionals for fear that it will be divulged to family members in the future.

Carers also stated that they should be allowed to say whether they are willing to be a named person. The next of kin has that role foisted on them by the state, but they might not be able or prepared to take it on. They might live a long distance away or might have fallen totally out of contact with the patient. It might simply be that they are not fit or do not have the ability to carry out such a complex role.

Some people are keen not to be the default named person, and they want to be able to decline appointment as a named person by the patient. They need to be able to say whether they are willing to take on the role. I believe that there should be no default position and that someone
who is nominated to be the named person should have the ability to decline the role.

That brings us to the question of who can speak for the patient if they cannot speak for themselves. The patient needs access to advocacy and needs to have an advocate appointed to look after their interests.

Carers also have a role; they should be heard at a tribunal and have their input listened to by medical staff. They can also give an insight into a patient's health, wishes and the like. However, carers should not have any access to a patient's records, because that would be an abuse of privacy.

Carers have told me previously that they have received very little information and support from clinicians. Their loved one often comes home with no information about the best way to support them. Suicide risk is at its highest when someone is discharged from hospital. Carers need to know what they should be doing to support their loved ones and to ensure their wellbeing. If someone is discharged with a physical illness, it is normal for them to come home with a sheaf of leaflets that tell them what to do and what not to do, and that same information is available to carers. Surely we should have the same standard for people who are suffering from mental health issues.

Advance statements are a good thing, but they are too complex and should perhaps have more information about the patient when they are well— their tastes and what they like—to help with their recovery.

We should support the bill at stage 1 and improve it at stage 2. We need to ensure that care and treatment are patient centred and that we do all that we can to promote autonomy at a difficult time in patients' lives. If we do that, we will promote recovery.

16:11

Linda Fabiani (East Kilbride) (SNP): I state first and foremost that I am not on the Health and Sport Committee. I have a particular interest in mental health issues. Even though the bill is fairly small—it is an amending bill to the 2003 act—there is a lot in it. Different members this afternoon with far more knowledge than I have of the bill have spoken about many of its aspects.

I took the time to read the committee's report on the bill, which I found extremely useful. There was a lot of food for thought in there. I understand that the committee found the public response to the proposals generally positive. Although overall

"the Committee supports the general principles of the Bill and recommends to the Parliament that they be agreed to", it noted that the bill could be strengthened and/or amended in relation to "protecting the rights of patients"

while ensuring that they can access effective treatment quickly and easily.

It has been really interesting to hear everything that has been said. To be honest, I do not remember who made the point that, although some of the emphasis in the bill is on having more effective treatment more quickly and more easily, the emphasis might be more towards the service provider than the patient. If there is even a perception that that is the case, perhaps those sections should be looked at again, because central to everything that we are doing should be the patients and how we can make things better for them.

Yesterday, along with my Labour colleague John Pentland, I attended the spring members meeting of Lanarkshire Links in Strathclyde park. Lanarkshire Links is a very active service user and carer organisation with an involvement in mental health. We had representatives from the health board and from both Lanarkshire councils, as well as from the Mental Welfare Commission for Scotland.

The meeting was primarily to talk about health and social care integration, which is starting as a shadow exercise very soon and moving further next year. One thing that came out strongly at the meeting was that people feel that there is a great deal of difference between consultation and participation. Although it could be said that people were consulted, they often felt as though they had not been able to participate.

One thing that is particular to mental health issues is the right and the need for people who are affected and who are using services to be able to participate in the formation of those services. Although there were a great many consultees, I would like an assurance from the minister that there was real participation in considering how we move forward.

From the committee report, from speaking to people and from what colleagues who have more knowledge than I do of the bill have said today, it has come through strongly to me that the right of access to advocacy is not as strong as it could be. The system certainly has not met the intention of the 2003 act. The bill is an opportunity to make the process much more effective, and I would like to think that we will take that opportunity. Advocacy is an issue generally, and it covers issues that are way beyond the bill's scope but, in relation to people's treatment and the named person issues that arise from the bill, independent and trustworthy advocacy is extremely important. Assurances on that would be useful.
I do not have much time to go into my next point, but I was struck by the section in the committee’s report that starts at paragraph 213 on page 31 about a review of legislation for those with learning disabilities and autistic spectrum disorders. It is time to look at that issue much more closely and in much more depth. I certainly do not have sufficient background knowledge and I have not been able to do enough learning of late to have definitive opinions on the issue, but the concerns that have been expressed in the committee and the acknowledgement that the minister gave to the committee about the need for on-going dialogue suggest that we have to take the issue seriously.

I note that the committee noted that no equality impact assessment was done to accompany the bill. Like the committee, I would appreciate clarification from the Government as to why that was not produced.

16:17

**Malcolm Chisholm (Edinburgh Northern and Leith) (Lab):** I am pleased to speak on the bill, which is for the most part a series of amendments to the Mental Health (Care and Treatment) (Scotland) Act 2003, which was passed exactly 12 years ago to the month, at the very end of the first four-year session of the Scottish Parliament. It was certainly the longest bill of that session and it is generally recognised as being one of the most significant and groundbreaking. It set up the then new Mental Health Tribunal, strengthened the Mental Welfare Commission, created a new community treatment order, established the right to independent advocacy and introduced measures on named persons, advance statements and a great deal more.

Crucially, the 2003 act had novel provisions to ensure the protection of mentally ill people. Everything was governed by a set of principles, including the principle of “the least restrictive manner and environment compatible with the delivery of safe and effective care”.

That leads me to my first point, which is about sections 11 and 12 of the bill, which are to do with appeals against the level of security. The 2003 act is the only act of this Parliament that I can think of that has ended up in the Supreme Court, although there may be another example. If there is somebody whom we need to blame for that—although I do not think that “blame” is the right word—it is the two Governments that did not implement the regulations that Mary Scanlon demanded in an amendment in March 2003, which said that regulations on the issue had to be laid by 2006. However, those regulations were never laid by my Government or by the Government that took over in 2007.

**Jamie Hepburn:** Does Malcolm Chisholm accept that the 2003 act does not reflect reality now, so it was not possible to introduce the regulations, which is why we need to make the change to the 2003 act that is proposed in the bill?

**Malcolm Chisholm:** I do not agree with that. The fact is that the court judgment is interesting.

Another interesting thing about the court judgment is that the person who brought the case was under low security, but the bill says that people can appeal only if they are under medium security. The Law Society of Scotland says that that is “restrictive and discriminatory”, and SAMH and many other organisations agree. It is clear in the 2003 act that that is a right for patients who are detained in hospitals other than the state hospital. There is also a right for people who are in the state hospital. There is no mention of medium-secure facilities, and intention is important. I also note that one of the conclusions in the Mental Welfare Commission’s response to the bill consultation was that people in low-secure settings should also have the right to appeal. I hope that the Government will amend the provision on that at stage 2 or 3. I also hope that the Government will, crucially, tell us when regulations will be introduced because we do not want to wait the 10 years that we waited for the regulations from the previous act.

The concerns about changes to timescale have been referred to by many members, so I will not spend much time on those except to say that all four of them are well described in the Mental Welfare Commission’s briefing for the debate. Ministers and MSPs should always pay very close attention to the Mental Welfare Commission for Scotland. It is concerned about all the changes to timescales that have been mentioned: the appeal against an order to transfer to the state hospital, which is being reduced from 12 weeks to 28 days; an extension of short-term detention pending the determination of a CTO application, which is going up from five days to 10; the current power of nurses to detain, which is going up from two hours to three hours against the wishes of the RCN and other nurses; and the extension from 14 days to 28 days in hospital for a mental health assessment in criminal cases. The MWC is concerned about all those and the Government should pay heed.

The Government should also always pay heed to SAMH, which has raised concerns about timescales, the level of security and the named person. The McManus review recommended that the default named person should be abolished, so let us abolish it.

SAMH is also concerned about the MWC holding advance statements that contain great detail about individuals’ circumstances. SAMH believes that that is breach of privacy and we
should follow that advice. Everyone is saying that we should do more to promote advance statements so I support placing a duty on local authorities and the NHS to do that.

We have not heard too much about the victim notification scheme. It is better now than it was in the consultation document, but it would be helpful to have a clear statement on minor offences that are committed by individuals who have a mental disorder not being included in the victim notification. In other words, there are levels of offence that would not be in the notification scheme if the offender has a mental disorder. There needs to be equality between the levels of offence that we are talking about. People are concerned about section 48, under which the Government could introduce regulations to include people who are on a compulsion order. That is still a concern for many people.

I have one minute left to talk about what has been omitted from the bill. We need more on the local authority obligation in sections 25 and 27, but most of all the McManus report highlighted a number of issues around access to independent advocacy, including the appropriate level of provision, adherence to the Scottish Independent Advocacy Alliance good practice guidance, collective advocacy and advocacy for carers. There is nothing whatsoever in the bill on those issues. Section 259 of the 2003 act gave every person with a mental disability the right to access independent advocacy. Many areas apply that right only to people who are subject to compulsory measures, which is a misreading of the 2003 act. We must strengthen the duty of the NHS and local authorities to ensure the availability of independent advocacy.

16:23

Sandra White (Glasgow Kelvin) (SNP): I am not a member of the Health and Sport Committee but I have been following the bill closely. As other members have said, we just have to look at our constituents or families; we all know someone who suffers from mental ill health. If there is anything that we can do to improve their lives and that of their carers and others, it is incumbent on Parliament to do so. That is why I say that this is a very important bill.

The bill seeks to improve the Mental Health (Care and Treatment) (Scotland) Act 2003 and to implement the recommendations of the McManus review, which was set up in 2008. I note that Malcolm Chisholm picked up on that point; I will come back to it later. The bill will improve the operation and efficiency of the existing legislation, both for users and for practitioners.

Mental illness is one of the greatest challenges that we face in Scotland; indeed, depression is the leading chronic condition in Europe, and 400 million people suffer from it globally. Women are more likely to be affected than men. I thank Scottish Governments present and past for recognising the real challenges that the illness presents to sufferers and to the agencies that work with them. I am sure that members share those sentiments.

Many members have mentioned issues in their constituencies, including instances of suicide and of mental suffering. The bill will be a very important piece of legislation.

Duncan McNeil mentioned mental health officers. Concerns about the number and retention of officers in Glasgow have been mentioned before. I understand that there will be some crossover with the Adults with Incapacity (Scotland) Act 2000, which might cause difficulties. There is also some crossover with the Mental Health (Care and Treatment) (Scotland) Act 2003, as was mentioned by Malcolm Chisholm. The minister will be aware that there is provision under both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 for the appointment of mental health officers in cases of guardianship. Under those provisions, an application may be made, by those who are responsible for mental health or adult protection, to a local authority social work department for the appointment of a mental health officer.

Constituents have recently raised with me concerns that the process is leading to delay in the appointment of mental health officers. Given that the overarching aim of the Mental Health (Scotland) Bill is to ensure that people with mental health disorders are able to access effective treatment quickly and easily, I wonder whether the minister could in summing up say whether that will be addressed under the eventual legislation or falls outwith the bill’s remit. That relates to Malcolm Chisholm’s point about whether the 2003 act is being delivered appropriately. Individual MSPs, in particular members of the Health and Sport Committee, might wish to consider that. I would be grateful if we could consider and get clarification on whether there is a crossover between the 2003 act and the Adults with Incapacity (Scotland) Act 2000.

I welcome the minister’s recognition of the difficulties that local authorities have regarding mental health officers and his assurances that the bill will not result in an increase in the number of reports that they will be required to produce.

I look forward to the bill making progress through Parliament, and I look forward to
continuing to take part in the scrutiny of various aspects of the bill.

16:28

Alison Johnstone (Lothian) (Green): I start by applauding the work of our front-line medical services in this area. They do a fantastic job with patients, who can present with some of the most complex needs in the NHS. Equally important are the community organisations that improve people’s mental health with support services, social inclusion projects and other preventative actions, often under testing circumstances and with limited resources. Thanks to the hard work of campaigners, more people now feel able to talk about mental health but, as colleagues have said, there is still a long way to go to bring mental ill health in line with physical ill health.

As we know, a staggering one in four adults will be affected by some form of mental ill health in their lifetime, which is similar to the number of people affected by cardiovascular complaints.

The majority of people suffering from mental ill health do not require hospital treatment. General practitioners and other mental health professionals are often people’s main contact with formal help, and they sometimes provide the only place where people feel they can open up, for fear of letting down family members or not wanting to worry loved ones—or perhaps just feeling afraid or ashamed. It is important to ensure that GPs have the support that they need.

There is a need to adopt and find more creative and innovative approaches to mental health care. For example, engagement in the arts is extremely beneficial to service users. It reduces medication consumption and hospital visits. Arts engagement not only helps patients but has been found to improve wellbeing among staff and to increase staff retention.

GPs are now prescribing exercise as an alternative or complementary treatment to medicine. A high-quality built environment and access to quality green space are well known to increase people’s wellbeing and improve their mental health. Education about mental health and happiness, and how they contribute to general wellbeing, is also important, especially for young people.

People in poverty, and individuals and communities who may feel marginalised, for example refugees and asylum seekers, have disproportionately higher levels of mental illness in Scotland. That health inequality needs to be acknowledged and confronted.

Hospital treatment is still needed for the most vulnerable patients. We know that the target waiting time for those with mental health issues is 18 weeks, although 4 per cent wait more than 35 weeks for treatment. Differences in targets for different illnesses and conditions should be based on sound medical reasons, and mental ill health should be treated on a par with physical ill health—the minister has pointed out that that is what the legislation requires.

I broadly welcome the new Mental Health (Scotland) Bill and the improvements that it will make to the treatment of those suffering from mental ill health. The Mental Health (Care and Treatment) (Scotland) Act 2003 was considered to be comprehensive and to provide better safeguards for patients in comparison to other parts of the United Kingdom.

In its briefing, SAMH indicates that appointing a patient’s nearest relative as a named person may, in some cases, be inappropriate. I am pleased that the minister has promised to revisit that.

The briefing from the Royal College of Psychiatrists highlights the lack of secure facilities for women and young people in Scotland. The problem is so severe that it results in young people being admitted to Carstairs state hospital. The solution that is suggested by the RCP would be to designate part of one of the secure schools—this is for young people—so that it has in-patient status, preventing young people from being admitted to Carstairs.

Currently, female patients who require high-security treatment are being transferred to Rampton hospital in the east midlands. That could greatly hamper a patient’s recovery, as they are far removed from friends and family and from an environment and community that they know. They are also being treated outwith the jurisdiction of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Concern has also been raised regarding the length of time it may take to transfer potentially acutely unwell prisoners to a psychiatric hospital for treatment.

Finally, Inclusion Scotland has highlighted the concern that people with learning difficulties and/or autistic spectrum disorders could be subject to a compulsory treatment order, whether they are suffering from mental ill health or not. It is vital that we get the balance right. Inclusion Scotland suggests that an alternative system is needed.

I broadly welcome the bill, but I encourage the minister to listen to the concerns and constructive suggestions from those with great experience.

We know that mental illness and physical illness are interlinked. People with depression suffer from tiredness and lethargy and an unwillingness to eat and their immune systems can be more
susceptible to other conditions. Mental health issues complicate health issues associated with old age, such as cardiovascular disease. Many eating disorders, which are certainly physically debilitating in many cases, have roots in mental ill health. That is why mental health needs to be treated with the same care as physical health.

The Deputy Presiding Officer: We move to closing speeches.

16:33

Mary Scanlon (Highlands and Islands) (Con): I commend the Health and Sport Committee for its scrutiny of the bill under the very able leadership of Duncan McNeil. Having listened to all the speeches today, I have to say that we may have leading mental health legislation in Scotland, but I am not convinced that we have leading mental health implementation. That is the issue that we are considering today.

Unfortunately, I cannot commend the Scottish Government for listening to and taking on board the recommendations of the Health and Sport Committee, given that we are still waiting for the response to our report. With no response after six weeks, today's stage 1 debate can look at only one side of the coin. That is unfortunate.

I seek your guidance, Presiding Officer, because normally at the end of the stage 1 debate, we go off, go through our speeches and hand in our amendments. I do not know when we should hand in our amendments because this is quite an unusual situation.

I will start with advocacy. In 2003, we spent quite a bit of time on advocacy, considering the right of access to advocacy and the right to independent advocacy. Again, we have a right to something, but if it does not happen, who do we go to? Nobody knows. That is my point about implementation—there is no sense in someone having a right unless there is something that they can do if it does not happen.

In considering the bill that became the 2003 act, I and many other members raised the issue of workforce planning. At that time, there was a need for more psychiatrists, psychologists, psychiatric nurses, social workers, care workers, mental health officers and so on, and today we face exactly the same problem. We have a workforce that is not sufficient to deal with existing demands, let alone with the new demands that the bill places on it, as the committee points out at paragraph 73 of its report.

It is difficult when the Government's own financial memorandum states that between 20 and 40 hearing reports will be required in a year, COSLA comes up with a figure of 563, and then the minister comes to committee with an apology and a figure of 15. We have gone from 30 to 563 to 15, which is quite a variation.

Jamie Hepburn: Will the member give way?

Mary Scanlon: Not at the moment.

That experience alone justifies the need to be clear and unambiguous with the calculations for additional work, because that is the basis on which appropriate staff can and should be recruited, trained and retained for the future.

Jamie Hepburn: I recognise entirely that we must be clear in our calculations. I was very frank when I went to the committee. We made a mistake, and I flagged it up. As I pointed out earlier when I intervened on Jim Hume, the Mental Welfare Commission has said that the additional responsibility would have resulted in about 11 reports during 2013-14.

Mary Scanlon: Yes, but my point is that the policy memorandum in 2003 under a Labour-Liberal Democrat Administration stated that there were 29 vacancies for psychiatrists and that an additional 28 psychiatrists were needed in order to implement the 2003 act. Where is the assessment of the exact need for staff that will result from this bill, let alone a plan for addressing the current staff shortages?

Other members have mentioned the principle of the least restrictive alternative, which was a core principle of the 2003 act, as Malcolm Chisholm, who was the relevant minister at that time, and Richard Simpson both know. My understanding, during the passage of that bill, was that the principle applied to all restrictions on patients with mental health issues, not just those who were being held under excessive security.

We discussed the state hospital at Carstairs, and I lodged an amendment that secured action in that regard, but the state hospital had 29 blocked beds at the time, and there was a huge need for more medium-secure units. I succeeded in gaining the support of all parties in the Parliament for my amendment on providing more medium-secure units.

I wanted to ensure that mental health patients in a high-security setting could be discharged and placed under a level of security that was appropriate to their needs, on the understanding that a patient can endure excessive security in the state hospital, in a medium-secure unit, in a low-secure unit or in any psychiatric unit at each and every level. Again, the Government has not helped matters by failing to bring forward any definition of a qualifying patient and a qualifying hospital, which has resulted in only patients who are detained in the state hospital having the right to appeal. Malcolm Chisholm mentioned the Supreme Court
case in 2012. The Scottish Government must come forward with a proper definition to allow fairness and rights of appeal for all mental health patients, whatever the level of excessive security under which they are being held.

Duncan McNeil mentioned the section of the bill that relates to nurse holding powers. Like Linda Fabiani, I read the Health and Sport Committee’s report, which highlights the comment from the Royal College of Nursing in evidence that

“We do not even know where the proposal came from; it certainly did not come from nursing.” — [Official Report, Health and Sport Committee, 7 October 2014; c 17.]

Nurses will be getting more holding powers, but the RCN does not even know where that proposal came from.

On time for appeal, referral or disposal, the committee asked the Government for a clear justification that the proposals might benefit the patient. It is bad enough that the Government does not listen to nurses—I had hoped that it might just listen to patients, but it obviously does not.

Dr Simpson and many other members mentioned advance statements, which we spent a lot of time discussing in 2003. Rather than looking at who holds advance statements or what should be in them, why does the Government not just ask whether patients have confidence that statements will be adhered to and whether they think that it is worth while writing an advance statement, or whether they think that it will just be overturned at the first whim? The patients I have talked to do not have confidence in advance statements.

The committee is waiting for the Government to respond to its suggestion that both mothers and fathers be allowed to look after young children in hospital when the mother is being treated for post-natal depression. I pay tribute to a Labour member who is not here today, Bill Butler, because it was he who secured provisions for mothers and babies to be held in hospital together when the mother is being treated for post-natal depression. I hope that the Government will go that step further.

There is still no response on the use of force, restraint or covert medication. I commend Hunter Watson on his campaign against covert medication, which is reasonably based on experience in his own family.

The Conservatives support the general principles of the bill. I am sorry that we did not get the Government’s response today, but we recognise that there is much more work to do.

**The Deputy Presiding Officer:** Thank you for raising those points. I draw to the chamber’s attention that, under rule 9.7.5, a bill may be amended at stage 2 and notice of amendment may be given by any member after the completion of stage 1, if the bill completes stage 1 today. Also, the Government is not obliged to respond to the stage 1 report before the stage 1 debate, but it must respond within two months. I hope that that is helpful.

16:41

**Dr Simpson:** Thank you for your clarification, Presiding Officer. I still think that the rules need to be examined. However, I want to deal with things in reverse order and take up the issue of homicides, which is not in the bill. I have been in discussions with a number of parties, since the committee heard evidence from John Crichton and others, about possible amendments covering the investigation and reporting of homicides and serious assaults perpetrated by people suffering from a mental disorder. I appreciate that the UK confidential inquiry into homicides and suicides is of some help and is relevant, but the intention of the amendments that I will lodge—at least for discussion—is to put in primary legislation clarity, consistency and accountability in relation to homicides and serious assaults, including attempted murder, involving someone with a mental illness who is already known to the services.

At present, the system is highly fragmented. Currently, out of 137 homicides committed by those with mental illness in the past 10 years, only two have been subject to a published report by the Mental Welfare Commission. Based on a freedom of information inquiry by Julian Hendy of the hundred families campaign, few of those incidents appear to have been subject to adverse incident reviews by boards. That should be compared to England where, out of 576 homicides, there have been 321 reviews, and it is suggested that as many as 25 or even 35 per cent of homicides might have been prevented by different actions. We need to address that area in the bill, and I will return to it.

The debate has been helpful and useful. We are all agreed that the bill is relatively modest, but the issues are becoming clearer. As Bob Doris said, the committee has received a broad spectrum of evidence, for which we are grateful. As he also said, the committee was acutely aware of the need to minimise detention or restriction; that is important. As Jim Hume and George Adam reminded us, safeguarding the Millan principles is at the core of Parliament’s wishes. As Linda Fabiani said, we need to see people in a holistic way. She also emphasised that even giving the impression of sacrificing human rights on the altar of administrative efficiency or the convenience of the provider might be damaging, and that was an important point.
Malcolm Chisholm, who was the minister in 2003, was clear on the concerns about increased detention and the reduction in some times for appeals. All reductions in rights must be considered extremely carefully. The issue that Inclusion Scotland mentioned, and to which Alison Johnstone referred, around learning disability and autism needs to be examined in the context of a review by an expert group, which I hope the minister will announce within a relatively short period of time. There are concerns out there about that area, particularly in relation to learning disability and autism but also in relation to detention of people with other conditions. Is the 2003 act up to date in terms of our thinking now? I do not think that anyone argues with the principles of the 1999 Millan report, which are still relevant today, but there are concerns that some of the issues are still not being addressed.

Alison Johnstone mentioned asylum seekers, refugees and young people, and I think that that is an important area. A number of members including Nanette Milne mentioned sections 25 to 31 of the 2003 act, on local authority functions, and the need to revisit that area. We need more rigorous inspection by the Care Inspectorate and Healthcare Improvement Scotland to ensure that the issues in those sections are being properly covered.

An area that we have debated in considerable detail today is the extension of the number of days for a tribunal hearing. I still feel that the blanket extension has to be properly justified, as it has not yet been justified. We need to consider that carefully. If the extension is in the interests of patients, we must give patients rights in relation to it rather than making it a blanket extension. We might risk creating problems in relation to the ECHR if a seven-week deadline was to become general and not the exception.

Bob Doris: Does the member take on board the point that I made in my speech that there is already an extension protocol and that, if it is not used in a blanket way, extending it by a further five working days would not lead to blanket use? We should get more data on where it is currently used in order to get more information on that.

Dr Simpson: That is a helpful and valuable point, and I welcome Bob Doris’s intervention.

A number of members spoke about mental health officers and the problems of that workforce, which are a concern. The fact that 52 per cent of patients do not have social circumstances reports when short-term detention certificates are being made is a problem, and the Mental Welfare Commission expressed concern about that.

I accept the Government’s frank admission that the original bits under sections 2 and 41 were not clear, but nevertheless we need to address workforce planning. There are concerns about the fall in the number of people who are undergoing training.

Mary Scanlon made the point about the nurse’s holding power well and I do not need to add to it. I think that those provisions need to be stopped. I do not think that we need them, and I think they should be dropped from the bill.

A number of members mentioned appeals against transfer. Again, I do not think that we have had clear justification for the provisions on that. Margaret McDougall emphasised that we need to be sure that they will not be damaging to patients’ rights. We will need to examine that closely at stage 2, and I look forward to greater justification from the Government of its decision.

Named persons were discussed extensively by Rhoda Grant, Bob Doris and Margaret Mc Dougall among others. Rhoda Grant reminded us of the complex duties that people take on. Often, they are surprised to find out exactly what will be involved. The question of a default person being appointed really needs to be looked at again. At the very least, the person should be able to decline, but if they do that, it will affect their relationship with their relative, so we should look at default very carefully. Rhoda Grant also suggested that the role of carers needs to be clarified, and I agree.

We looked briefly at advance statements. Nanette Milne talked about that, as did Margaret Mc Dougall, Jim Hume and Bob Doris. The issues are clear. How can we get good signposting to a secure register and ensure that individuals have confidence that it will be secure? How do we ensure that it will be implemented and that, if there is a failure of implementation, there is clear reporting to the Mental Welfare Commission? How can it do more to support advance statements being effective? We debated that area in 2003 and we regarded it as being of considerable importance in protecting people’s rights and wishes, so we need to look at it closely.

Appeals against detention in various levels of security were discussed at length. Do I have another 20 seconds, Presiding Officer?

The Deputy Presiding Officer: Yes.

Dr Simpson: We need to look at the low-secure units as well as the medium-secure ones. We need to get that right, and we need to look at allowing transfer back and appeals against that. We also need to look at low-secure units in various settings.

I finish with a comment on advocacy, which Linda Fabiani mentioned. The current right is not extended to everyone. The time has come for a
right to advocacy to be available to anyone with a mental illness problem, and that should be enshrined in the bill.

16:49

Jamie Hepburn: I am grateful to members across the chamber for their contributions to what has been, as Richard Simpson said—and I agree—a very useful debate. It is encouraging to hear the passion and commitment from so many members who want to ensure that our mental health legislation works as well as possible for service users and those who support them and provide care in the system.

I will reflect on some of the issues raised. I am afraid that it will be only some, as the debate has been wide ranging. However, I will endeavour to ensure that the issues to which I do not respond are picked up in the Scottish Government’s response to the Health and Sport Committee’s report.

Having said that, I very much recognise the perspective of many that it would have been better for the Scottish Government to have responded in advance of the debate. The Presiding Officer set out the standing orders on such matters and I observe that Parliament’s standing orders are not my sole responsibility; they are our collective responsibility. I will endeavour to get that response finalised as quickly as possible, and it will include issues that have been raised in the debate. As I go forward in my ministerial role, I will take on board the perspective that has been expressed in dealing with future legislation.

Duncan McNeil raised the issue of monitoring the increase from five to 10 days in the extension period for short-term detention certificates, until an application is determined. We are working closely with the tribunal to get further information and discuss that. Any changes under the bill will be accompanied by revised guidance, and the code of practice will reflect the Government’s policy that the process should be in line with the principle of least restriction and should operate in the service user’s interests.

Dr Simpson offered suggestions about how he might seek to amend the bill at stage 2. Should he wish to do so, I would be happy to meet him to discuss that and any other area. I will happily consider what he suggests.

The Government is developing regulations on appeals against excessive security and is committed to providing the committee with draft regulations during the passage of the bill, so that it can adequately assess the proposals. We want to provide a right of appeal for patients in medium-secure settings. Addressing that would fully deliver the Millan committee’s recommendation that

“Patients should have a right of appeal to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security.”

I appreciate that some stakeholders have concerns about the area more generally, and it is important that we get the balance right on what is a complex matter. I will be happy to engage with stakeholders and members on that.

Bob Doris suggested that we look at the amount of time that a person might have to wait for a tribunal hearing as a way of dealing with matters. I appreciate that innovative suggestion, which we would be happy to look at.

Members should be assured that we are looking carefully at the matter, because we have to. Jim Hume and others made the point that there has been a Supreme Court ruling and that we must put in place provisions for appeals—it is a necessity that we do so. However, I observe that the Supreme Court was not specific about what the provisions should be. Malcolm Chisholm and others made the point that the patient who brought forward the challenge was held in a low-security setting, but the Supreme Court did not base the judgment on the appellant’s level of secure accommodation. We must get arrangements in place and I will be happy to look at members’ suggestions.

Mary Scanlon: Does the minister agree that, even though a patient can be held in the state hospital under a low level of security, that can still be considered excessive?

Jamie Hepburn: We need to consider the issue carefully, because we need to determine who considers the level to be excessive—the patient or an outside person. I make the general point that we are looking carefully at the issue and, should members care to make suggestions, as Bob Doris has done, we will consider them carefully.

I emphasise that the nurse’s holding power provision is not about administrative efficiency or making things easier; it is about providing clarity for service users about the maximum time for which they can be held and the purpose of their detention. I am not particularly clear that the power is new, as has been suggested. Under the bill, as under existing legislation, no patient can be held for any longer than three hours.

I am not convinced that it is as clear as it could be under the current legislation that a patient could be held for three hours. The standard is two hours, and the period can be extended to three, whereas the arrangement that we are discussing would be clearer from the outset. Of course, the power will be accompanied by clear guidance in the code of practice, which will make it clear that the power should be used in line with the principle of least restriction and with guidance on reporting to the
Mental Welfare Commission. The provision will make it clear that the power is for detention of up to three hours, which can be for the purpose of a medical examination.

I recognise the concerns about the default position on named persons and the lack of appetite there seems to be for that. I am currently minded to propose an amendment to remove the provision. We want to move forward in a way that does not disadvantage the most vulnerable service users, and we are exploring how to strike the right balance.

I believe that the provisions on the registration of advance statements strengthen the position of the statements by ensuring that they are held in medical records. Scottish Government officials are working with the Mental Welfare Commission and other stakeholders to ensure that concerns about privacy and confidentiality will be met. Advance statements will be held in line with the strict controls on other patient information that the commission holds. It is important to emphasise that the commission already keeps personal data, so the process is not a new one for it. The commission has strict data protection protocols to ensure that records are accessed lawfully and appropriately.

Richard Simpson made the point that the statements should be available 24/7; Nanette Milne talked of having quick access to them; and George Adam said that the change is an important one that will make the system more effective. I think that we can strike the right balance between the need for privacy and the requirement for quick, 24/7 access to the statements.

I very much agree with the committee’s belief that more can be done to promote advance statements. I want to ensure that that is done in the most meaningful way and in a way that has the most impact. I am not convinced that using legislation would necessarily achieve that. Instead, I am considering what can be done outwith legislation, perhaps by using specific and targeted guidance. However, if constructive amendments are lodged, I will of course actively consider them.

On advocacy and awareness of patients’ rights, Mary Scanlon made the reasonable point that a person having rights does not have much effect if the person does not know that they have those rights. I very much agree with that sentiment. As part of implementing the bill, we will update our guidance for users. The Government will work closely with stakeholders on that and will take their views on how to promote awareness of rights through the work that we do.

There is a strong duty in the 2003 act on the right to advocacy. I am a strong believer in advocacy, which greatly empowers people. I have not called for greater monitoring and we are discussing with relevant organisations how best to do that. I am not necessarily convinced that legislation is required to do that. However, as I have said before, if members want to lodge relevant amendments, I will happily consider them.

As I feared, time has not allowed me to cover every issue. I will close by saying that I recognise that the bill, as presented, might not be the final article. Bob Doris mentioned that he looks forward to engaging constructively on amendments at stage 2. I welcome that approach, which I will take and which I hope that we will all take. It is the approach that professionals, patients and the public expect us to take to ensure that we have the most effective system to support those who have an identified mental health disorder. I look forward to continuing that work at stage 2.
Mental Health (Scotland) Bill:  
Financial Resolution

The Deputy Presiding Officer (John Scott): The next item of business is consideration of motion S4M-12285, in the name of John Swinney, on the Mental Health (Scotland) Bill financial resolution.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Mental Health (Scotland) Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3(b) of the Parliament’s Standing Orders arising in consequence of the Act.—[John Swinney.]

The Deputy Presiding Officer: The question on the motion will be put at decision time.
The Deputy Presiding Officer: The next question is, that motion S4M-12624, in the name of Jamie Hepburn, on the Mental Health (Scotland) Bill, be agreed to.

Motion agreed to,

That the Parliament agrees to the general principles of the Mental Health (Scotland) Bill.
The Deputy Presiding Officer: The next question is, that motion S4M-12285, in the name of John Swinney, on the financial resolution to the Mental Health (Scotland) Bill, be agreed to.

Motion agreed to,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Mental Health (Scotland) Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3(b) of the Parliament's Standing Orders arising in consequence of the Act.
27th March 2015

Dear Duncan,

I very much welcome the Committee's Stage 1 Report and the Committee's support for the general principles of the Bill. The Government has considered carefully the points raised in the report and by members at the Stage 1 Debate in producing the response in the attached annex.

I note that the report refers, in its concluding remarks, to the Committee's interests in "ensuring the Bill delivers on protecting the rights of patients whilst improving administrative efficiency". I hope that this response addresses this concern. I am very keen to reiterate that protecting the rights of patients is central to the intentions of the Bill. Where, for example, we have made changes to timescales, we have done so with the aim of making the system work better for service users and any changes made will be accompanied by guidance reasserting the principle of least restriction.

JAMIE HEPBURN
MENTAL HEALTH (SCOTLAND) BILL: SCOTTISH GOVERNMENT RESPONSE TO STAGE 1 REPORT

The Scottish Government welcomes the Committee’s support for the general principles of the Bill. The Government hopes that the Committee will find this response helpful ahead of Stage 2.

Measures until application determined

Extract from Committee report:

46. The Committee welcomes the reduction, since the McManus report, in the number of cases requiring more than one hearing, and the Committee recognises the key role the Tribunal has played in improving its performance in this regard.

47. The Committee recognises that it is important that measures are taken to ensure tribunals do not exacerbate the circumstances and the stress for the service user.

48. The Committee notes the response from the Minister to concerns raised regarding whether this provision would be compliant with Article 5 of the ECHR. To ensure this is the case the Committee believes that it is important that the Scottish Government assesses the implementation of this provision closely.

49. The Committee recommends that, in response to this report, the Scottish Government provides a detailed plan of the estimates in relation to the reduction in multiple hearings which could be expected as a result of these changes, and what the average number of days detained is likely to be following its introduction.

50. The Committee recommends that this provision be supported by a clear monitoring regime which records the reasons for delayed, rearranged and repeat tribunals and the length of pre-hearing detention for service users. The aim in gathering this information is to identify whether there are particular types of case or specific issues causing the delay. This approach would seek to ensure that the policy aim of improving the experience for those in short term detention was delivered and it did not result in an overall longer period of pre-hearing detention.

51. The Committee asks the Scottish Government to respond to the concerns raised regarding how deducting the proposed extension time from the continuous period of detention would be calculated. The Committee believes that it would be beneficial if further clarification was provided regarding how this provision would operate in conjunction with certain detention orders.

Scottish Government response:

The Government has carefully considered the views of the Committee and stakeholders on this issue. It recognises the concerns about the extension applying in principle to all cases, and the views of many stakeholders that the problem of repeat hearings has much reduced since the time of the McManus report. However, it also recognises the views of the Mental Health Tribunal that there could be benefits from allowing service users more time to prepare.
The Government is exploring whether an amendment could be made which would mean the extension does not apply automatically in all cases and are continuing consultation with stakeholders to determine if this would be workable in practice. The Government may also consider an amendment at Stage 2 which will remove this provision.

We will work with the Tribunal to make appropriate arrangements for monitoring its implementation, if the provision is retained.

In response to the point raised at paragraph 51, we have noted the concerns raised around calculating the new period of the CTO, and are continuing to discuss with stakeholders to ascertain whether any amendment to the provision is required, or if the effect of the provision would more usefully be explained in guidance, such as the Code of Practice.

**New duties for Mental Health Officers**

**Extract from Committee report:**

71. The Committee notes that an error has been made in the drafting of the Bill’s accompanying documents, resulting in a discrepancy between what is presented in the Policy Memorandum and the FM. This has caused some confusion and concern from interested parties, including COSLA. The Committee welcomes the clarification provided by the Minister on the circumstances in which an MHO report would be required and the assurance that provisions in the Bill would not result in a large increase in the number and costs of reports needed to be produced by MHOs.

72. Whilst the Committee notes the clarification provided by the Minister that there would only be a minimal increase in the number of reports required to be produced by MHOs, concerns remain regarding the capacity of the MHO workforce to deliver further duties under the Bill’s proposals. MHOs are already under pressure due to an increased workload, an ageing workforce and difficulties in attracting new social workers into the role.

73. The Committee seeks further assurances from the Scottish Government that the funding to support MHOs is adequate to ensure that the provisions relating to MHO duties in the Bill could be delivered effectively. The Committee asks the Scottish Government to respond to requests for a strategic review of MHO provision to improve the recruitment, training and retention of MHOs.

**Scottish Government response:**

The Scottish Government values the essential work done by mental health officers and notes the concerns raised about workforce capacity. The Bill introduces some new duties for MHOs, but our assessment is that these will have a limited impact on MHOs. At the same time the Bill removes certain duties from MHOs with regard to named persons (making a record of steps taken to establish that a patient does not have a named person and the ability to apply to the Tribunal for the appointment of a named person). As a result, the Scottish Government is of the view the provisions relating to MHO duties in the Bill can be delivered effectively.
The Scottish Government is aware, however, of broader concerns regarding the capacity of the MHO workforce. We are exploring such issues with key stakeholders, including local authorities and mental health officers, to better understand what the issues are and what plans there are locally to address any issues with the recruitment, training and retention of MHOs.

Suspension of detention

Extract from Committee report:

75. In written evidence to the Committee, the Mental Welfare Commission ("the Commission") for Scotland welcomed the move to 200 days. However, it did not agree with the provision to allow the tribunal to extend suspension by 100 days. The Commission argued—

"if a patient has been in the community for over six months, and it is felt that he or she should remain in the community but subject to compulsion, the appropriate next step should be to invite the Tribunal to vary the order to a community-based compulsory treatment order".

76. The Tribunal also questioned the provision and considered that it may "add unnecessary complexity into the systems when the very intention was to reduce complexity".

77. The Law Society of Scotland held a similar view to the Commission. It supported the move to 200 days but did not support the power for the Tribunal to extend suspension by 100 days. The Law Society also did not support Section 9(2) to exclude periods less than 12 hours between 9pm and 8am. It detailed in its written submission that it did not believe that the Scottish Government had consulted on these provisions.

78. The Committee asks the Scottish Government to respond to the specific concerns, raised in written evidence, relating to the suspension of detention provisions regarding allowing the tribunal to extend suspension by 100 days and to exclude periods less than 12 hours between 9pm and 8am.

Scottish Government response:

In relation to paragraphs 77 and 78, it is important to be clear that the provision is that any periods of less than 12 hours which do not include any time between 9pm and 8am do not count towards the cumulative total of 200 days.

We note the comments raised around these provisions, which are based closely on recommendations in the McManus report. Our aim, as noted by the Minister at the debate, is to amend the system to ensure that it provides a flexible, workable system to allow suspension of detention to be used in the best way for the care and recovery of the service user, whilst also retaining necessary protections for the service user.

Strong guidance will accompany the new provisions. We agree that it would not be appropriate for the cumulative limit to be extended if the service user was ready for a community-based order, and would not expect the Tribunal to grant the extension in such a circumstance. However, there may be some service users who require a little more testing
out in the community before their order is varied, and we do not want to amend the system in such a way that this is not possible.

The McManus report noted the relatively rare occasion where the patient can reach the cumulative limit but “at the same time, because of his or her mental state and care circumstances, it is not appropriate to apply for a variation to the powers of the compulsory treatment order”. It went on to note that “The responsible medical officer then has to decide whether to revoke the suspension in circumstances where the patient who does not, in the short term, require to return to hospital”. It is only in these circumstances that we would expect the Tribunal to grant an extension and guidance will make this clear. It should be noted that under the current system, detention can be suspended for a cumulative total of up to 9 months, which is closer to 300 days than 200.

In relation to exclusion of periods less than 12 hours between 8am and 9pm, the McManus report was very clear in its view that brief periods out of hospital (not overnight) should not count towards the cumulative limit on any total time out of hospital while subject to detention. From the discussions officials have had with stakeholders, excluding brief periods has generally been seen as sensible in relation to how suspension of detention is used in practice.

The Government’s position is that the principle set out in the McManus report of excluding brief period out of hospital remains right and will seek, through guidance, to ensure that the amended system is as clear for all as possible. However, the Government is considering whether an adjustment should be made to those periods of time which are excluded from counting towards the maximum period of suspension of detention, in light of views from stakeholders as to whether setting the timescales at 12 hours is the best way to achieve the intended aim.

Orders regarding level of security

Extract from Committee report:

89. The Committee supports the comments made by witnesses and the Minister for a need to act swiftly to bring the right of appeal against being held in conditions of excessive security into force. The Committee therefore, recommends that the Scottish Government, in its response to this report, provide a proposed timetable for bringing regulations forward on these provisions.

90. The Committee notes the comments made by the Minister regarding the appeal process not being extended to those in low secure settings. The Committee is however mindful of the comments made by some witnesses that there may be occasions where an individual in a low secure setting could appeal and move from one level of security to another and still remain in low-secure accommodation. The Committee asks the Minister to respond to whether he considers this scenario to be an appropriate one to merit the inclusion of the right of appeal for individuals in low secure settings.

91. The Committee also asks the Minister to comment on the SHRC suggestions that individuals on civil orders in medium secure settings should also have the right to appeal.
Scottish Government response:

The Government is developing the regulations on these provisions and the intention is to provide the Health and Sport Committee with draft regulations during the passage of this Bill. It should be noted that even beyond consideration of at which level these should apply, this is a very technical and complex matter and it is important that sufficient and full consideration is given to precisely how the regulations are shaped. The regulations are subject to the affirmative procedure, which means there will be the opportunity for further involvement and scrutiny by the Committee.

In regards to patients in low secure settings, the Scottish Government has been considering the points that have been made but its intention is still to extend the ability to appeal to medium secure settings only, in line with the recommendations of the Millan report. We must ensure going forward that there is a sensible and workable system for appeals against being held in conditions of excessive security. This is a complex matter that we must get right.

On the point raised in paragraph 91, the right to appeal will apply to individuals on civil orders at medium secure level. The use of the term ‘Relevant patient’ refers to restricted patients in relation to whom Ministers have a role, in agreeing the choice of hospital or unit to which they are moved following successful appeal. The Bill does not limit the right of appeal to those patients.

Nurse’s holding power

Extract from Committee report:

101. In relation to extending the timescales for nurses to detain an individual for up to three hours pending medical examination, the Committee notes the comments from the RCN, the professional body whose members would be directly affected by this provision, that it does not believe there is any evidence that there would be any advantage in an extension.

102. While the Committee understands the rationale set out by the Minister on the reasons for this provision, it also believes that any provision which could lead to the restriction of a service user’s liberty must be fully justified by robust evidence. The Committee therefore asks the Scottish Government to provide further information on the number of occasions on which an emergency detention order has been necessary because of delays in the attendance of a RMO.

103. The Committee also notes the comments from the Mental Welfare Commission that the current use of the power may be being under-reported to the Commission and that the data currently collected was limited. The Committee asks the Scottish Government what steps can be taken to increase the accuracy and detail of the data recorded on nurse holding powers.

Scottish Government response:

The Scottish Government’s key reason for amending this provision was to make the maximum period of detention and the purposes of that detention clearer for everyone involved, particularly around detention being for the purposes of the medical examination.
We feel that these provisions achieve this, making it clearer for the patient from the outset the maximum time they can be held for and for what reason.

We are very clear that the provision does not extend the period of detention. The maximum period of detention under the provisions introduced by the Bill remains, as now, 3 hours. The only difference is that the maximum period of detention under the 2003 Act is currently for a period of 2 hours, extendable to 3; and under the Bill’s proposals the maximum period will be 3 hours from the outset. We consider this added clarity will be beneficial to service users, and will not result in patients being detained for any longer than under the current legislation.

It is also important to note that the 3 hours is an upper limit, not a fixed period. The provision will be accompanied by clear updated guidance in the Code of Practice, which will confirm that the provision should be used in line with the principle of least restriction. A Working Group has been set up involving a range of stakeholders to advise the Government on updates to the Code. The Group includes representation from the Commission and we will look to address concerns around the accuracy and detail of reporting through the Code.

The Minister noted the comments from stakeholders, including Social Work Scotland, that suggested the additional flexibility brought by the new provisions could see more Short Term Detention Certificates (which have additional safeguards) issued in place of an Emergency Detention Certificate. This is not our prime reason for introducing this provision but is a possible additional benefit. However, data is not collected along these lines, and it is not possible to provide a number of occasions that we expect this to happen. We are not aware of an issue of EDCs being issued due to the delay in attendance of an RMO and this is not the issue we are trying to solve.

**Time for appeal, referral or disposal**

**Extract from Committee report:**

110. The Committee notes the concerns of witnesses regarding the proposed reduction of the appeal period for people transferred from one hospital to another from 12 weeks to 28 days.

111. As with other provisions in the Bill, there needs to be clear justification that this provision is for the benefit of the patient. The Committee asks the Scottish Government to provide further information on the rationale and evidence which has informed its decision to include this provision in the Bill.

112. The Committee recognises the importance of protecting the patient’s rights. The Committee therefore asks the Scottish Government to respond to the suggestion that there be a guarantee for the patient that, should a transfer take place before the outcome of an appeal has been determined, the place that the patient had come from would be held until the appeal had been determined.
Scottish Government response:

We have listened to what Members and stakeholders have said about concerns regarding a reduction in rights related to this provision. We therefore intend to propose an amendment removing it.

In response to the point raised at paragraph 112, the Government recognises the importance of protecting the patient’s rights, though understands that there is only one instance where a patient has won an appeal and been unable to return to the place they were held previously. In this context, we believe that holding places open would adversely affect the capacity and flexibility of the estate to respond to the significant demands it faces.

Representation by named persons

Extract from Committee report:

121. The Committee notes the Scottish Government’s policy intention that an individual should only have a named person if they choose to have one. However, the Committee believes that as currently drafted ‘the opt out’ approach to provision of a named person may not deliver this policy aim.

122. The Committee recognises the importance of protecting individuals who lack capacity, but notes the possibility that the approach currently proposed in the Bill could result in individuals having a named person whom they do not want or with whom they are not comfortable. The Committee therefore welcomes both the comments from the Minister that the right balance has perhaps not been struck in regard to this provision and the commitment to reconsider the matter. The Committee looks forward to hearing the Scottish Government’s revised proposals and to the possibility of these proposals being taken forward by amendment at stage 2.

134. The Committee welcomes and supports the improvements proposed for individuals taking on the role of named person. The role of named person can be a challenging and demanding one. The Committee asks the Scottish Government to consider whether there is scope for provision of further training and information resources for named persons to ensure they are well supported in their role.

135. Whilst families and carers may not wish to take on the role of named person, they can make an important contribution to ensuring the delivery of good outcomes for the patient. The Committee welcomes the comments by the Minister that there should be a role for next of kin and carers who are not named persons. The Committee asks the Scottish Government to consider whether any of the current provisions in the Bill could be strengthened to give individuals in this situation a clearer role in the process.

136. The Committee agrees with the Minister that the NHS, local authorities and Scottish Government all have a role to play in promoting the use of named persons. The Committee asks the Scottish Government to consider whether further guidance can be issued to NHS boards and local authorities regarding how the named person role could be promoted by them.
137. The Committee notes the arguments from a number of witnesses that young people under the age of 16 should be able to nominate a named person. However, the Committee accepts the explanation given by the Minister that, while it is important that a young person be allowed to express a view on matters that will directly affect them, this needs to be balanced with the need to protect those who are most vulnerable. The Committee does not, therefore, support the calls for the right to nominate a named person to be extended to children and young people under the age of 16.

Scottish Government response:

As the Minister said at the Stage 1 debate, the Government expects to propose amendments to remove the default position at Stage 2. We very much recognise the concerns that have been raised, particularly regarding service users’ involvement and autonomy and their right to privacy. We still are very conscious of ensuring that vulnerable service users are not disadvantaged and we will look at non-legislative ways to promote involvement of carers and nearest relatives, for example looking at what we can do to promote their right to apply to the Tribunal to be an interested party.

In response to comments made at the debate, the Government would like to make it clear that we will retain the ability for a named person to choose whether to act in this position. As provided for by section 19 of the Bill, the named person’s consent is required to their nomination, and a person may decide to cease to be the named person at any time.

The Scottish Government will be working with stakeholders to produce a revised Code of Practice for those discharging functions under the Act as well as revised leaflets with guidance for service users, their carers and families. This is likely to include updated information about the role of the named person and more guidance to professionals with a role under the Act about how to support named persons and carers at certain times when they come into contact with the Act.

Advance statements

Extract from Committee report:

157. The Committee believes that advance statements are a useful tool for ensuring greater involvement of the service user in their mental health treatment. However, they are currently underutilised.

158. The Committee recognises that there are several potential barriers to their usage, including lack of engagement by the service user in the system, concern that the advance statement will be overturned and the quality and currency of the information contained in an advance statement. Whilst the Committee notes the comments from the Scottish Government regarding the importance of raising awareness of advance statements from the grassroots, it notes that there is no direct provision in the Bill to assist with that improvement. The Committee believes that more work needs to be done to promote advance statements amongst service users and professionals and to identify and overcome the barriers to their usage. The Committee recommends that the Scottish Government consider placing a statutory duty on health boards and local authorities to promote advance statements.
159. The Committee supports the comments made by the Minister that a central depository for advance statements will be useful in enabling statements to be accessed more quickly. The Committee recognises that there is a need to balance privacy and confidentiality with ensuring that the advance statement can be accessed when it is required. The Committee seeks further assurances from the Scottish Government on how it will ensure the approach proposed achieves that balance.

**Scottish Government response:**

In response to the suggestion in paragraph 158 about a statutory duty to promote advance statements, the Government is keen that any action is taken in the most effective and meaningful way and is not persuaded that legislation is more effective in this instance than guidance.

As part of updating the Code of Practice, we will explore how the Code can highlight the best opportunities for promoting the use of Advance Statements. We are also aware that there are effective ways for service users to be supported and encouraged to make an advance statement, beyond through those professionals undertaking duties under the Act, such as MHOs or medical practitioners. For example, we are aware that a range of peer support initiatives have already proven beneficial in promoting the development of Advance Statements with this becoming an integral element of the Peer Support Worker’s role.

The need to balance privacy and confidentiality with ensuring access will remain a key consideration in developments in relation to Advance Statements. While the Government believes that the provisions around access to the register are already strong, and is confident that the Mental Welfare Commission will ensure that strong data protection controls are in place. We will continue to engage with stakeholders and consider any proposals made.

**Care for a child under the age of one**

**Extract from Committee report:**

163. The Committee asks the Scottish Government to respond to the suggestions made in written evidence that the provision allowing mothers to care for their child in hospital should be extended to include fathers and mothers of children aged up to two years old.

**Scottish Government response:**

The Scottish Government notes the broad welcome for this proposal, and the suggestion that the provision be extended to fathers and mothers of children aged up to two years old.

Officials have sought advice from those with the relevant medical expertise. They have noted that it is often the case for children approaching 12 months that it is not in their interests to be on an acute psychiatry ward (including the dedicated mother and baby units) for weeks at a time. This would almost inevitably be the case for older children. It is more practical and safer to provide accommodation for less mobile, very young children than those over the age of one. For these reasons we are not minded to extend this provision for children over the age of one.
The policy intention centres on the particular benefit for mothers and babies through maintaining and supporting this relationship in these first months. In extending the provision beyond post-natal depression we are trying to meet a need that goes beyond post-natal depression to other women with a high risk of severe mental illness in the early postnatal period, a risk that expert advice suggests is not faced in the same way by fathers. It is this need that we are trying to meet with this provision which is why we had extended it to mothers only.

**Cross-border transfer of patients and dealing with absconding patients**

**Extract from Committee report:**

169. The Committee notes the concerns raised regarding cross-border transfer of patients and dealing with absconding patients. The Committee asks the Scottish Government to respond to these issues and seeks assurances that patients will not be disadvantaged as a result of these provisions.

**Scottish Government response:**

In response to the points raised by the Mental Welfare Commission regarding cross-border transfer of patients, these are in reference to current issues related to rights of appeal under cross-border transfer regulations made under the 2003 Act, rather than provisions within the Bill. We are considering whether and how to address these but these would most likely be taken forward through regulations under the 2003 Act, rather than requiring primary legislation.

On the provisions relating to absconding patients, these provisions will relate to patients while they wait for transport back to their original hospital, which may not be immediately available. In the meantime, the current law does not allow them to receive basic or continuing treatment, for example medication that the patient has been receiving during their treatment before they absconded. The provisions will ensure that the patient’s treatment is able to continue whilst in Scotland, and give Ministers powers to make regulations to ensure that the safeguards in Part 16 of the Act can be applied to ensure that treatment is given appropriately. It is not the Government’s policy that the more invasive treatments permitted in accordance with Part 16 would be given to patients who have absconded to Scotland, and Ministers have new powers to make regulations containing specific provision to make this subject to stringent controls.

**Mental health disposals in criminal cases**

**Extract from Committee report:**

176. The Committee asks the Scottish Government to respond to the comments it received questioning the necessity and justification for the provision which would enable the court to extend an assessment order to 14 days.

**Scottish Government response:**

As Dr Crichton from the Royal College of Psychiatrists noted when giving evidence before the Committee, extending the period for the assessment order will allow the clinical team
enough time to fully assess patients in the most complex cases where more time is needed than is presently available under the 2003 Act to determine if the patient meets treatability and other criteria as set out in the Act. The extension may only be granted by the court, on the basis of a report from the patient’s responsible medical officer and will be done on the basis of clinical need, and we feel these safeguards provide suitable protections.

**Victim Notification scheme**

**Extract from Committee report:**

193. The Committee welcomes the introduction of a Victim Notification Scheme for victims of MDOs. The Committee recognises that a balance needs to be struck between the rights of the patient and of the victim and it supports the approach taken in the Bill to apply the scheme to victims of MDOs subject to certain orders.

194. The Committee notes concerns raised by SHRC regarding the Ministerial power to amend the provision so that it would apply to people who were subject only to a compulsion order. The Committee asks for further information on why the Scottish Government has included this provision in light of concerns raised by witnesses that this could result in it being applied to a person who had only committed a minor offence.

195. The Committee recognises the importance of ensuring that the VNS would not operate in a way that would discriminate against mentally disordered offenders. The Committee supports the view that the implementation of the scheme would need to be monitored closely. The Committee asks the Scottish Government for further information on how it will monitor the delivery of the scheme, including its uptake and the assessment of whether it has had any impact on an offender’s recovery.

196. In light of the comments made by witnesses on the provision regarding withholding information relating to offenders who were subject to a compulsion order and a restriction order in exceptional circumstances, the Committee seeks further clarification from the Scottish Government on what would constitute ‘exceptional circumstances’.

**Scottish Government response:**

In response to the point raised in paragraph 194 about the power to amend the provision to apply to those on a compulsion order, we have to bear in mind that the recent EU Directive around minimum rights for victims simply refers to “offenders” and does not differentiate between offenders and mentally disordered offenders. However, the Scottish Government is clear that if the scheme is extended beyond those on a Restriction Order, we would do so in a way that does not put mentally disordered offenders in a disadvantaged position in relation to other offenders.

A Short Life Working Group is currently considering how to implement the provisions in the Bill. Following completion of this work, consideration will be given to how delivery of the scheme can be monitored.

The exceptional circumstances referred to in paragraph 196 would mirror the existing Victims Notification Scheme which came into force in 2004. It would apply in individual cases where it is considered that disclosure of the information under the scheme would
cause significant harm to the patient, for example, in terms of having a significant negative impact on their mental health. This will be considered further in development of any associated guidance.

**Right of access to advocacy**

**Extract from Committee report:**

208. The Committee recognises the importance of advocacy in improving the experience for service users. The Committee received evidence which suggested that the provision of advocacy services across Scotland may be patchy and that services are often required to be targeted at supporting people who are subject to compulsory proceedings. The Committee believes that the benefits of the provision of advocacy services should be felt throughout the system.

209. The Committee believes that whilst the current provision for advocacy is quite strong in the 2003 Act, concern lies with regard to whether the provisions in the 2003 Act are being fully met. The Committee believes that there needs to be more assessment of advocacy services to establish whether there is a need to increase provision and access to independent advocacy.

210. The Committee believes that strengthening the line of accountability may help ensure that local authorities are delivering their duty to provide advocacy services. The Committee notes that assessment of advocacy provision by local authorities could become part of the Care Inspectorate’s review programme and therefore welcomes the comments from the Minister that discussions have taken place regarding this possibility.

211. The Committee also asks the Scottish Government to provide further information on how it will ensure that, in addition to monitoring the provision of advocacy services by local authorities, it will seek to assess advocacy provision in secure settings and hospitals, which lie outside the responsibilities of the Care Inspectorate.

212. The Committee welcomes the Minister’s comments that it is planning to launch guidance on advocacy for carers. The Committee seeks further information from the Scottish Government regarding whether this guidance will seek to strengthen the rights of carers to access independent advocacy.

**Scottish Government response:**

The Government agrees with the Committee’s views about the importance of independent advocacy and also believes that the 2003 Act contained a strong enough duty to provide advocacy to service users.

As with other issues raised in the report and the debate, we believe it is appropriate to take a non-legislative route where possible. We will therefore investigate what further can be done outwith legislation, to ensure that this duty is being fulfilled, including working with public bodies who have a role in monitoring of mental health provision.

The Carers (Scotland) Bill, which was introduced into the Scottish Parliament on 9 March, contains a duty for each local authority to establish and maintain an information and advice
service for carers in its area. The service must provide information and advice in particular about advocacy for carers and about a range of other issues.

In addition, the Scottish Government will issue soon guidance on advocacy for carers. This will set out a range of issues including why a carer may need advocacy, different types of advocacy, managing conflict of interest and professional practice.

**Learning disabilities, autistic spectrum disorders and wider review of legislation**

**Extract from Committee report:**

222. The Committee notes the comments made in evidence calling for the removal of people with learning disabilities and autism spectrum disorders from mental health law and for further consideration to be given to a review of mental health and incapacity legislation. The Committee recognises that this Bill does not seek to deliver a wholesale review of mental health legislation in Scotland and is not calling for such a review at this time. Nevertheless, the Committee invites the Scottish Government to set out its views on whether a wider review of mental health legislation is required.

223. The Committee believes that an open and on-going dialogue between the Scottish Government the mental health sector and people with learning disabilities and autistic spectrum disorders is vitally important to ensure that individuals' needs are met.

224. The Committee supports the comments made by the Scottish Government regarding the future development of adults with incapacity legislation and the need to take these issues into account.

225. The Committee notes that no Equality Impact Assessment (EQIA) has been produced to accompany this Bill. The Committee seeks clarification from the Scottish Government regarding why this has not been produced.

**Scottish Government response:**

The Government recognises that many people with learning disabilities and autistic spectrum disorders have a genuine and heartfelt belief that individuals with their specific conditions should not be dealt with under mental health legislation but rather should have separate legislation to cover their respective conditions.

Mental Health legislation provides people with learning disabilities and autistic spectrum disorders with important protections and safeguards and access to care and treatment. If removed from the definition of “mental disorder,” protective legislation would still be required, which would add another layer of complexity to an already complex legislative landscape. The Scottish Government’s concerns have been that this may also result in some people with learning disabilities and autistic spectrum disorders finding their care impacted by up to four different pieces of legislation (Mental Health Legislation, Incapacity legislation, Adult Support and Protection legislation and the “new” legislation).

However, the Minister has met with some stakeholders who have raised this matter with him and believes that we do need to review the existing mental health and incapacity legislative framework with regard to people with learning disabilities or autistic spectrum disorders as
well as people with dementia. This will be complicated given the range of legislation involved and it is going to take some time to establish the detail of the review. The Scottish Government will update Parliament on how the Scottish Government will deliver this review in due course.

In response to the query in paragraph 225, an Equality Impact Assessment is in progress and will be published in due course. Equalities have been a consideration at the heart of the Bill.

The use of force, covert medication and restraint

229. The Committee asks the Scottish Government to respond to the comments made by witnesses for a greater reference to the use of force, restraint or covert medication in legislation and in the 2003 Act’s Code of Practice.

Scottish Government response:

The Government will consider whether it will be appropriate to address reference to the use of force, covert medication and restraint through the Code of Practice as part of the activity of the working group to revise the Code of Practice. The Government does not, however, consider that change to the legislation is required.

Consideration by Delegated Powers and Law Reform Committee

Extract from Committee report:

235. The Committee draws the specific recommendation made by the DPLRC for amendment to the Bill to the attention of the Scottish Government.

Scottish Government response:

The Scottish Government does not agree with the recommendation made by the Delegated Powers and Law Reform Committee and has given its reasons for disagreeing with the DPLRC’s recommendation in its response to the DPLRC’s report. Following the DPLRC’s consideration of the Government’s response on 16 December 2014, the Government wrote again to the Committee on 3 February setting out in greater detail the Government’s reasons for disagreeing with the recommendation. The DPLRC has not responded to the Government’s last letter on the matter and the Government has no further points to add to what is said in that letter (which can be found on the Parliament’s website: http://www.scottish.parliament.uk/S4_SubordinateLegislationCommittee/2015-02-03_MH_Bill_SG_follow_up_response.pdf).

Other points raised at the debate

In this closing remarks during the debate, the Minister committed to responding in this report to any points that he did not have time to address then. We have tried to do so, where relevant, in this report and have endeavoured to respond to any further points below.

Monitoring of sections 25 to 31 of the 2003 Act (local authority responsibilities)
Several members noted concerns that these responsibilities are not always being met by local authorities. We also noted similar concerns raised by the Mental Welfare Commission in their briefing to MSPs and that the Commission is investigating this further. We do not think that this is best addressed through the Bill, but will of course consider the findings of the Commission’s investigation.

**Homicide enquiries**

The Government has noted calls at the debate for investigation and reporting on homicides perpetrated by people who are suffering from mental illness.

The Mental Welfare Commission is in discussion with Health Improvement Scotland over developing a robust, transparent system of review in conjunction with Health Boards in those cases of homicide where the perpetrator was known to mental health services. This will include engaging with the family of the victim.
24 April 2015

Dear Mr McNeil

In the Committee’s Stage 1 Report, the Committee recommended that the Scottish Government, provide a proposed timetable for bringing forward regulations on orders regarding level of security. The Scottish Government also said that it would provide a draft of the proposed regulations during the passage of the Bill.

I therefore have pleasure in providing the Committee with draft proposed amendments to the Bill, draft regulations and a draft timetable for their introduction for the Committee’s information. We will continue to discuss the proposals around orders regarding level of security with key stakeholders, but given the interest in this area it is prudent for us to be clear about the Government’s intentions now. In light of these continuing discussions the drafts remain subject to some change.

Draft Proposed Amendments

The Government intends to bring forward amendments to the Bill at Stage 2 that:

- Requires a supportive report prepared by an approved medical practitioner to accompany an application for an appeal.
- Makes it clear that the test that the Tribunal must apply when considering excessive security appeals is set out in regulations and clarifies the regulation making powers.

Draft Regulations

The draft regulations specify Scotland’s three medium-secure units as qualifying hospitals. It is the Government’s intention for patients in the medium-secure units to have a right of appeal against being held in conditions of excessive security. This delivers the recommendation of the Millan Committee and fulfils the intention behind the excessive security provisions outwith the state hospital in the 2003 Act.
The draft regulations also set out a test under which the Tribunal must determine whether a patient is being subject to a level of security that is excessive.

These provisions are set out in regulations, because the nature of the secure estate in Scotland is such that resources need to adapt to the changing needs of patients quickly. The flexibility of regulations rather than primary legislation is needed to ensure the legislative framework can adapt to the changes in the secure estate.

It is the Government's intention to lay final draft regulations before Parliament for scrutiny through the affirmative procedures as soon as possible after Royal Assent. I look forward to more detailed discussions on the regulations at that time.

Draft timetable

Also attached is a draft timetable for the introduction of the right of appeal against being held in conditions of excessive security. We intend to introduce the right of appeal to medium secure patients as soon as possible after the Bill is enacted. This is, of course, subject to parliamentary approval.

I hope the Committee find this information helpful. I would also like to thank the committee for the work it has undertaken in scrutinising the Mental Health (Scotland) Bill thus far, and I look forward to engaging with the committee at Stage 2 of the Bill process.

JAMIE HEPBURN

Copy to Nigel Don, Convener of Delegated Powers and Law Reform Committee
MENTAL HEALTH (SCOTLAND) BILL – EXCESSIVE SECURITY REGULATIONS

Draft Timetable for the introduction of orders regarding level of security

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 May</td>
<td>Scottish Government lodge Bill amendments</td>
</tr>
<tr>
<td>14 May</td>
<td>Non-Government Bill amendments lodged</td>
</tr>
<tr>
<td>19 May</td>
<td>Health and Sport Committee – Stage 2 of the Bill process, day 1</td>
</tr>
<tr>
<td>26 May</td>
<td>Health and Sport Committee – Stage 2 of the Bill process, day 2</td>
</tr>
<tr>
<td>2 June (if required)</td>
<td>Health and Sport Committee – Stage 2 of the Bill process, day 3</td>
</tr>
<tr>
<td>16/17 June</td>
<td>Scottish Parliament – Stage 3</td>
</tr>
<tr>
<td>27 June</td>
<td>Parliamentary recess begins</td>
</tr>
<tr>
<td>Mid-July</td>
<td>Royal Assent sought</td>
</tr>
<tr>
<td>mid-August</td>
<td>Royal Assent granted</td>
</tr>
<tr>
<td>Mid-late August</td>
<td>Commence provision on excessive security for the purpose of developing the Regulations</td>
</tr>
<tr>
<td>by end August</td>
<td>Lay draft Regulations in Parliament</td>
</tr>
<tr>
<td>30 August</td>
<td>Parliamentary recess ends</td>
</tr>
<tr>
<td>9 October</td>
<td>Deadline for Health and Sport Committee to report to the Parliament</td>
</tr>
<tr>
<td></td>
<td>If the lead committee votes for approval the motion to approve the SSI is subsequently put before the Parliament as a Parliamentary Bureau motion and voted on.</td>
</tr>
<tr>
<td></td>
<td>If the lead committee votes against the motion it is for the Parliamentary Bureau to decide whether to schedule time for a motion to approve the instrument to be taken in the Chamber and voted on.</td>
</tr>
<tr>
<td>10 October</td>
<td>Parliamentary recess begins</td>
</tr>
<tr>
<td>25 October</td>
<td>Parliamentary recess ends</td>
</tr>
<tr>
<td>End October – Early November</td>
<td>Commence provisions on excessive security in full at the same time as regulations come into force.</td>
</tr>
</tbody>
</table>

Note: Dates in bold are set dates.
The Scottish Ministers make the following Regulations in exercise of the powers conferred by section 271A(1), (2) and (4) of the Mental Health (Care and Treatment) (Scotland) Act 2003 and all other powers enabling them to do so.

In accordance with section 326(4) of that Act, a draft of this instrument has been laid before and approved by a resolution of the Scottish Parliament.

Citation and commencement

1. These Regulations may be cited as the Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015 and come into force on ***.

Interpretation

2. In these Regulations—
   (a) “the Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003;
   (b) reference to a hospital includes a hospital unit as defined in section 273(3) of the Act.

Meaning of qualifying hospital

3. The following are qualifying hospitals for the purposes of sections 268 to 271 of the Act—
   (a) the Orchard Clinic in Royal Edinburgh Hospital, Morningside Terrace, Edinburgh;
   (b) the Rowanbank Clinic, 133C Balornock Road, Glasgow;
   (c) the Medium Secure Service, Rohallion Clinic, Murray Royal Hospital, Muirhall Road, Perth.

Test to be applied under sections 268(2), 269(3) and 271(2)(a) of the Act

4. The test for the purposes of sections 268(2), 269(3) and 271(2)(a) of the Act is met in relation to a patient if detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient’s case.
Further provision about when a hospital’s level of security is excessive

5.—(1) Paragraph (2) makes provision for the purposes of—
(a) sections 268 to 271 of the Act, and
(b) regulation 4.

(2) A patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case when the security at the hospital is greater than is necessary to safely manage—
(a) the risk that the patient may pose to—
   (i) the patient’s own safety; and
   (ii) the safety of any other person; and
(b) any risk to the patient’s safety that other persons may pose.
Before section 10

1 Before section 10, insert—

<Requirement for medical report

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 264 (detention in conditions of excessive security: state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by an approved medical practitioner which—

(a) states that in the practitioner’s opinion the patient does not require to be detained under conditions of special security that can be provided only in a state hospital, and

(b) sets out the practitioner’s reasons for being of that opinion.”.

(3) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by an approved medical practitioner which—

(a) states that in the practitioner’s opinion the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, and

(b) sets out the practitioner’s reasons for being of that opinion.”>

Section 11

2 In section 11, page 8, leave out line 19 and insert—

<( ) in subsection (2), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”>

3 In section 11, page 8, leave out lines 32 and 33 and insert—

<( ) in subsection (3), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”>
Jamie Hepburn

4 In section 11, page 9, leave out lines 1 and 2 and insert—

<( ) in subsection (2)(a), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is not met in relation to the patient”>

Jamie Hepburn

5 In section 11, page 9, line 2, at end insert—

<( ) After section 271 there is inserted—

“Process for orders: further provision

271A Regulation-making powers

(1) A hospital is a “qualifying hospital” for the purposes of sections 268 to 271 of this Act if—

(a) it is not a state hospital, and

(b) it is specified, or is of a description specified, in regulations.

(2) Regulations may specify the test for the purposes of sections 268(2), 269(3) and 271(2)(a) of this Act.

(3) Regulations under subsection (2) above specifying the test—

(a) must include as a requirement for the test to be met in relation to a patient that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient’s case, and

(b) may include further requirements for the test to be met in relation to a patient.

(4) Regulations may make provision about when, for the purposes of—

(a) any regulations made under subsection (2) above, and

(b) sections 268 to 271 of this Act,

a patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case.

(5) Regulations may modify sections 264 and 268 of this Act so as to provide that a person must meet criteria besides being an approved medical practitioner in order to prepare a report for the purpose of subsection (7A) in each of those sections.”.>

Jamie Hepburn

6 In section 11, page 9, line 10, at end insert—

<( ) In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “268(11) to (14)” there is substituted “271A”>
draft amendments as at 24 April 2015

After section 11

Jamie Hepburn

7 After section 11, insert—

<Hospital units>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 273 (interpretation of Chapter)—

(a) the words up to the end of the definition of “relevant patient” become subsection (1),

(b) after that subsection there is inserted—

“(2) In this Chapter, a reference to a hospital may be read as a reference to a hospital unit.

(3) For the purposes of this Chapter, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Section 12

Jamie Hepburn

8 Leave out section 12
Mental Health (Scotland) Bill

1st Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 51  Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Bob Doris

1 In section 1, page 1, line 12, leave out <under section> and insert <by virtue of section 47(4)(a) or>

Bob Doris

2 In section 1, page 1, line 21, leave out <under section> and insert <by virtue of section 47(4)(a) or>

Bob Doris

3 In section 1, page 1, line 25, leave out subsections (4) and (5)

Dr Richard Simpson

66 In section 1, page 1, line 25, leave out subsection (4) and insert—

<In section 68 (extension of short-term detention pending determination of application)—

(a) in the text following paragraph (b) of subsection (1), for the words “are authorised” there is substituted “may be authorised by the Tribunal providing that either of the conditions set out in subsection (1A) are met”,

(b) after subsection (1) there is inserted—

“(1A) Those conditions are—

(a) that the Tribunal determines on its own initiative that the delay in determining the application made under section 63 is unavoidable; or

(b) that an application is made to the Tribunal by a person mentioned in subsection (1B) and the Tribunal is satisfied that the delay in determining the application made under section 63 is unavoidable.

(1B) Those persons are—

(a) the patient;

(b) if the patient has a responsible medical officer, that officer, but only with the consent of—
(i) the patient; or
(ii) where the patient is incapable of consenting, a person mentioned in paragraph (c); or
(c) where the patient is incapable of making the application—
   (i) the patient’s named person;
   (ii) any guardian of the patient;
   (iii) any legal representative of the patient;
   (iv) a person who, to the knowledge of the Tribunal, is providing independent advocacy services to the patient under section 259 of this Act.”,
(c) in subsection (2)(a), for the word “5” there is substituted “10”,
(d) after subsection (2) there is inserted—
“(2A) Where the Tribunal authorises the measures mentioned in subsection (2), the Tribunal must give notice to the persons mentioned in subsection (2B)—
   (a) of its authorisation;
   (b) the reasons for its decision.
(2B) Those persons are—
   (a) if the patient made or consented to the application, the patient;
   (b) in all other cases—
     (i) the patient’s named person;
     (ii) any guardian of the patient;
     (iii) any legal representative of the patient;
     (iv) the patient’s responsible medical officer;
     (v) a person who, to the knowledge of the Tribunal, is providing independent advocacy services to the patient under section 259 of this Act;
     (vi) the Commission.”.

Section 2

Jamie Hepburn
4 In section 2, page 2, line 8, leave out <101(2)> and insert <101(2)(a)>

After section 2

Jamie Hepburn
93 After section 2, insert—
   <Transfer to another hospital
   (1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 124 (transfer to other hospital)—
(a) in subsection (1), for the words “by a compulsory treatment order.” there is substituted “by—
   (a) a compulsory treatment order, or
   (b) an interim compulsory treatment order.”,
(b) in subsection (14), for the words “compulsory treatment order” there is substituted “order in question”.

Section 3

Dr Richard Simpson

67 In section 3, page 3, line 20, leave out <may, so far as they consider it appropriate> and insert <must, unless it is impracticable to do so>

Dr Richard Simpson

68 In section 3, page 3, line 22, at end insert—
<“(3B) Where it is impracticable for the managers of the hospital to notify any persons mentioned in subsection (4) below, they must notify any person who, to the knowledge of the managers, is providing independent advocacy services to the patient under section 259 of this Act.”>

Dr Richard Simpson

69 In section 3, page 3, line 25, leave out <and (3A)> and insert <, 3A and 3B>

Section 8

Jamie Hepburn

5 In section 8, page 5, line 22, at end insert—
<“( ) in subsection (1), the words “not exceeding 6 months” are repealed,
   ( ) after subsection (1) there is inserted—
   “(1A) A certificate under subsection (1) above may specify—
       (a) a single period not exceeding 200 days, or
       (b) a series of more than one individual period falling within a particular 6 month period.”,
   ( ) after subsection (3) there is inserted—
   “(3A) A certificate under subsection (3) above may specify—
       (a) a single period, or
       (b) a series of more than one individual period.”>

Jamie Hepburn

6 In section 8, page 5, line 27, at end insert—
after subsection (2) there is inserted—

“(2A) A certificate under subsection (2) above may specify—

(a) a single period, or
(b) a series of more than one individual period.”;

In section 8, page 6, line 2, at end insert—

In subsection (2), the words “not exceeding 3 months” are repealed, after subsection (2) there is inserted—

“(2A) A certificate under subsection (2) above may specify—

(a) a single period not exceeding 90 days, or
(b) a series of more than one individual period falling within a particular 3 month period.”;

In section 9, page 6, leave out lines 17 to 26 and insert—

for subsection (2) there is substituted—

“(2) The total period that an order does not, by reason of certification under subsection (1) above, authorise the measure mentioned in section 66(1)(a) of this Act must not exceed 200 days (or a higher total by virtue of subsection (10) below)—

(a) in the 12 month period beginning with the day on which the order is made, or
(b) in each subsequent period of 12 months.”,

after subsection (2) there is inserted—

“(2A) For the purpose of subsection (2) above—

(a) a day does not count towards the total period if the measure is (by reason of such certification) not authorised for a period of 8 hours or less in that day,
(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”;

In section 9, page 6, line 17, leave out from <(or)> to <below> in line 18

In section 9, page 6, leave out lines 27 to 39
In section 9, page 6, line 29, after <by> insert <an order of>

In section 9, page 6, line 30, leave out from <, but> to end of line 35

In section 9, page 6, line 38, at end insert <once determined (including any order made in connection with it under subsection (11B) below)>

In section 9, page 6, line 38, at end insert—

<((11A)Where the Tribunal receives an application under subsection (10) above, the Tribunal must inform the patient and the patient’s named person—

(a) that they may make representations (oral or written), and

(b) of the result of the application once determined (including any order made in connection with it under subsection (11B) below).>

In section 9, page 6, line 38, at end insert—

<((11B)If the Tribunal decides not to make an order approving a higher total on an application under subsection (10) above, the Tribunal may make an order varying the compulsory treatment order to which the patient is subject so that it no longer authorises the measure mentioned in section 66(1)(a) of this Act.>

In section 9, page 6, line 39, leave out<300> and insert <230>

In section 128 (suspension of other measures), in each of subsections (1) and (2), for the words “3 months” there is substituted “90 days”.

In section 9, page 7, leave out lines 3 to 12 and insert—

<( ) for subsection (4) there is substituted—

“(4) The total period that an order or direction does not, by reason of certification under subsection (2) above, authorise the detention of a patient in hospital must not exceed 200 days (or a higher total by virtue of subsection (11) below)—

(a) in the 12 month period beginning with the day on which the order or direction is made, or
(b) in each subsequent period of 12 months.”,

( ) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above—

(a) a day does not count towards the total period if the detention is (by reason of such certification) not authorised for a period of 8 hours or less in that day,

(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”.

Jamie Hepburn
16 In section 9, page 7, line 15, after <by> insert <an order of>

Jamie Hepburn
17 In section 9, page 7, line 16, leave out from <, but> to end of line 21

Jamie Hepburn
18 In section 9, page 7, line 24, at end insert <once determined (including any order made in connection with it under subsection (12B) below)>

Jamie Hepburn
18A* As an amendment to amendment 18, line 1, leave out from <(including)> to end of line 2

Jamie Hepburn
19 In section 9, page 7, line 24, at end insert—

<(12A) Where the Tribunal receives an application under subsection (11) above, the Tribunal must inform the patient and the patient’s named person—

(a) that they may make representations (oral or written), and

(b) of the result of the application once determined (including any order made in connection with it under subsection (12B) below).>

Jamie Hepburn
19A* As an amendment to amendment 19, line 5, leave out from <(including)> to end of line 6

Jamie Hepburn
20 In section 9, page 7, line 24, at end insert—

<(12B) If the Tribunal decides not to make an order approving a higher total on an application under subsection (11) above, the Tribunal may make an order varying the order or direction in question so that it no longer authorises the detention of the patient in hospital.>
Dr Richard Simpson

71 In section 9, page 7, line 25, leave out <300> and insert <230>

Jamie Hepburn

21 In section 9, page 7, line 25, at end insert—

<( ) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal), in subsection (1)—

(a) after paragraph (l) there is inserted—

“(la) a decision to make an order under section 127(11B) of this Act arising by virtue of an application under section 127(10) of this Act;”,

(b) after paragraph (s) there is inserted—

“(sa) a decision to make an order under section 224(12B) of this Act arising by virtue of an application under section 224(11) of this Act;”.

Jamie Hepburn

21A* As an amendment to amendment 21, leave out lines 7 to 9

After section 9

Jamie Hepburn

22 After section 9, insert—

<Specification of hospital units

Specification for detention measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 36 (emergency detention in hospital), after subsection (12) there is inserted—

“(13) A reference in this section to a hospital may be read as a reference to a hospital unit.

(14) For the purpose of subsection (13) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(3) In section 44 (short-term detention in hospital), after subsection (11) there is inserted—

“(12) In this section and sections 46 to 49 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(13) For the purposes of subsection (12) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(4) After section 71 there is inserted—

“71A Compulsory treatment in hospital unit

(1) In sections 62 to 68 of this Act, a reference to a hospital may be read as a reference to a hospital unit.
(2) For the purposes of subsection (1) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Jamie Hepburn

23 After section 9, insert—

<Transfer of prisoner to hospital unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after subsection (10) there is inserted—

“(11) A reference in this section to a hospital may be read as a reference to a hospital unit.

(12) For the purpose of subsection (11) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Jamie Hepburn

96 After section 9, insert—

<Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 124 there is inserted—

“124A Transfer to other hospital unit

(1) Subsection (2) below applies where—

(a) the detention of a patient in hospital is authorised by—

(i) a compulsory treatment order, or

(ii) an interim compulsory treatment order, and

(b) that order specifies the hospital unit in which the patient is to be detained.

(2) The managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) In relation to a transfer or proposed transfer under subsection (2) above, section 124(4) to (14) of this Act applies subject to the following modifications—

(a) a reference to section 124(2) is to be read as a reference to subsection (2) above,

(b) subsection (10)(a) is to be ignored,

(c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,

(d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.
(4) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Before section 10

Jamie Hepburn

24 Before section 10, insert—

<Requirement for medical report>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 264 (detention in conditions of excessive security: state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—

(a) states that in the practitioner’s opinion the patient does not require to be detained under conditions of special security that can be provided only in a state hospital, and

(b) sets out the practitioner’s reasons for being of that opinion.”.

(3) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—

(a) states that in the practitioner’s opinion the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, and

(b) sets out the practitioner’s reasons for being of that opinion.”.

Section 10

Jamie Hepburn

25 In section 10, page 8, line 11, leave out subsection (9)

Section 11

Dr Richard Simpson

72 In section 11, page 8, line 17, leave out <first> and insert <second>

Jamie Hepburn

26 In section 11, page 8, leave out line 19 and insert—

<( ) in subsection (2), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”>
Dr Richard Simpson

73 In section 11, page 8, line 19, leave out <each> and insert <the second>

Dr Richard Simpson

74 In section 11, page 8, leave out line 23

Dr Richard Simpson

75 In section 11, page 8, leave out lines 25 and 26

Dr Richard Simpson

76 In section 11, page 8, leave out line 29 and insert—

<(  ) subsection (12) is repealed,
  (  ) in subsection (13), paragraph (b) is repealed,
  (  ) after subsection (14), there is inserted—

“(15) Regulations must specify the minimum period for which a patient must be
  detained before an application may be made under this section.

(16) Regulations may—

(a) make different provision for different purposes, including providing for
    different dates for the different measures of security or containment
    under which a patient is detained to come into force,

(b) include consequential, supplementary, incidental, transitional, transitory
    or saving provision.”.>

Dr Richard Simpson

77 In section 11, page 8, leave out line 31

Jamie Hepburn

27 In section 11, page 8, leave out lines 32 and 33 and insert—

<(  ) in subsection (3), for the words from “detention” to “patient’s case” there is
  substituted “the test specified in regulations made under section 271A(2) of this
  Act is met in relation to the patient”>

Dr Richard Simpson

78* In section 11, page 8, line 36, at end insert—

<(  ) In section 270 (orders under section 269: further provision)—
  (a) in subsection (3), the word “qualifying” is repealed,

(b) in subsection (6), for the words “qualifying hospital” there is substituted “hospital
    in which the patient is detained”.>

Dr Richard Simpson

79 In section 11, page 8, leave out line 38
In section 11, page 9, leave out lines 1 and 2 and insert—

<(  ) in subsection (2)(a), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is not met in relation to the patient”>

In section 11, page 9, line 2, at end insert—

<(  ) After section 271 there is inserted—

“Process for orders: further provision

“271A Regulation-making powers

(1) A hospital is a “qualifying hospital” for the purposes of sections 268 to 271 of this Act if—

(a) it is not a state hospital, and

(b) it is specified, or is of a description specified, in regulations.

(2) Regulations may specify the test for the purposes of sections 268(2), 269(3) and 271(2)(a) of this Act.

(3) Regulations under subsection (2) above specifying the test—

(a) must include as a requirement for the test to be met in relation to a patient that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient’s case, and

(b) may include further requirements for the test to be met in relation to a patient.

(4) Regulations may make provision about when, for the purposes of—

(a) any regulations made under subsection (2) above, and

(b) sections 268 to 271 of this Act,

a patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case.

(5) Regulations may modify sections 264 and 268 of this Act so as to provide that a person must meet criteria besides being a medical practitioner in order to prepare a report for the purpose of subsection (7A) in each of those sections.”>

In section 11, page 9, line 5, leave out <is authorised in hospital> and insert <in hospital is authorised>

In section 11, page 9, line 10, at end insert—
In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “268(11) to (14)” there is substituted “271A”.

Dr Richard Simpson

In section 11, page 9, line 10, at end insert—

In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “to (14)” there is substituted “and (13) to (16)”.

After section 11

Jamie Hepburn

After section 11, insert—

Meaning of hospital in sections 268 to 273 of the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 273 (interpretation of Chapter)—

(a) the words up to the end of the definition of “relevant patient” become subsection (1),

(b) after that subsection there is inserted—

“(2) In this Chapter, a reference to a hospital may be read as a reference to a hospital unit.

(3) For the purposes of this Chapter, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Section 12

Jamie Hepburn

Leave out section 12

Section 14

Jamie Hepburn

In section 14, page 10, line 28, leave out <purposes mentioned in subsection (3A) below> and insert <purpose of enabling the carrying out of a medical examination of the patient by a medical practitioner>

Nanette Milne

In section 14, page 10, line 30, leave out <paragraph (c) of>

Nanette Milne

In section 14, page 10, line 30, after <subsection (3)> insert <—

(i) in the text following paragraph (b), the words “from leaving the hospital” are repealed,
(ii) in paragraph (c)>

Jamie Hepburn
35 In section 14, page 10, leave out lines 33 to 39

Dr Richard Simpson
81 Leave out section 14

Section 15

Jamie Hepburn
36 Leave out section 15

Section 16

Jamie Hepburn
37 In section 16, page 11, line 8, at end insert—

<( ) In subsection (3)(c) of section 101 (Tribunal’s duty to review determination under section 86), for the words “made to” there is substituted “determined by”.

Jamie Hepburn
38 In section 16, page 11, line 23, leave out from <paragraph> to <are> in line 24 and insert <Schedule 2 (the Mental Health Tribunal for Scotland), paragraph 13A is>

Dr Richard Simpson
99 Leave out section 16

Section 17

Dr Richard Simpson
100 Leave out section 17

After section 17

Adam Ingram
101 After section 17, insert—

<Safeguards for other medical treatment

Psychotropic substances

(1) The Mental Health (Care and Treatment) (Scotland) Bill is amended as follows.

(2) After section 237, there is inserted—

“237A Psychotropic substances
(1) Medical treatment mentioned in subsection (2) below may be given to a patient who has a mental disorder only in accordance with the requirements set out in subsection (3).

(2) The medical treatment referred to in subsection (1) is treatment by way of psychotropic substances.

(3) The requirements are—
   (a) where practicable, the patient has been afforded the opportunity to choose the medical practitioner to administer such treatment;
   (b) the patient has been provided with information, as appropriate, about the treatment or range of treatments, as the case may be, as an alternative to treatment by psychotropic substances;
   (c) a medical assessment has been carried out to ascertain whether the patient has any underlying medical condition which may contraindicate the use of psychotropic substances.

(4) For the purposes of this section, a psychotropic substance is a substance which is listed in any of Schedules I to IV of the Psychotropic Substances Convention.”

Adam Ingram

102 After section 17, insert—

<Code of practice: use of psychotropic substances

Psychotropic substances

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 274 (code of practice), there is inserted—

<“Code of practice: use of psychotropic substances

(1) The code of practice under section 274 must make provision about the treatment of a patient who has a mental disorder by way of psychotropic substances.

(2) The code of practice must, in particular, make provision regarding—
   (a) the desirability of enabling the patient to choose, where practicable, the medical practitioner to administer such treatment;
   (b) the need for a medical assessment prior to such treatment to ascertain any underlying medical conditions of the patient that might contraindicate such treatment;
   (c) the need for information to be provided to the patient on the treatment options available to the patient as an alternative to the proposed treatment.

(3) For the purposes of this section, a psychotropic substance is a substance which is listed in any of Schedules I to IV of the Psychotropic Substances Convention.”>
Section 18

Nanette Milne

103 In section 18, page 12, line 18, leave out <in writing> and insert <by any means or in any way>

Jamie Hepburn

39 Leave out section 18

After section 18

Jamie Hepburn

40 After section 18, insert—

<Named person not to be automatic

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Sections 251 and 253 are repealed.

(3) In subsection (2) of section 318 (false statements), sub-paragraph (ii) of paragraph (b) is repealed.>

Section 19

Jamie Hepburn

41 In section 19, page 12, line 35, leave out subsection (3)

Section 20

Jamie Hepburn

42 In section 20, page 14, line 6, at end insert—

<( ) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal), paragraph (t) of subsection (1) is repealed.>

After section 20

Jamie Hepburn

43* After section 20, insert—

<Ability to act if no named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 257 there is inserted—

“Ability to act if no named person

257A Ability to act if no named person

(1) This section applies if—
(a) a patient does not have a named person,
(b) the patient has attained the age of 16 years, and
(c) the patient is incapable in relation to a decision as to whether to initiate an application or appeal in the patient’s case.

(2) In subsection (1)(c) above, “incapable” has the same meaning as in section 250 of this Act.

(3) Each of the persons listed in subsection (9)(a) to (d) below has authority to initiate an application or appeal that may be made by the patient under section 50(1), 99(1), 100(2), 120(2), 125(2), 126(2), 163(1), 164(2), 192(2), 201(1), 204(1), 214(2), 219(2), 220(2), 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act.

(4) Each of the persons listed in subsection (9)(a) and (b) below has authority to obtain any notice or information that is to be provided under section 54(3), 60(1), 87(2)(c), 124(4) or (6), 127(7) or (11A)(b), 128(3), 129(3) or (4), 200(3), 218(4), (6) or (10)(b), 218A(4), 224(8) or (12A)(b) or 226(3) of this Act.

(5) The reference in subsection (3) above to section 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act does not apply in relation to a guardian or a welfare attorney of the patient (as that person is already entitled to make an application or appeal under that section).

(6) In the application of subsection (4) above—
(a) the reference to section 87(2)(c) relates only to notice of the determination mentioned in that section (and not also to a copy of the record mentioned in that section),
(b) the reference to section 128(3) or 129(4) relates to a responsible medical officer’s reasons only if that officer is satisfied that it is appropriate to give notice of them to a guardian or a welfare attorney of the patient (having regard to the need to ensure the patient’s wellbeing and confidentiality).

(7) Neither of the persons listed in subsection (9)(c) or (d) below has authority to act in relation to a patient by virtue of this section if the patient has made a written declaration precluding the person (or all persons) from so acting.

(8) Subsections (2) to (5) and (7) of section 250 of this Act apply to a declaration mentioned in subsection (7) above as they apply to a nomination to which subsection (1) of that section relates (with that section to be read accordingly).

(9) The listed persons are—
(a) any guardian of the patient,
(b) any welfare attorney of the patient,
(c) the patient’s primary carer (if any),
(d) the patient’s nearest relative.”.

Rhoda Grant

105* After section 20, insert—

<Provision of independent advocacy services if no named person>
(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 255 (named person: mental health officer’s duties etc.)—
   (a) in subsection (4)(b) after the word “257” there is inserted “or 257B”,
   (b) in subsection (7)(b) after the word “257” there is inserted “or 257B”.

(3) In subsection (1) of section 256 (named person: application by patient etc.) after the word “257” there is inserted “or 257B”.

(2) After section 257, there is inserted—

“257B  Provision of independent advocacy services if no named person

(1) This section applies if—
   (a) the Tribunal is satisfied that the person does not have a named person;
   and
   (b) the patient has attained the age of 16 years.

(2) Where an application is made under section 255(4)(b) or (7)(b)(i) or 256(1)(a) of this Act the Tribunal may make an order appointing a person to provide independent advocacy services to the patient.

(3) The Scottish Ministers may by regulations prescribe the functions under this Act that a person appointed under subsection (2) may provide to a patient.

(4) Regulations under subsection (3) must not, however, provide for the person appointed under subsection (2) to have access to the patient’s medical records.”.

Rhoda Grant

104 After section 20, insert—

<Involvement of carers and relatives

Involvement of carers and relatives

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 274 (code of practice), after subsection (1) there is inserted—

“(1A) A code of practice drawn up under subsection (1) shall give guidance on the role of carers and relatives, but may not make provision for carers and relatives to have access to a patient’s medical records.”.

Dr Richard Simpson

82 After section 20, insert—

<Advocacy

Advocacy

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 46, after paragraph (d) of subsection (2) there is inserted—
“(e) any person who, to the knowledge of the managers, is providing independent advocacy services to the patient under section 259 of this Act.”.

(3) In section 50, after subsection (3) there is inserted—

“(3A) The Tribunal may afford any person who, to the knowledge of the Tribunal, is providing independent advocacy services to the patient under section 259 of this Act the opportunity mentioned under subsection (2).”.

(4) In section 52, after paragraph (g) there is inserted—

“(h) any person who, to the knowledge of the Commission, is providing independent advocacy services to the patient under section 259 of this Act.”.

(5) In section 54, after paragraph (c) of subsection (3) there is inserted—

“(ca) any person who, to the knowledge of the responsible medical officer, is providing independent advocacy services to the patient under section 259 of this Act.”.

(6) In section 64, after subsection (3) there is inserted—

“(3A) The Tribunal may afford any person who, to the knowledge of the Tribunal, is providing independent advocacy services to the patient under section 259 of this Act the opportunity mentioned under subsection (2).”.

(7) In section 268, after paragraph (e) of subsection (6) there is inserted—

“(f) any person who, to the knowledge of the Tribunal, is providing independent advocacy services to the patient under section 259 of this Act.”.

Dr Richard Simpson

83 After section 20, insert—

<Access to advocacy services

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 259, after subsection (11) there is inserted—

“(12) Regulations may make provision for the circumstances in which providers of independent advocacy services under this Act must be—

(a) notified of matters relating to a patient;

(b) afforded an opportunity to make representations on behalf of a patient;

(c) afforded an opportunity to make applications on behalf of a patient.”.

Dr Richard Simpson

84 After section 20, insert—

<Review of access to advocacy

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 259, there is inserted—

“259A Review of access to advocacy

18
(1) The Commission must—
(a) monitor the availability and accessibility of independent advocacy services provided under section 259,
(b) from time to time, report to the Scottish Ministers on the exercise of the functions under section 259 by the bodies mentioned in subsection (3).

(2) Each body mentioned in subsection (3) must provide the Commission with a report every 2 years, or at such other intervals as Ministers may determine, setting out—
(a) how it has exercised its functions under section 259 during the reporting period,
(b) its plans to ensure that it is in a position to secure independent advocacy services for any person requiring such services in the next reporting period.

(3) Those bodies are—
(a) a local authority,
(b) a Health Board.

(4) In this section, “reporting period” means—
(a) in the case of the first report, the period of time from the date on which this section comes into force until the date on which the first report is provided,
(b) in the case of a subsequent report, the period of time from the date on which the previous report is provided until the date on which the subsequent report is provided.”.

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**Section 21**

**Jamie Hepburn**

44 In section 21, page 14, leave out line 21 and insert—

- inform the Commission—
  (i) that a copy of the statement or document is held with the person’s medical records, and
  (ii) of the premises at which the medical records are kept (and the personal and administrative details essential for identifying the records as the person’s).

**Jamie Hepburn**

45 In section 21, page 14, line 23, leave out from <a> to the end of line 32 and insert <information by virtue of section 276A(2) of this Act.

(2) The Commission must enter the information in a register of advance statements maintained by it (and mark the date on which the entry is made).
Jamie Hepburn

46 In section 21, page 14, line 36, leave out from <anything> to the end of line 38 and insert <an entry in the register to be inspected at a reasonable time—

(a) by the person whose medical records are referred to in the entry,>

Nanette Milne

106 In section 21, page 14, line 36, leave out <anything> and insert <any advance statement>

Nanette Milne

107 In section 21, page 14, line 38, leave out <thing> and insert <advance statement>

Dr Richard Simpson

85 In section 21, page 15, line 7, at end insert—

<276D Access to advance statements

(1) The Scottish Ministers must, by regulations, set out the circumstances where a person mentioned in subsection (2) may, for the purpose of exercising functions under this Act, access an advance statement or document withdrawing an advance statement held by a Health Board.

(2) Those persons are—

(a) the patient’s named person;
(b) any person who, to the knowledge of the Health Board, is providing independent advocacy services to the patient under section 259 of this Act;
(c) a designated medical practitioner in respect of section 239(1) or 241(1) of this Act;
(d) a person employed by the Health Board;
(e) the Commission;
(f) the Tribunal.”.>

Dr Richard Simpson

86 In section 21, page 15, line 7, at end insert—

<( ) In section 326 (orders, regulations and rules), in subsection (4)(c) after the words “to (14),” there is inserted “276D(1).”.

Bob Doris

87 In section 21, page 15, line 7, at end insert—

<Duty to promote advance statements

Each Health Board, working with each local authority in its area, must regularly publish and promote (in such manner as it considers appropriate and in accordance with guidance in the Code of Practice) information about—

20
(a) the existence, effect and status of provisions in this Act about advance statements,

(b) the exercise of those provisions,

(c) the arrangements for making, revising and lodging an advance statement in relation to a person who has a mental disorder,

(d) the support available in the Health Board area to assist a person who has a mental disorder in making, lodging or revising an advance statement.”.>

After section 21

Dr Richard Simpson

88 After section 21, insert—

<Effect of advance statements

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 276 (advance statements: effect)—

(a) in subsection (1), at beginning there is inserted “Subject to subsection (3A),”,

(b) in subsection (3), at beginning there is inserted “Subject to subsection (3A),”,

(c) after subsection (3), there is inserted—

“(3A) Where the conditions in subsection (3B) apply, the person proposing the medical treatment must make an application to the Tribunal for a decision as to whether the treatment may be given or not.

(3B) Those conditions are—

(a) the treatment conflicts with wishes specified in the advance statement;

(b) the patient’s named person objects to the medical treatment; and

(c) it appears to the person proposing the medical treatment or to the patient’s named person that, while the patient’s ability to make decisions about the matters referred to in paragraphs (a) and (b) of subsection (1) of section 275 of this Act, is, because of mental disorder, significantly impaired, the patient is not incapable of consenting to the treatment.

(3C) For the purposes of this section, “incapable” means incapable of—

(a) acting,

(b) making decisions,

(c) communicating decisions,

(d) understanding decisions, or

(e) retaining the memory of decisions,

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

>
Section 22

Jamie Hepburn

47 In section 22, page 15, line 27, leave out <, 57A(2)>

After section 22

Jamie Hepburn

48 After section 22, insert—

<Conflicts of interest to be avoided>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 291 there is inserted—

“Conflicts of interest to be avoided

291A Conflicts of interest to be avoided

(1) There must not be a conflict of interest in relation to a medical examination to be carried out for the purpose of section 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of this Act.

(2) Regulations may—

(a) specify circumstances in which, in the application of subsection (1) above—

(i) there is to be taken to be a conflict of interest,

(ii) there is not to be taken to be a conflict of interest,

(b) specify circumstances in which subsection (1) above does not apply.”.

(3) These provisions are repealed—

(a) in section 36 (emergency detention in hospital)—

(i) paragraph (a) of subsection (3),

(ii) subsection (9),

(b) in section 44 (short-term detention in hospital)—

(i) paragraph (a) of subsection (3),

(ii) subsection (8),

(c) in section 47 (extension of detention pending application for compulsory treatment order)—

(i) paragraph (a) of subsection (2),

(ii) subsection (5),

(d) in section 58 (medical examination: requirements), subsection (5).>

Jamie Hepburn

49 After section 22, insert—

<Safeguarding the patient’s interest>
(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 245 (certificates under sections 235, 236, 239 and 241), in subsection (3)—
   (a) the word “and” immediately preceding sub-paragraph (ii) of paragraph (a) is repealed,
   (b) after sub-paragraph (ii) of paragraph (a) there is inserted—
       “(iii) any guardian of the patient; and
       (iv) any welfare attorney of the patient;”.

Section 23

Jamie Hepburn

50 In section 23, page 16, line 8, leave out <, for the words “for post-natal depression,” in subsection (1)(d)> and insert—

<(< ) in paragraph (d) of subsection (1), for the words “for post-natal depression,”>

Jamie Hepburn

51 In section 23, page 16, line 11, at end insert—

<( ) after subsection (1) there is inserted—

“(1A) But a Health Board is required to provide services and accommodation under subsection (1) above only if it is satisfied that doing so would be beneficial to the wellbeing of the child.”>

Section 24

Nanette Milne

108 In section 24, page 16, line 29, at end insert—

<( ) in paragraph (f) of subsection (1), after the word “patient” there is inserted “. or the patient’s named person,”>

Section 25

Bob Doris

52 In section 25, page 17, line 14, leave out <some or all of> and insert <specific provisions in>

Dr Richard Simpson

89 In section 25, page 17, line 14, leave out <some or all of Part 16> and insert <section 243>

Dr Richard Simpson

90 In section 25, page 17, line 18, leave out <that Part> and insert <section 243>
Dr Richard Simpson
91 In section 25, page 17, line 19, leave out <any of that Part> and insert <section 243>

Bob Doris
53* In section 25, page 17, line 21, at end insert <, or
( ) authorise medical treatment of the types mentioned in section 234(2) or 237(3) of this Act.”>

Section 26

Jamie Hepburn
54 In section 26, page 17, line 30, leave out from <subsection> to the end of line 33 and insert <paragraph (a) of subsection (3) there is inserted—
“(aa) that—
(i) a mental health officer has agreed to the making of the direction, or
(ii) it has been impracticable to obtain the agreement of a mental health officer;”>

After section 27

Dr Richard Simpson
55 After section 27, insert—

<Meaning of “mental disorder”

Meaning of “mental disorder”
(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 328 (meaning of “mental disorder”)—
(a) paragraph (c) of subsection (1) is repealed together with the word “or” immediately preceding it,
(b) before paragraph (a) in subsection (2) there is inserted—
<“(za) learning disability;”>
<“(zb) autism spectrum disorder;”>

Jackie Baillie
56 After section 27, insert—

<Review of the meaning of “mental disorder”

328A Review of the meaning of “mental disorder”
(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 328 there is inserted—
“Review of meaning of “mental disorder”
(1) The Scottish Ministers must carry out a review of the definition of mental disorder no later than one year after the Mental Health (Scotland) Act 2015 receives Royal Assent.

(2) The purpose of the review under subsection (1) is to consider whether “learning disability” should continue to be within the meaning of “mental disorder”.

(3) In carrying out a review under subsection (1) the Scottish Ministers must consult such persons as they consider appropriate.

(4) The Scottish Ministers must—
   (a) publish a report—
      (i) setting out the findings of the report under subsection (1),
      (ii) making a recommendation as to whether “learning disability” should continue to be within the meaning of “mental disorder”,
   (b) lay a copy of that report before the Parliament.

(5) The Scottish Ministers must make provision by regulations for the removal of “learning disability” from the meaning of “mental disorder” where a report under subsection (4) recommends that “learning disability” should not continue to be within the meaning of “mental disorder”.

(3) In section 326 (orders, regulations and rules), in subsection (4)(c) for the words “or 310” there is substituted “310 or 328A”.

Adam Ingram

109 After section 27, insert—

The Commission: statistical information

Information on adverse incidents etc.

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 19, there is inserted—

“19A Statistical information: further provision

(1) The Commission must make arrangements for the collection of the statistical information mentioned in subsection (2) in respect of patients detained in hospital by virtue of—
   (a) this Act; or
   (b) the 1995 Act.

(2) That information is the annual number of—
   (a) deaths;
   (b) suicides;
   (c) assaults recorded against a patient;
   (d) recorded adverse incidents;
   (e) occasions on which restraints have been used in relation to a patient.

(3) The information mentioned in subsection (2) must be broken down by—
(a) age;
(b) gender;
(c) diagnosis;
(d) class of drug prescribed (where appropriate);
(e) Health Board;
(f) such other categories as may be prescribed by regulations.

(4) The Commission must in accordance with directions given to it by the Scottish Ministers, from time to time, and not less than once in every Parliamentary session, lay before the Parliament a report summarising the findings of the information collected under subsection (1) since the laying of the last report.

(5) Subsections (6) and (7) apply where—

(a) the Parliament is dissolved before the period of 12 months has elapsed since the commencement of the session of Parliament, and

(b) as at the date of dissolution a report under subsection (4) has not been published.

(6) The session in which the Parliament is so dissolved is not to be regarded as a session in which a report under subsection (4) is to be published.

(7) A report under subsection (4) must be published in the session of the Parliament which—

(a) next follows the session in which the Parliament is so dissolved, and

(b) is not itself a session in which the Parliament is so dissolved.>

Dr Richard Simpson

110 After section 27, insert—

Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

Scottish Ministers review of deaths in detention or otherwise in hospital for treatment for a mental disorder

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 4A, there is inserted—

“Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

4AA Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

(1) The Scottish Ministers must carry out a review of the arrangements for investigating the death of a patient who was—

(a) detained in hospital by virtue of—

(i) this Act;

(ii) the 1995 Act; or

(b) admitted voluntarily to hospital for the purpose receiving treatment for a mental disorder.
(2) The review must be carried out within 2 years of this section coming into force.

(3) In carrying out a review under subsection (1) the Scottish Ministers must consult—
   (a) the nearest relative of a patient within the meaning of subsection (1);
   (b) such persons as they consider appropriate.

(4) The Scottish Ministers must—
   (a) publish a report setting out the findings of the review under subsection (1);
   (b) lay a copy of that report before the Parliament;
   (c) notify those persons consulted under subsection (3) of the publication of the report.”.

After section 28

Jamie Hepburn

57 After section 28, insert—

<Detention under compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 57 (disposal of case where accused found not criminally responsible or unfit for trial), in subsection (2)—
   (a) in paragraph (a), for the words “authorising the detention of the person in a hospital” there is substituted “(whether or not authorising the detention of the person in a hospital),”;
   (b) for paragraph (b) there is substituted—
      “(b) subject to subsection (4A) below, make a restriction order in respect of the person (that is, in addition to a compulsion order authorising the detention of the person in a hospital),”.

Section 29

Dr Richard Simpson

111 In section 29, page 19, leave out lines 16 to 22

Section 35

Jamie Hepburn

58 In section 35, page 22, line 25, at end insert <, or

( ) a temporary compulsion order (see section 54(1)(c) of this Act).>
In section 35, page 22, line 26, leave out from beginning to <question,> in line 27

Before section 36

Before section 36, insert—

<Specification of unit

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 61 there is inserted—

“61B Specification of hospital unit

(1) A reference in this Part to a hospital may be read as a reference to a hospital unit.

(2) In the operation of section 61A of this Act in relation to a transfer from one hospital unit to another within the same hospital—

(a) subsection (2) of that section applies by virtue of subsection (1) of that section where the order in question specifies the hospital unit in which the person is to be detained,

(b) in subsection (5) of that section—

(i) paragraph (b) is to be ignored,

(ii) in paragraph (c)(i), the reference to the managers of the other hospital is to be read as a reference to the managers of the hospital in which the person is detained.

(3) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”>

Section 36

Leave out section 36

Section 37

Leave out section 37

Section 38

Leave out section 38
After section 40

Dr Richard Simpson

92 After section 40, insert—

Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 63 (appeal by prosecutor in case involving insanity), there is inserted—

“Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

63A Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) Subsection (2) applies where a person—

(a) is charged with a relevant offence, and

(b) has prior to being charged with that relevant offence been—

(i) in receipt of care and treatment from a health board under the Mental Health (Treatment and Care) (Scotland) Act 2003 (“the 2003 Act”), or

(ii) referred to a Health Board for care and treatment under the 2003 Act.

(2) As soon as practicable after the person is charged with a relevant offence, the procurator fiscal must, where it appears to the procurator fiscal that the person meets the conditions specified in subsection (1), notify—

(a) the Health Board—

(i) which provided care and treatment to the mentally disordered person under the 2003 Act, or

(ii) to which the mentally disordered person was referred for care and treatment under the 2003 Act, and

(b) the Mental Welfare Commission,

that the mentally disordered person has been charged with a relevant offence.

(3) A Health Board which has been notified under subsection (2) must—

(a) undertake an inquiry into the mentally disordered person’s interaction with the Health Board,

(b) prepare and publish a report setting out the findings of the inquiry, and

(c) as soon as practicable after the publication of a report under paragraph (b), prepare an action plan responding to the findings of the report.

(4) As soon as practicable after the publication of a report and action plan under subsection (3), the Health Board must provide the report and action plan to—

(a) the Mental Welfare Commission,
(b) any natural person against whom a relevant offence has been perpetrated, provided that the Health Board has ascertained that the person to be given the information wishes to receive it.

(5) The Mental Welfare Commission must, in accordance with directions given to it by the Scottish Ministers, from time to time, and not less than once in every parliamentary session, lay before the Parliament a report summarising the findings of the reports received since the laying of the last such report.

(6) Subsections (7) and (8) apply where—

(a) the Parliament is dissolved before the period of 12 months has elapsed since the commencement of the session of Parliament, and

(b) as at the date of dissolution a report under subsection (5) has not been published.

(7) The session in which the Parliament is so dissolved is not to be regarded as a session in which a report under subsection (5) is to be published.

(8) A report under subsection (5) must be published in the session of the Parliament which—

(a) next follows the session in which the Parliament is so dissolved, and

(b) is not itself a session in which the Parliament is so dissolved.

(9) Health Boards must, in exercising any function under this section, have regard to any guidance issued by the Scottish Ministers.

(10) The Scottish Ministers must publish any guidance they issue for the purposes of this section.

(11) The Scottish Ministers may revise and revoke such guidance.

(12) For the purposes of this section, “relevant offence” means the committing of the offence of—

(a) murder,

(b) culpable homicide,

(c) such other offence as the Scottish Ministers may by regulations prescribe.

(13) For the purposes of this section, “referred” means referred to a Health Board by a medical practitioner, or such other person as the Scottish Ministers may by regulations prescribe.

(14) The Scottish Ministers may by regulations amend subsections (1) to (9), so as to—

(a) incorporate within the meaning of this section persons charged with a relevant offence who have been in receipt of care and treatment under the 2003 Act from a body other than a Health Board,

(b) to require that body to be notified of the charging of that person and to be subject to the requirements of subsections (3) to (6).

(15) Regulations under subsections (12) and (14) are subject to the affirmative procedure.

(16) Regulations under subsection (13) are subject to the negative procedure.
Before section 41

Dr Richard Simpson

113 Before section 41, insert—

<Referral by Tribunal to High Court

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 195 there is inserted—

‘Reference to High Court by Tribunal

195A Tribunal’s powers to make reference to High Court

(1) This section applies where—

(a) a person—

(i) was convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or

(ii) was remitted to the High Court by the sheriff under any enactment for sentence for such an offence;

(b) the person is subject to—

(i) a compulsion order; or

(ii) a compulsion order and a restriction order; and

(c) a determination or order is made under this Act changing the category of the patient’s mental disorder.

(2) If the conditions in subsection (3) apply, the Tribunal may refer the matter to the High Court.

(3) Those conditions are that—

(a) the Tribunal is satisfied that the category of the patient’s mental disorder has changed from that specified at the time at which the court made the compulsion order or compulsion and restriction order, as the case may be;

(b) it appears to the Tribunal that, given the change in category, it is appropriate for the patient to be remitted to the High Court for sentence for the offence for which the person was convicted; and

(c) the Tribunal considers that it is in the interests of justice and consistent with the principles of this Act that such a reference should be made.

(4) In determining whether a reference is in the interests of justice, the Tribunal must have regard to the need for finality and certainty in the determination of criminal proceedings.

(5) In considering whether or not to make a reference, the Tribunal may at any time refer to the High Court for the Court’s opinion on any point on which it desires the Court’s assistance; and on a reference under this subsection the High Court must consider the point referred and provide the Tribunal with its opinion on the point.
(6) A reference under subsection (2) may be made by the Tribunal under this Act—
   (a) on the Tribunal’s own initiative;
   (b) on application to the Tribunal by;
      (i) the patient;
      (ii) the responsible medical officer;
      (iii) the Commission;
      (iv) any other person mentioned in subsection (8).

(7) Before making a reference to the High Court under this section the Tribunal must—
   (a) afford the persons mentioned in subsection (8) below the opportunity—
      (i) of making representations (whether orally or in writing); and
      (ii) of leading, or producing, evidence; and
   (b) whether or not such representations are made, hold a hearing.

(8) Those persons are—
   (a) the patient;
   (b) the patient’s named person;
   (c) the patient’s primary carer;
   (d) any guardian of the patient;
   (e) any welfare attorney of the patient;
   (f) any curator ad litem appointed by the Tribunal in respect of the patient;
   (g) the Scottish Ministers;
   (i) the mental health officer;
   (j) any other person appearing to the Tribunal to have an interest.”

(3) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(4) After section 61 there is inserted—

   “Reference by the Tribunal to the High Court

   61A Reference by the Tribunal to the High Court

   (1) Where the Tribunal makes a reference to the High Court under section 195A of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Tribunal must—
      (a) give to the Court a statement of its reasons for making the reference; and
      (b) send a copy of the statement to every person who appears to them to be likely to be a party to any proceedings arising from the reference.

   (2) The High Court must hear and determine the case, subject to any directions the High Court may make, as if it were an appeal under Part VIII or, as the case may be, Part X of this Act.

   61B Further provision on reference
(1) The High Court may reject the reference if the Court considers that it is not in the interests of justice that any proceedings arising from the reference should proceed.

(2) In determining whether or not it is in the interests of justice that any proceedings should proceed, the High Court must have regard to the need for finality and certainty in the determination of criminal proceedings.

(3) On rejecting a reference under this section, the High Court may make such order as it consider necessary or appropriate.

61C Supplementary provision

(1) The Scottish Ministers may by order make such incidental, consequential, transitional or supplementary provisions as may appear to them to be necessary or expedient for the purpose of bring section 61A and 61B into operation.

(2) Regulations under subsection (1) are subject to the affirmative procedure.”.

Section 41

Jamie Hepburn

64 In section 41, page 25, line 12, leave out <165(2)> and insert <165(2)(a)>

After section 42

Jamie Hepburn

65 After section 42, insert—

<Effect of revocation of restriction order>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 198 (effect of revocation of restriction order), for the words “Tribunal revoked the restriction order” there is substituted “order revoking the restriction order has effect in accordance with section 196 of this Act”.

Section 44

Dr Richard Simpson

114 In section 44, page 27, leave out line 17 and insert—

<(1) Where—>

Dr Richard Simpson

115 In section 44, page 27, line 24, after <years> insert—

<(e) there are no exceptional circumstances which, in the opinion of the Scottish Ministers, make it inappropriate to do so, the Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).>
Dr Richard Simpson

116 In section 44, page 27, leave out lines 25 to 33

Section 49

Dr Richard Simpson

117 In section 49, page 32, line 20, at end insert—

<(  ) In paragraph (a) of subsection (2) of section 167 (powers of tribunal on application under section 149, 158, 161, 163 or 164) after “measures” there is inserted “, or any recorded matter”.>

Nanette Milne

118* In section 49, page 32, line 38, at end insert—

<(  ) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal)—

(a) after paragraph (b) of subsection (5) there is inserted—

“(ba) that person’s curator ad litem;”,

(b) after paragraph (b) of subsection (6) there is inserted—

“(ba) that person’s curator ad litem;”,

(c) after paragraph (b) of subsection (8) there is inserted—

“(ba) that person’s curator ad litem;”,

(d) after paragraph (b) of subsection (9) there is inserted—

“(ba) that person’s curator ad litem;”.

(  ) In section 322 (appeal to the Court of Session against certain decisions of the Tribunal)—

(a) after paragraph (b) of subsection (3) there is inserted—

“(ba) that person’s curator ad litem;”,

(b) after paragraph (b) of subsection (4) there is inserted—

“(ba) that person’s curator ad litem;”.

Before section 50

Nanette Milne

119 Before section 50, insert—

<Interpretation

In section 329 (interpretation) of the 2003 Act, in the definition of “medical practitioner”, after the word “practitioner” where it second appears there is inserted “or practitioner psychologist”.

>
Mental Health (Scotland) Bill

1st Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated on the first day of Stage 2 consideration, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

**Groupings of amendments**

**Compulsory treatment**

1, 2, 3, 66, 4, 64

_Notes on amendments in this group_

Amendment 3 pre-empts amendment 66

**Transfers and hospital units**

93, 22, 23, 96, 112, 61, 62, 63

**Emergency detention in hospital**

67, 68, 69

**Suspension of detention**

5, 6, 7, 8, 94, 95, 9, 10, 11, 12, 13, 70, 14, 15, 16, 17, 18, 18A, 19, 19A 20, 71, 21, 21A

_Notes on amendments in this group_

Amendment 8 pre-empts amendment 94
Amendment 95 pre-empts amendments 9, 10, 11, 12, 13, 70

**Excessive security**

24, 25, 72, 26, 73, 74, 75, 76, 77, 27, 78, 79, 28, 29, 30, 31, 80, 32, 33

_Notes on amendments in this group_

Amendment 26 pre-empts amendment 73

**Nurse’s holding power**

34, 97, 98, 35, 81

**Appeal on hospital transfer**

36

SP Bill 53-G1 1 Session 4 (2015)
Periodical referral of cases
37, 38, 99

Recording of late disposal
100

Psychotropic substances
101, 102

Named person
103, 39, 40, 41, 42, 43, 105, 108

Carers’ involvement
104

Advocacy
82, 83, 84

Registration of advance statements
44, 45, 46, 106, 107

Notes on amendments in this group
Amendment 46 pre-empts amendments 106, 107

Advance statements: further provision
85, 86, 87

Effect of advance statements
88

Support, conflicts of interest and safeguarding patients
47, 48, 49

Services and accommodation for mothers
50, 51

Absconding patients
52, 89, 90, 91, 53

Notes on amendments in this group
Amendment 52 pre-empts amendment 89

Agreement to transfer prisoners
54

Meaning of mental disorder
55, 56

Information on adverse incidents
109
Review of deaths in detention
110

Detention under compulsion orders
57

Period of assessment order
111

Transfer of patients to suitable hospital
58, 59

Duty of Health Boards: homicide reporting
92

Referral to the High Court
113

Effect of restriction order
65

Right to information: compulsion order
114, 115, 116

Compulsion order: recorded matter
117

Involvement of curator ad litem: appeals
118

Practitioner psychologists
119
HEALTH AND SPORT COMMITTEE

EXTRACT FROM THE MINUTES

16th Meeting, 2015 (Session 4)

Tuesday 19 May 2015

Present:
Bob Doris (Deputy Convener) Rhoda Grant
Colin Keir Richard Lyle
Mike MacKenzie Duncan McNeil (Convener)
Nanette Milne Dennis Robertson
Dr Richard Simpson

Also present: Jackie Baillie, Adam Ingram

Mental Health (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 1).

The following amendments were agreed to (without division): 1, 2, 3, 4, 93, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18A, 18, 19A, 19, 21A, 21, 22, 23, 96, 24, 25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 100, 39, 40, 41, 42, 43, 44, 45, 46 and 47.

The following amendments were agreed to (by division)—

8 (For 6, Against 0, Abstentions 3)
26 (For 5, Against 0, Abstentions 4)

The following amendments were disagreed to (by division)—

70 (For 4, Against 5, Abstentions 0)
81 (For 4, Against 5, Abstentions 0)
85 (For 4, Against 5, Abstentions 0)
86 (For 4, Against 5, Abstentions 0)
87 (For 4, Against 5, Abstentions 0)
88 (For 4, Against 5, Abstentions 0)

The following amendments were moved and, no member having objected, withdrawn: 67, 101, 103, 104 and 82.

The following amendments were pre-empted: 66, 94, 73, 106 and 107.

The following amendments were not moved: 68, 69, 95, 20, 71, 72, 74, 75, 76, 77, 78, 79, 80, 97, 98, 99, 102, 105, 83 and 84.

Sections 3, 4, 5, 6, 7 and 13 were agreed to without amendment.

The following provisions were agreed to as amended: sections 1, 2, 8, 9, 10, 11, 14, 16, 19, 20, 21 and 22.
The Committee ended consideration of the Bill for the day section 22 having been agreed to.
Mental Health (Scotland) Bill: Stage 2

09:48

The Convener: Agenda item 2 is stage 2 consideration of the Mental Health (Scotland) Bill. Members should have a copy of the first groupings of amendments, the first marshalled list of amendments and the bill as introduced. I assume that everyone has those.

I remind members that the minister’s officials are here in a strictly supportive capacity and that they cannot speak during proceedings or be questioned by members.

There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment and to speak to all the other amendments in the group. I will then call the other members who have amendments in the group. Finally, the member who lodged the first amendment in the group will be asked to wind up the debate and to press or withdraw the amendment. Members who have not lodged an amendment in the group but who wish to speak should catch my attention and make the request in the usual way.

If a member wishes to withdraw their amendment after it has been moved, I must check whether any member objects to its being withdrawn. If any member objects, the committee will immediately move to the vote on the amendment. Any member who does not want to move their amendment when it is called should say, “Not moved.” Any other MSP can move the amendment, of course, but I will not specifically invite other members to do so. If no one moves the amendment, I will call the next one.

Section 1—Measures until application determined

The Convener: Amendment 1, in the name of Bob Doris, is grouped with amendments 2, 3, 66, 4 and 64. I point out that if amendment 3 is agreed to, I cannot call amendment 66, as it will have been pre-empted.

Bob Doris (Glasgow) (SNP): I thank the Government for the dialogue that it had with me as I was preparing these amendments.

On amendments 1 and 2, concerns were expressed to the committee that the changes in the bill that would deduct a period of time from the end of a compulsory treatment order under sections 1, 2 and 3 could be unclear and, indeed, could be inequitable as they do not take the extension certificate into account. In its stage 1
The amendments that I have lodged seek to deduct from the end of the CTO or interim CTO any period of detention between the expiry of the original short-term detention certificate and the first tribunal hearing. I hope that they meet the concerns that were expressed by committee members and which were highlighted in our stage 1 report.

Amendment 3 seeks to remove from the bill the provision to extend from five to 10 days the period of short-term detention possible under section 68(2)(a) of the Mental Health (Care and Treatment) (Scotland) Act 2003 to allow the tribunal to arrange the first hearing in relation to a CTO application, and the consequential amendments to section 39 of the 2003 act. That will mean that the existing arrangements in the 2003 act that limit the period authorised to five days are retained. Although we were all keen for the period to be increased from five to 10 days, the evidence to the committee suggests that the problem that the bill sought to solve seems to have receded in recent years. As a result, amendment 3 seeks to take us back to the status quo position.

I move amendment 1.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I welcome amendments 1, 2 and 3 in the name of Bob Doris. As you have indicated, convener, if amendment 3 is agreed to, amendment 66, in my name, will fall.

The justification for the proposed extension in the period of short-term detention from five to 10 days was that it was in the patient's interest to reduce the number of repeat hearings. There was a firm denial that the rationale behind the proposal was administrative convenience; instead, it was made clear that the focus was on protecting the patient. However, as Mr Doris has indicated, many witnesses suggested that such an extension might become the norm rather than the exception and that increasing flexibility would lower the pressure to reduce the number of repeat hearings, which, as was acknowledged, has been significantly reduced under the tribunal's current president.

That said, Karen Kirk of the Legal Services Agency suggested that a further reduction in hearings might not be an entirely appropriate ambition and expressed concern that the provision as drafted might not be compliant with article 5 of the European convention on human rights, which relates to liberty and security. That view was partly supported by the witnesses from the Scottish Human Rights Commission.

Despite the reservations that have been expressed, I and, I think, the rest of the committee supported the extension of the period from five to 10 days. In the event that amendment 3 is not agreed to, amendment 66 would ensure that such a move would occur only in specific circumstances. In essence, I propose that an extension be granted only on application by the patient or the patient's representative because they need more time, or, in cases where an application is made by health professionals, with the consent of the patient or the patient's representative. As a result, the extension to 10 days would happen only if the patient or the patient's representative had consented or if the tribunal made a clear statement of the reasons for the extension. I expect those exceptional circumstances to be spelt out more clearly, if not fully defined, in regulations or guidance.

I believe that the amendments are broadly in line with the committee's report and will allow for flexibility. I ask Mr Doris, in his summing up, and perhaps the minister, when he addresses the amendments, to clarify whether the tribunal is now happy for the extension to 10 days to be completely removed. If that is the case, my amendment will clearly not be necessary.

The Convener: I formally welcome the minister to the committee and invite him to speak to amendment 4 and other amendments in the group.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I thank Bob Doris and Dr Simpson for lodging their amendments. In the Scottish Government's response to the committee's stage 1 report, I recognised the concerns about the extension of a short-term detention certificate applying in all cases. On the other side of the argument are the views of the Mental Health Tribunal for Scotland that there could be benefits in allowing service users more time to prepare. The response committed us to an exploration of whether an amendment could be made that would mean that the extension would not apply automatically in all cases.

We explored several solutions, including giving the patient and their representatives the option to request more time as part of the interview with a mental health officer when an application for a compulsory treatment order is being considered, or the option to make such a request after the application has been made. The latter option seems to be most like what Dr Simpson has proposed.
Another solution was to have a procedural or paper hearing of the tribunal to consider whether it would be appropriate for there to be an additional five days before the hearing. However, although that might take account of some of the issues that Dr Simpson mentioned, I understand that the tribunal has expressed some reservations about pursuing that approach. On balance, it did not seem practical to ask an unwell patient, who may not yet have seen the application in full or who may not yet have appointed legal representation, to make a decision as to whether they would like to be detained for a longer period when they may be distressed by detention in the first place.

Allowing a hearing to be arranged and then postponed on request at short notice as it becomes clear that the patient is not ready is likely to be expensive and to cause last-minute issues for all involved, including panel members, responsible medical officers and mental health officers, let alone the patient and named person.

I understand that the tribunal also gave views on whether it could make a judgment as to whether more time was required. Our view, having reflected on that, is that it would not be fair to expect the tribunal to make such a judgment without significant information from the patient, but that it would also be an unfair additional request of an unwell patient.

Overall, having taken the tribunal’s views into account, our concern is that amendments to that effect, including that proposed by Dr Simpson, could add a cumbersome process to the tight time period that ensures that a patient has a hearing promptly.

I thank Dr Simpson for applying some thought to seeking a resolution to the issue, but I ask members to support amendment 3 in preference to amendment 66.

On amendments 1 and 2, on reducing the overall period of detention, I agree that the result will be a fairer and more equitable system. I ask members to support those amendments.

When I appeared before the committee at stage 1, I gave a commitment to propose amendments along the lines of amendments 4 and 64. The amendments relate to the new duties brought in by the bill, whereby a mental health officer must provide a report to the tribunal in relation to a determination to extend a compulsory treatment order or compulsion order. The amendments mean that the report will be required only where there has been a change in diagnosis, where the mental health officer disagrees with the determination, or where the mental health officer has failed to comply with their duty to express a view. They remove the requirement to provide a report to the tribunal for all two-year reviews of compulsory treatment orders and compulsion orders.

I ask members to support amendments 4 and 64.

Bob Doris: I thank Dr Simpson for his comments and for elaborating further on my reasons for lodging amendment 3. The driving force behind amendment 3 was the reduction in multiple hearings over the years since the initial recommendation to allow an extension from five to 10 days. I note that amendment 66, in the name of Dr Simpson, could in theory provide an alternative solution, but I tend to agree with the minister that it could create unnecessary complexity and bureaucracy and could put additional burdens on patients.

Other policy solutions could have given the practical effect that amendments 1 and 2 achieve, but in drafting the amendments I was minded to keep things as simple, straightforward, unbureaucratic and uncomplicated as possible, so that the provisions can be used effectively in practice if they are agreed to today.

I therefore press amendment 1.
That will support the movement of patients within as well as between hospitals. Related to that is the need to address the fact that there is currently no procedure for transferring patients who are subject to interim compulsory treatment orders. The amendments are a response to concerns that were expressed by the Mental Welfare Commission for Scotland. As it is a complex group of amendments, it will take me some time to go through them, so I hope that members will bear with me.

On the civil side is amendment 22, which will mean that references to a “hospital” in sections 36, 44 and 62 to 68 of the Mental Health (Care and Treatment) (Scotland) Act 2003 may be read as references to a “hospital unit”. It will allow emergency detention orders, short-term detention orders, interim compulsory treatment orders and compulsory treatment orders to authorise detention in a specified hospital unit, and a mental health officer’s proposed care plan to propose that a patient is detained in a specified hospital unit. Amendment 22 will also enable the removal of patients who are subject to emergency or short-term detention certificates to a particular hospital unit or to a different unit within the same hospital.

On the criminal side, amendment 112 proposes the introduction of a new section in part VI of the Criminal Procedure (Scotland) Act 1995, on the specification of hospital units. The provisions in part VI of the 1995 act deal with mentally disordered people in the criminal justice system in Scotland. The purpose of amendment 112 is, first, to provide that any reference to a “hospital” in that part of the 1995 act may be read as a reference to a “hospital unit”, where a “hospital unit” means any part of a hospital that is treated as a separate unit. That means that any order or direction that may already be made under part VI of the 1995 act authorising the detention of a person or patient in a specified hospital may authorise their detention in a specified hospital unit. The provision relates to assessment orders and treatment orders relating to remand patients as well as the following orders relating to mentally disordered offenders: interim compulsion orders; temporary compulsion orders; compulsion orders; compulsion orders and restriction orders; hospital directions; and transfer for treatment directions.

That goes further than the effect that would have been achieved by sections 36 to 38 of the bill, which are consequentially to be removed by amendments 61 to 63. Sections 36 to 38 related only to compulsion orders made with a restriction order, hospital directions and transfer for treatment directions.

Amendment 23 seeks to amend section 136 of the 2003 act, which provides for the Scottish ministers to authorise the transfer of prisoners to hospital for treatment for mental disorder. It will allow references to a “hospital” to be read as references to a “hospital unit”, and it provides a definition of “hospital unit” as meaning any part of a hospital that is treated as a separate unit.

Amendment 112 makes provision as to how proposed new section 61A of the 1995 act, which section 35 of the bill will insert, is to apply in relation to a transfer from one hospital unit to another within the same hospital.

As far as the secondary driver that I referred to is concerned, amendment 93 amends section 124 of the 2003 act to include reference to interim compulsory treatment orders, which are orders made under section 65(2) of the 2003 act that authorise the detention of a patient in hospital.

That measure will enable the transfer between hospitals of patients who are subject to interim compulsory treatment orders, as well as patients who are subject to compulsory treatment orders, providing a formal process to authorise a transfer from one hospital to another for a patient who has been detained under an interim compulsory treatment order.

Amendment 96 proposes the insertion of a new section—section 124A—into the 2003 act to make new provision on transfers between hospital units. Proposed new section 124A will apply to patients who are subject to compulsory treatment orders and interim compulsory treatment orders where the order specifies the particular hospital unit in which the patient is to be detained. New section 124A will enable the managers of the hospital in which the patient is detained to transfer the patient to another unit within the same hospital or hospital unit.

The effect of both amendments 93 and 96 will be that patients under interim compulsory treatment orders can also be transferred from one hospital unit to another where the interim compulsory treatment order has authorised detention in a specified hospital.

I move amendment 93.

Dr Simpson: I have one question for the minister. A concern has been expressed to me that we do not now have accommodation in the state hospital for female prisoners—or rather, for those who have been charged. Will the amendments in this group, or the amendments that we will consider later, on cross-border issues, allow ministers to transfer individuals south of the border?

I want to get that point straight because, at the moment, I am not sure where female individuals who are charged and who have an interim order made against them because of criminal acts will be detained. Will they be detained in a medium-
secure unit or in a unit in England? We do not have top-security units for female prisoners any longer.

Jamie Hepburn: We will probably come back to Dr Simpson with greater detail in writing on that point, but my instinct is that the court could direct them either to a medium-secure unit or to a place furth of Scotland. It could be the case that the amendments that come down the line for debate later will be relevant here.

I observe, however, that there is great merit in the amendments in this group. It seems somewhat onerous that, at present, it is not possible to move people from one part of a hospital to another. I hope that the committee will support the amendments.

Amendment 93 agreed to.

Section 3—Emergency detention in hospital

The Convener: Amendment 67, in the name of Dr Richard Simpson, is grouped with amendments 68 and 69.

Dr Simpson: These three amendments arose partly from my feeling that the bill as introduced was, to a great extent, a diminution of patient rights. It was a fairly administrative bill, or a provider bill, and many of the changes that are being proposed by the Government today roll back on some of the reductions in patient rights that concerned me.

With amendment 67, I highlight a particular place in the bill where I felt rather worried about the language, and I would like to have the Government’s reply on record when I decide whether to press it. The amendment relates to section 3 of the bill which, at page 3, line 20, sets out proposed new section 38(3A) of the 2003 act:

“The managers of the hospital may, so far as they consider it appropriate, give notice of the matters notified to them under section 37 of this Act to the persons mentioned in subsection (4) below.”

When managers have a “may” instruction, that simply allows them to do something. The further caveat that they can decide whether that is “appropriate” or not really worries me. Amendment 67 changes that to “must”, and adds the words: “unless it is impracticable to do so”.

That allows a get-out for managers if it is not possible for them to notify people, but I think that they should notify people of things that are going on.

The other main amendment in the group, amendment 68, is simply to include advocates among those who are notified of the matters concerned. Amendment 69 is merely a consequential amendment.

I look forward to hearing the Government’s response. I move amendment 67.

Jamie Hepburn: I understand Dr Simpson’s rationale in lodging amendment 67, but I hope to be able to reassure him. The rationale for allowing hospital managers to share information only where they consider it appropriate is to give them discretion on sharing information with, for example, the person’s nearest relative or someone who resides with them. Currently, the hospital manager is required to provide a copy of an emergency detention certificate to those people, even if contains very sensitive information that the patient may not want them to have. The provision in section 3 was not introduced to allow hospital managers to exercise discretion about whether it is practicable to inform relatives, carers or named persons. The discretion would not be available if amendment 67 were agreed to.

I hope that it will be possible to address Dr Simpson’s concerns through the code of practice, which could set out in further detail the circumstances when and how the discretion should be used. Therefore, I would be very happy to have further discussions with Dr Simpson to see whether an alternative approach can be agreed. On that basis, I invite Dr Simpson not to press amendment 67.

Amendment 68 and consequential amendment 69 seem to go beyond the role of the independent advocate under the act and to be dependent on the changes in amendment 67 that I have argued against, noting that the discretion is not over the practicability of informing the nearest relative or person who resides with the patient. I request that Dr Simpson not press amendments 68 and 69.

The Convener: I call Dr Simpson to wind up and press or withdraw his amendment.

Dr Simpson: I do not need to wind up. I will move us on and not press amendment 67.

Amendment 67, by agreement, withdrawn.

Amendments 68 and 69 not moved.

Section 3 agreed to.

Sections 4 to 7 agreed to.

Section 8—Suspension of detention for certain purposes

The Convener: Amendment 5, in the name of the minister, is grouped with amendments 6 to 8, 94, 95, 9 to 13, 70, 14 to 18, 16A, 19, 19A, 20, 71, 21 and 21A.

If amendment 8 is agreed to, I cannot call amendment 94 because of pre-emption. If amendment 95 is agreed to, I cannot call
amendments 9 to 13 and 70 because of preemption.

Jamie Hepburn: Our overall policy aims on suspension of detention have been to realise best the suggestions that were made in the McManus report. Those recommendations included removing brief periods of suspension of detention from the cumulative total and aiding calculation of total periods by converting them to days rather than months. The report also recommended a total cumulative permissible period of suspension of 200 days, which could be extended by the tribunal in the small number of cases in which a patient has reached the limit but, because of the patient's individual mental state and care circumstances, it is not yet appropriate to apply to vary the order.

Our proposals will provide a sensible and workable framework for suspension of detention that suits the patient's individual requirements. It will also provide safeguards to ensure that it is used in the most appropriate way.

Amendments 5 to 7 will provide for more effective legislation on suspension of detention to complement the changes the bill introduces.

Amendment 5 makes changes for compulsory treatment orders in the interim. For compulsory treatment orders, it allows a single certificate to authorise either a single period of suspension of detention or a series of periods of suspension of detention. For compulsory treatment orders, any single continuous period of suspension and detention cannot exceed 200 days. The change is to express the period in days rather than months, in common with other changes in the bill relating to suspension of detention.

For compulsory treatment orders, the amendment states that the maximum duration for any certificate authorising multiple periods of suspension of detention is six months. The aim of the amendment is to produce a consistent and administratively sensible system of suspension of detention that is not burdensome to responsible medical officers and can be used in patients' best interests. The changes will also carry across to compulsory orders by virtue of section 179 of the 2003 act.

Amendment 6 allows a single certificate to specify either a single period of suspension of detention or a series of periods of suspension of detention in respect of assessment orders.

10:15

Amendment 7 relates to treatment orders, interim compulsion orders, compulsion orders and restriction orders—COROs—hospital directions, transfer for treatment directions and temporary compulsion orders. The amendment allows a single certificate to specify either a single period of suspension of detention or a series of periods of suspension of detention. Any single period cannot exceed 90 days. The change addresses an anomaly in the bill in that it expresses certain timescales in relation to suspension of detention in months rather than days. The amendment also states that the maximum period of time for any certificate authorising multiple periods of suspension of detention is three months.

The main changes to policy brought about by amendments 8 and 15 have the effect that any period of suspension authorised for up to eight hours does not count towards the total of 200 days. The bill as introduced did not count periods of up to 12 hours towards the total. We listened to concerns from stakeholders that 12 hours might not quite reflect the brief periods that the McManus report suggested should not be counted towards the cumulative total.

Broadly speaking, suspension of detention is used in two different ways. The first is for short trips out of hospital, usually escorted, during the working day. The second is for testing out, in which the patient has an overnight stay out of hospital and eventually several nights out at a time. Testing out helps the patient and their care team to see how the patient will cope with being out of hospital when their order is revoked or varied to a community order.

By changing the time period to eight hours—roughly the standard working day—we are ensuring that the first type of suspension of detention, in which the patient is escorted, does not count towards the cumulative total but testing-out periods do. We believe that that best reflects the McManus report's recommendations on the subject.

The amendments also make provision for how periods of more than eight hours and less than 24 hours are counted towards the cumulative total, how the maximum cumulative period of 200 days is calculated and the manner of granting certificates.

Amendment 8 relates to compulsory treatment orders. Amendment 15 relates to treatment orders, interim compulsion orders, compulsion orders and restriction orders, hospital directions, transfer for treatment orders and temporary compulsion orders.

Amendments 9 and 16 make clear that, when the tribunal approves an additional 100 days of suspension of detention, it does so by an order.

Amendments 10 and 17 remove certain text from section 9 of the bill on how the additional 100 days of suspension of detention could be authorised by the tribunal. They are a consequence of other amendments.
Amendments 11 and 18 clarify requirements in the small number of cases in which a responsible medical officer applies for an extra 100 days of suspension of detention in relation to a patient’s treatment. They ensure that the Mental Welfare Commission receives notification that that has occurred, in order to help with the commission’s wider monitoring of the 2003 act.

Amendments 12 and 19 give patients and their named person the opportunity to make representations to the tribunal in relation to a hearing to extend the maximum total period of cumulative detention or to vary an order to a community-based order. They also ensure that the patient and named person will be informed of the result of the application. That adds to safeguards for the patient in relation to any application to extend the total period of cumulative detention.

Amendment 13 is introduced in response to concerns that an extension of 100 days to the cumulative total of suspension of detention might be granted by the tribunal when it would be more appropriate to vary the order to a community-based order. The amendment gives the tribunal the ability to reject the additional 100 days and instead vary the order to a community-based order. That should ensure that suspension of detention is not used on a long-term basis when a community-based order would be more appropriate. It should also avoid unnecessary extra hearings being held when the tribunal judges that a community-based order is more suitable.

At the same time, by retaining the additional 100 days, we have kept the flexibility for the very small number of patients the McManus report identified as needing further testing out before a community-based order would be appropriate. That disposal will be available in relation to a compulsory treatment order or a compulsion order.

Amendment 14 relates to suspension of measures other than detention for compulsory treatment orders. It changes the maximum period of suspension of measures other than detention to 90 days from three months. That change is made to be consistent with other changes made by the bill that convert time in months to time in days to facilitate calculation of those periods.

Amendment 21 provides an additional safeguard for patients. It will apply only for the small number of patients for whom an application is made to extend the maximum cumulative limit by a further 100 days. It will allow certain persons, including the patient and named person, to appeal the decision of the tribunal on whether to vary the order to a community-based order.

I will not move amendment 20; I thank the committee for its understanding. The intention behind the amendment was to provide a consistent approach in line with amendment 13 but for certain other orders and directions. However, on further reflection, I am not satisfied that it is appropriate to confer powers on the tribunal to vary those orders and directions to remove the detention requirement. The tribunal does not elsewhere in the act have powers to remove the detention element of those orders, and we do not want to introduce that power only in relation to where an application to the tribunal has been made to increase the total period of suspension of detention. Suspension of detention in relation to these orders is for rehabilitative purposes; conversion to a community-based order is a formal decision in relation to the order.

For a compulsion order and restriction order, the compulsion order would be varied only when the restriction order has been lifted. If a patient who is subject to a hospital direction or a transfer for treatment direction no longer requires to be detained in hospital, the mechanism would be for them to return to prison to serve the remainder of their sentence.

Amendments 18A, 19A and 21A make changes to those amendments as a consequence of the intention not to move amendment 20. They remove references to subsection (12B), which would have been inserted by that amendment. I am grateful to the convener for accepting those manuscript amendments.

I thank Dr Simpson for lodging amendments 94, 95, 70 and 71, which look to alter or remove the ability of the tribunal to extend the 200-day cumulative limit of suspension of detention by a further 100 days. As I have now described, we have responded to concerns that the cumulative total may be extended where a conversion to a community-based order would be more appropriate and we have brought in safeguards for the patient. Amendments 94 and 95 would remove the ability to increase the total period of suspension of detention by up to 100 days, although only in relation to compulsory treatment orders, and amendments 70 and 71 would allow an extension by only a further 30 days. I do not believe that that provides as much flexibility for the individual circumstances of the patient as the Government’s suggested way forward does. I believe that our proposals provide the best balance between a flexible system that meets individual needs and protection for patients and I ask that those amendments are not pressed.

I move amendment 5.

Dr Simpson: First, I thank the minister for addressing some of the concerns that were expressed to the committee. There is a view that the community orders, which were one of the new things that came in with the 2003 act, have been successful. My only concern about what the
The minister has just said is that he talked about a small number of patients, but we have no indication of what that means. Is the number in single digits? Is it 30 or 40? What number is likely to apply in relation to the community treatment orders? However, I recognise that the minister has gone some way towards reinforcing the patient’s right to say that the order should not be extended, and the tribunal will be given powers to ensure that it is not.

The amendments in my name are based on the written evidence from the Mental Welfare Commission. I believe that the 200-day or nine-month period that is in the act is sufficient. A number of witnesses have said that it would be inappropriate if, after 200 days, no decision has been made about whether the patient should continue under a restrictive order—it is better than being in hospital, but it is still a restrictive order—and we should therefore leave the act as it is, with the requirement for decisions to be made within the 200-day period. We should remember that the period of time could be much longer, because there could be a series of periods that amount in total to 200 days but which have suspensions in between.

The second set of amendments in the group, which will come into play only if the first set is not passed, offers an alternative. The amendments in the second set would allow a short period of extension of 30 days beyond the original period, rather than another 100 days. A hundred days is 50 per cent of the original period, which seems excessive. I am not sure why a 100-day period was decided on instead of a shorter period that would enable those who are concerned with the patient’s health to determine whether a continuation of the compulsory order was appropriate, whether some other order should be put in place or whether treatment should continue on an entirely voluntary basis. For example, if, after 200 days, the patient is seen to be not taking their medicine to a sufficient extent to prevent them from relapsing, I can understand that it might be a good idea to extend the order for a further period of time.

I welcome the fact that the minister has gone some way towards addressing my concerns. I am not sure that he has gone far enough, but I will wait to see what he says in his summing up before deciding how to proceed.

The Convener: As no other member wishes to speak at this time, I ask the minister to wind up and respond.

Jamie Hepburn: Taking on board some of what has been raised by Dr Simpson, I should say that, at this stage, it has not been possible to get exact figures on how many patients reach the current nine-month limit. However, the snapshot figures that we have received from the commission suggest that very few do—the number is likely to be in single figures.

Although I recognise that there is validity to what Dr Simpson says, the Government’s approach is that there is merit in having a more flexible system, which our amendments would allow for. That is more in line with what was recommended in the McManus report. On that basis, I urge the committee to support the amendments presented by the Government.

Amendment 5 agreed to.

Amendments 6 and 7 moved—[Jamie Hepburn]—and agreed to.

Section 8, as amended, agreed to.

Section 9—Maximum suspension of detention measures

Amendment 8 moved—[Jamie Hepburn].

The Convener: I remind members that if amendment 8 is agreed to, I cannot call amendment 94. The question is, that amendment 8 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Milne, Nanette (North East Scotland) (Con)
Robertson, Dennis (Aberdeenshire West) (SNP)

Abstentions
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 6, Against 0, Abstentions 3.

Amendment 8 agreed to.

Amendment 95 not moved.

Amendments 9 to 13 moved—[Jamie Hepburn]—and agreed to.

Amendment 70 moved—[Richard Simpson].

The Convener: The question is, that amendment 70 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

10:30

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.
Amendment 70 disagreed to.

Amendments 14 to 17 moved—[Jamie Hepburn]—and agreed to.
Amendment 18 moved—[Jamie Hepburn].
Amendment 18A moved—[Jamie Hepburn]—and agreed to.
Amendment 18, as amended, agreed to.
Amendment 19 moved—[Jamie Hepburn].
Amendment 19A moved—[Jamie Hepburn]—and agreed to.
Amendment 19, as amended, agreed to.
Amendments 20 and 71 not moved.
Amendment 21 moved—[Jamie Hepburn].
Amendment 21A moved—[Jamie Hepburn]—and agreed to.
Amendment 21, as amended, agreed to.

After section 9
Amendments 22, 23 and 96 moved—[Jamie Hepburn]—and agreed to.

Before section 10

The Convener: Amendment 24, in the name of the minister, is grouped with amendments 25, 72, 26, 73 to 77, 27, 78, 79, 28 to 31, 80, 32 and 33. If amendment 26 is agreed to, amendment 73 will be pre-empted.

Jamie Hepburn: The amendments in the group relate to an important issue, so I hope that the committee will understand if I take some time to talk about the Government’s position on it. The Government’s stated intention was set out in the draft amendments, draft regulations and draft timetable for the introduction of the right of appeal outwith the state hospital that were provided to the committee on 24 April. I hope that the committee found them helpful in clearly setting out our position and demonstrating our commitment to bringing effective regulations into force as soon as possible after royal assent.

The amendments in the group relate to sections 10 to 12 of the bill, which amend the sections of the 2003 act that relate to appeals against being detained in conditions of excessive security in the state hospital and in hospitals other than the state hospital. I will focus first on amendments 26 to 31, which relate only to hospitals other than the state hospital, as they go to the heart of the differences between the Government’s approach and the alternative approach that Dr Simpson appears to propose.

It is clear from the debate on the relevant provisions when the bill that became the 2003 act was considered that the intention in introducing them was to enable patients in the state hospital—and, in the future, those in medium-secure units—to seek to move to a lower level of security. That was the Millan recommendation.

The bill will fulfil that intention, and amendment 24 and the amendments grouped with it build on that intention. What the Government considers is needed is to ensure that the scheme that was provided for in 2003 can operate effectively in the present secure estate. We do not seek to extend that scheme to persons or purposes that it was never intended to cover.

It is clear that the scheme has always been about a move from one place to another. It is not about challenging the imposition of particular security measures in the place that a patient is in. That is clear when we consider that the only available remedy under the scheme is a move to another hospital or unit and not, for example, an order for certain measures to be lifted.

If there were a wish to change the appeal in a way that meant that it could sensibly be extended to all patients, that would require a more fundamental reworking of the scheme set out in the 2003 act than has been consulted on. As far as I am aware, there is no consensus in favour of that.

In its stage 1 report, the committee asked for consideration to be given to whether an individual in a low-secure setting could appeal so that they could move from one level of security to another and still remain in low-secure accommodation and asked whether that would appropriately merit the inclusion of a right to appeal for individuals in low-secure settings.

My response is that, as I have explained, the scheme that the 2003 act provided for is not about challenging particular security measures, including that of being locked. I do not consider the scenario of being locked while in low-secure accommodation to be one where the level of security is excessive. That is what we are talking about—levels of security that go beyond the proper limit or degree.
In general, patients in low-security accommodation are initially cared for in a ward for a period. They then have gradually increasing periods outwith the ward in the wider hospital environment, either escorted or unescorted, and then community access, progressing to overnight passes. Finally, they are discharged.

The committee has already considered amendments that allow patients being treated in hospital to have access to the community for up to 200 days—possibly even up to 300 days with tribunal agreement—in every 365 days. Other applications that might be made under the 2003 act would allow such patients to seek to vary or revoke their detention orders. We should also be mindful that everyone discharging functions under the 2003 act has a legal duty to do so in a manner that appears to them to involve the minimum restriction on the patient’s freedom that is necessary in the circumstances.

I am interested to hear Dr Simpson’s explanation of his amendments. I say with respect that, if they are intended to lay the groundwork for regulations that do not limit the right of appeal to patients in medium-secure units, I will be unable to support them. The Government’s clear position is that the right to make an application under section 268 of the 2003 act should be made available only to patients in medium-secure units. We cannot support amendments that seek to provide otherwise.

If what I described is not the intention, I nonetheless prefer my proposed approach, which seeks to build on what is in the 2003 act by providing additional powers to make regulations in relation to the test to be applied by the tribunal, as well as providing for supportive medical reports. I will discuss my amendments and, I hope, persuade the committee that my proposed approach is the better option.

Amendments 26 to 29 ensure that the core of the test that is set out in the 2003 act remains unaltered while allowing flexibility for the test to be refined through regulations that would add extra limbs to it, should experience of the tribunal’s operation indicate a need for the test to be refined. Amendments 26 and 27 do that by replacing the requirement for the tribunal to be satisfied, before making an order, that detention of the patient in the qualifying hospital involves the patient being subject to a level of security that is excessive in their case with a requirement that the tribunal may make an order only if it is satisfied that the test specified in regulations under new section 271A of the 2003 act, introduced by amendment 29, is met in relation to that patient. Amendment 28 is similar, but it will require the tribunal to be satisfied that the test specified in regulations is not met in relation to the patient before an order can be recalled.

Amendment 29 introduces new section 271A of the 2003 act, which sets out the regulation-making powers relating to detention in conditions of excessive security. It allows for a definition of a qualifying hospital so that the scheme that was provided for in 2003 can operate effectively in the present secure estate by allowing those in medium-secure units to seek a move to accommodation with a lower level of security.

Proposed new section 271A provides a regulatory framework for the test that must be met if the tribunal is to make an order that a patient is being detained in conditions of excessive security. That framework includes a requirement that the tribunal is satisfied that detention of the patient in the hospital where they are being detained involves the patient being subject to a level of security that is excessive in their case.

Section 271A also allows regulations to provide for the test to include further requirements in relation to a patient. Those could include factors such as the impact on a patient’s care and treatment if they were to be moved, if that was felt to be an important consideration.

The proposal allows for flexibility for the test in the light of changes in practice or the tribunal’s experience of hearing appeals and the subsequent effect on patients. Anything that was included in regulations would be subject to scrutiny by the committee and Parliament.

Amendment 31 makes regulations under proposed new section 271A of the 2003 act subject to the affirmative procedure.

Amendment 30 is a minor technical amendment to reorder the words in the first line of the definition of a relevant patient so that, instead of saying “is authorised in hospital”, it reads “in hospital is authorised”. That has no impact on the provision’s effect.

Amendments 24, 25, 32 and 33 relate to appeals under sections 10 to 12 of the bill, whether they relate to the state hospital or hospitals other than the state hospital.

On amendment 24, we know that appeals that have a medical practitioner’s support are significantly more likely to succeed. Of the first 100 state hospital patients to make an application, 93 per cent of those who were successful had responsible medical officer support and, of those whose applications were unsuccessful, 91 per cent did not have responsible medical officer support. Research into the first 100 state hospital patients to appeal found that 23 per cent of appeals were rejected and a further 23 per cent were withdrawn. A number of reasons may be in
play, but it is not unreasonable to assume that, in the majority of those 46 per cent of cases, there was no supportive report from a medical practitioner.

Amendment 24 allows a medical practitioner to consider a patient’s case and assess whether, in their opinion, the test that is intended to be set out in regulations is met. It will not prevent any appeals that would have succeeded without the new requirement for a supportive report by a medical practitioner. Additional criteria that a medical practitioner might be required to meet could be set out in the regulations that are introduced under amendment 29.

Amendment 25 takes out section 10(9) of the bill, which was included to allow an application to be made even if one had previously been made and then withdrawn. On further reflection, we are not persuaded of the need for that provision. We are not aware from the 10 years of operation of appeals from the state hospital that the 2003 act’s provisions to allow for only one application per 12 months in respect of the same patient have been an issue. There have not been calls for change. Following discussions with the tribunal, we have also considered the possibility of applications being made and withdrawn multiple times from any of the people with the right to make an application, which could have the impact of an increase in tribunal hearings. On balance, it was felt that we should maintain the considered position as set out in the 2003 act, but we are open to considering the matter again if there is evidence of a practical issue.

Amendment 32 inserts a new subsection that provides that, in chapter 3 of part 17 of the 2003 act,

“a reference to a hospital may be read as a reference to a hospital unit”

and that, for the purposes of that chapter,

“hospital unit’ means any part of a hospital which is treated as a separate unit.”

That will, for example, mean that the duty on a health board under proposed new section 268(3) of the 2003 act to identify a hospital can be fulfilled by identifying a hospital unit, whether or not that is in the hospital in which the patient is currently detained.

Amendment 33 removes section 12 of the bill, which would insert proposed new section 272A in the 2003 act, as its terms are now included in other provisions. Powers to make regulations on the definition of a qualifying hospital and the question whether a patient’s detention in hospital involves the patient being subject to excessive security are instead addressed in proposed new section 271A, as introduced by amendment 29.

Provision in relation to hospital units that extends to all of chapter 3 of part 17 of the 2003 act and not just provisions that relate to patients not in the state hospital is in proposed section 273(2) of the 2003 act, as introduced by amendment 32.

I move amendment 24.

Dr Simpson: I welcome the proposals in the bill and the minister’s amendments. The ability to appeal against an overly restrictive level of detention being applied in a medium-secure unit is welcome.

As the minister said, one of the major principles of the Millan committee, which was incorporated into the 2003 act, was that restrictions should be at the minimum level that is compatible with the safety of the patient and of others. Hitherto, that has meant that appeals could be made against continued excessive security in the state hospital. When we passed the 2003 act, there was only one medium-secure unit—the Orchard clinic in Edinburgh—and the number who were held in the state hospital was more than twice the number who are currently held. We now have additional medium-secure units at Stobhill and the new unit at Murray royal hospital in Perth, which is in my constituency.

10:45

I very much welcome the fact that the minister published the regulations early. That allowed us to be clear that the proposal is about appeals against restriction in medium-secure units, which is to be very much welcomed.

The purpose of my amendments is to take us further. If we look back to 2003, there was the state hospital and one medium-secure unit, so the possibilities for transfer were not particularly numerous, but there are now low-secure units. There are units at the state hospital level, medium-secure units and low-secure units, but they are not discrete. Increasingly, there will be different levels of security within low-secure units.

In line with the Millan committee requirement that restriction should be at a minimum level, I believe that the time has come to consider whether people should have a right of appeal without having to appeal against the detention order. They should be able to appeal against being held in a particular low-secure unit and should be able to move to another low-secure unit, which may have a different approach. The amendments in my name deal with that.

Having had discussions with mental health professionals, I recognise that, although they are ready for the changes that the Government has proposed in respect of medium-secure units, they are not yet ready to tackle low-secure units. It would therefore be more sensible to include the
proposal in regulations, which can be put through when the service is ready to deal with the matter.

Does the minister agree in principle that we should now look at transfer between low-secure units or does he believe that the time is not right? If he believes that the time is not right and therefore does not accept the principle at this time, I take it that he would not be prepared to work with me to produce suitable amendments at stage 3. However, I hope that he will undertake that, if he agrees to a major review of the 2003 act at a future date—I hope that he will do that later when we come to other amendments—the issue will be an element of that, because we have to give patients greater rights to appeal against detention in a particular type of secure unit. That point is reinforced by the fact that the minister is making the change from an appeal against a hospital to an appeal against a unit. The issue is the differentiation between units, which will become increasingly supported. My amendments would future proof the bill.

Bob Doris: I have listened carefully to the arguments that the minister and Dr Simpson made. I also considered whether to lodge amendments.

Some of the minister’s comments were quite interesting and got me thinking about whether an appeal against low security is an appeal against excessive security or against security itself. He made the point well that the various low-secure settings may be part of a continuum and may be preparation for a community disposal. I would like more information about whether there are, for example, various levels of security in medium-secure settings. I understand that the bill will allow someone to appeal against detention in a medium-secure setting but not against detention in the various types of setting within medium secure.

I am more content with the minister’s proposals if we view the low-secure setting as a continuum towards a potential community disposal. We heard that it is possible to suspend a CTO for 200 days. Does the minister agree that more work needs to be done to get a greater understanding of precisely what happens in a low-secure setting to prepare those who have had their liberty withdrawn from them for a return to the community?

I am minded to support the minister’s position, but the interesting points that Dr Simpson made about how we look at various security settings in low-secure and medium-secure units and the state hospital require further discussion at a later date.

Rhoda Grant (Highlands and Islands) (Lab): The Scottish Association for Mental Health has raised some concerns about amendments in the group. First, it raises a concern about amendment 29, which defines a qualifying hospital and states that a patient must be in a qualifying hospital to appeal against detention on the ground of excessive security. SAMH’s concern is that the issue should be the conditions in which a patient is held rather than the hospital that they are held in. I look forward to hearing the minister’s comments on that.

SAMH has also flagged up concerns about amendments 24 and 25. On amendment 24, which requires an appeal to be accompanied by a medical practitioner’s report, I believe that I heard the minister correctly when he said that 91 per cent of appeals were rejected if they were not accompanied by a medical practitioner’s report. What would happen to the 9 per cent that go through without such support if amendment 24 were agreed to?

On amendment 25, which relates to the withdrawal of appeals, I acknowledge the minister’s comment that he would consider the matter again if any evidence emerged of such a move creating any barriers, but 12 months seems a long time between an individual withdrawing an appeal and their being able to lodge another if, say, their circumstances changed. I would therefore welcome hearing his comments about that.

Jamie Hepburn: A number of issues have been raised, and I will try to pick everything up as well as I can.

Mr Doris is correct to say that we are talking about appeals against the level of security and not the specific circumstances of medium-secure settings in the estate. As for Rhoda Grant’s point about SAMH’s concern over our reference to “qualifying hospital” and the comment that the issue is the conditions in which the patient is held, I suggest that that is a bit of a moot point, given that the conditions in which the individual is held are defined as medium secure. However, I am always happy to consider concerns that have been expressed.

As for the other concerns that Rhoda Grant raised, she is right that I mentioned that 91 per cent of unsuccessful applications did not come with the support of a responsible medical officer, but I point out that I was referring to a sample of the first 100 state hospital patients to make an application. She asked what would happen to the 9 per cent of applications that were successful, and I pointed out that they would still be successful; the difference is that, under these provisions, they would have to get the report in the first instance. Those individuals did not need to get the report before, but I expect that, under these provisions, that 9 per cent will get a report in support of their applications and will still be successful.
Dr Simpson set out a different approach in his amendments. I entirely understand his perspective, but I note his point that professionals in the field do not feel that they are ready at this stage for what he proposes. I agree that we should always seek to reinforce patients’ rights—that is why we have lodged the amendments—but I am not convinced that we should go forward in his preferred way. He asked whether we can discuss the matter; I am always happy to have such dialogue and I commit myself to having the discussion that he seeks, but I suspect that, if we were to consider the move that he proposes, it would be a longer-term thing rather than something that would be achieved through the bill.

Amendment 24 agreed to.

Section 10—Process for enforcement of orders
Amendment 25 moved—[Jamie Hepburn]—and agreed to.

Section 10, as amended, agreed to.

Section 11—Orders relating to non-state hospitals
Amendment 72 not moved.  
Amendment 26 moved—[Jamie Hepburn].

The Convener: I remind members that, if amendment 26 is agreed to, I cannot call amendment 73. The question is, that amendment 26 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Doris, Bob (Glasgow) (SNP)  
Keir, Colin (Edinburgh Western) (SNP)  
Lyle, Richard (Central Scotland) (SNP)  
MacKenzie, Mike (Highlands and Islands) (SNP)  
Robertson, Dennis (Aberdeenshire West) (SNP)

Abstentions
Grant, Rhoda (Highlands and Islands) (Lab)  
McNeil, Duncan (Greenock and Inverclyde) (Lab)  
Milne, Nanette (North East Scotland) (Con)  
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 5, Against 0, Abstentions 4.

Amendment 26 agreed to.

Amendments 74 to 77 not moved.

Amendment 27 moved—[Jamie Hepburn]—and agreed to.

Amendments 78 and 79 not moved.

Amendments 28 to 31 moved—[Jamie Hepburn]—and agreed to.

Amendment 80 not moved.

Section 11, as amended, agreed to.

After section 11
Amendment 32 moved—[Jamie Hepburn]—and agreed to.

Section 12—Qualifying non-state hospitals and units
Amendment 33 moved—[Jamie Hepburn]—and agreed to.

Section 12, as amended, agreed to.

Section 13 agreed to.

The Convener: I propose at this point, with the committee’s agreement, to have a 10-minute comfort break. We will resume at 10 past 11 for approximately another hour.

10:59
Meeting suspended.

11:09
On resuming—

The Convener: We welcome Adam Ingram to the meeting. He has amendments coming up in a wee while—we hope.

Section 14—Detention pending medical examination

The Convener: Amendment 34, in the name of the minister, is grouped with amendments 97, 98, 35 and 81.

Jamie Hepburn: The Scottish Government’s key reason for amending the existing provisions is to make the maximum period of detention and the purposes of that detention clearer for everyone involved, particularly in respect of detention being for the purposes of medical examination.

I am very clear that the provisions that will be introduced by the bill will not extend the period of detention. The maximum period of detention under the provisions will remain as it is now, at three hours. The only difference is that the maximum period of detention under the 2003 act is currently two hours, extendable to three, and under the bill, the maximum period will be three hours from the outset. I consider that that added clarity will be beneficial to service users and will not result in patients being detained for any longer than is the case under the current legislation.

It is important to note that the three hours is an upper limit, not a fixed period. The provision will be accompanied by clear updated guidance in the code of practice, which will confirm that the provision should be used in line with the principle
of least restriction. A working group that includes a range of stakeholders has been set up to advise the Government on updates to the code.

Aside from the issue of the maximum period of detention, I am aware that a number of stakeholders have concerns that the proposals could result in restriction of service users’ liberty. Amendment 35 responds to those concerns by seeking to remove the provision that would have allowed the nurse’s holding power to be used for the purpose of detaining the patient to ensure that he or she did not leave the hospital before the granting of an EDC or STDC. On reflection, I do not believe that that would be in line with the principle of least restriction. Amendment 34 will simply remove from section 14 text that is no longer required because of the changes that will be made by amendment 35.

I turn to amendments 97 and 98, in the name of Nanette Milne. Amendment 98 is intended to remove any suggestion that patients must actively leave the hospital before nurses can exercise the holding power. I am not convinced that that addresses a significant practical problem. The Mental Welfare Commission’s guidance covers the fine line between encouraging a patient to stay in hospital, which does not require use of the nurse’s power to detain under section 299 of the 2003 act, and telling the patient that they cannot leave and will be restrained the moment that they try to do so, which could amount to de facto detention and should normally trigger use of the power.

Amendment 97 is a structural amendment that would be necessary to allow amendment 98 to work.

I ask Nanette Milne not to move her two amendments.

Amendment 81 would remove the entirety of section 14. I believe that it is right to remove the provision which would have allowed the nurse’s holding power to be used for the purpose of detaining the patient to ensure that they did not leave the hospital before the granting of an emergency detention certificate or short-term detention certificate, as covered by amendments 34 and 35. However, I believe that the nurse’s holding power will benefit from it being made more clear in terms that its purpose is for arranging a medical examination, and from it being made clear to the patient from the outset that the power can last for up three hours.

I therefore ask Dr Simpson not to move amendment 81.

I move amendment 34.

Nanette Milne (North East Scotland) (Con): I appreciate the minister’s comments. What he has said probably makes my amendments more or less redundant. The reason for lodging them, however, was basically that section 299(3)(b) of the 2003 act says that the nurse’s power to detain is required only where “it is necessary for the protection of ... the health, safety or welfare of the patient; or ... the safety of any other person, that the patient be immediately restrained from leaving the hospital”.

My amendments sought to address the words “leaving the hospital”. The Law Society of Scotland highlighted the fact that those words have caused confusion, which has left the question whether detention under section 299 of the 2003 act is lawful when a patient has not made an overt attempt to leave the hospital. I will leave it at that.

Dr Simpson: I welcome amendments 34 and 35 because they will clarify aspects of the nurse’s power to detain. My amendment 81 was formulated before those Government amendments were lodged, however, so I might have approached it slightly differently.

Amendment 81, to delete the whole of section 14, which would return the situation to the status quo ante, was lodged because both SAMH and the Royal College of Nursing representative who spoke at the Health and Sport Committee, who is the chair of the mental health nursing forum Scotland, were of the view that the proposed amendment to the 2003 act that is contained in section 14 of the bill—to make a change from two hours with an extension to three hours, to three hours—is unnecessary.

11:15

Section 14 appears to be a tidying-up amendment to the 2003 act. The minister said that the period will be a maximum, but knowing as I do the way things go, I think that people are likely to drift towards the maximum just because it is there. The ability to extend from two hours to three was a deliberate inclusion in the 2003 act. If the minister and the Government had produced a justification for the proposal based on statistical analysis or data collection, I would have been happier to support it, but as Mr Barron said—I quote from our report—

“We do not even know where the proposal came from; it certainly did not come from nursing”.

That seems to me to be a real problem. I remain confused about where the proposal came from.

Furthermore, without considerable enhancement of both the numbers and availability of mental health officers, it appears that it is unlikely that the proposal—if this is what it is about—will lead to greater involvement of MHOs. We know that they are already under pressure, and I do not think that the proposed change is going to increase their involvement.
Psychiatry is also facing significant challenges, particularly in view of the fact that—as the latest report from the Royal College of Psychiatrists indicates—42 per cent of psychiatrists in training are emigrating after completing their foundation exams. A failure in workforce planning should not be a basis for changing a provision and extending it to allow that fewer psychiatrists need attend medical examinations. Overall, what is proposed would be an unnecessary diminution of patients’ rights, so it should be deleted. However, had I seen amendments 34 and 35 before I lodged my amendment 81, I would have proposed simply to return the situation to the status quo ante with the enhanced power that people could be detained only for the purposes of a medical examination. I will probably look at that at stage 3.

Jamie Hepburn: I thank Nanette Milne for her comments. I am glad that what we propose takes care of her concerns: I think that that is what she said.

Turning to Dr Simpson’s amendment 81, I note that we could have run around and sought to bring statistical justification for the position that we are taking. I should not call it a change, because I do not perceive it to be that. I believe that what is in the bill is far clearer for patients than the current position. They will know at the outset that the maximum time for which they can be held is three hours, whereas at present it is two hours extendable to three. I do not consider that to be a great diminution of patients’ rights—especially when we consider the other safeguards that we are putting in place. It will enhance patients’ rights because it offers greater clarity for the patient.

I hear that the RCN has another position; indeed, it has made a submission to the Scottish Government in which it sets out its position. It has not sought to meet me directly, although I will be meeting it later today in relation to another matter, so the subject might be something that we will discuss. However, I am comfortable with the provision that we have included in the bill.

I urge members to support the Government amendments and to reject Richard Simpson’s amendment and the amendments in the name of Dr Milne, if she chooses to move them.

Amendment 34 agreed to.

Amendments 97 and 98 not moved.

Amendment 35 moved—[Jamie Hepburn]—and agreed to.

Amendment 81 moved—[Richard Simpson].

The Convener: The question is, that amendment 81 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeill, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 81 disagreed to.

Section 14, as amended, agreed to.

Section 15—Appeal on hospital transfer

The Convener: Amendment 36, in the name of the minister, is in a group on its own.

Jamie Hepburn: Amendment 36 will remove section 15, which would have shortened the period of appeal against transfer to the state hospital from 12 weeks to 28 days. The amendment means that patients will continue to have 12 weeks to appeal against their transfer under section 220 of the 2003 act.

The provision was intended to ensure that potential treatment was not delayed. However, we have listened to stakeholders’ views, including those of the committee, about the potential difficulties for patients in having to appeal in the proposed 28-day timescale. I accept that the concerns outweigh the potential benefits.

I move amendment 36.

Amendment 36 agreed to.

Section 16—Periodical referral of cases

The Convener: Amendment 37, in the name of the minister, is grouped with amendments 38 and 99.

Jamie Hepburn: Amendment 37 will amend section 16 to make it clear that, on compulsory treatment orders, the periodical referral by the tribunal is to take place where no application has been “determined by” it, rather than “made to” it, in the preceding two years. That will avoid the situation where a review is not triggered because an application has been made to the tribunal and then withdrawn by the patient. The amendment will ensure consistency with the changes that are made under section 16, for compulsion orders and restriction orders to be reviewed every two years.

Amendment 38 is consequential to amendment 37 and will ensure that paragraph 13A of schedule 2 to the 2003 act is repealed in its entirety because it will no longer be necessary. Section 16
is intended to solve a genuine problem that has led to reviews under section 189 of that act being delayed. The need for a section 189 reference is calculated by whether reference was made in the two years prior to the relevant day, which is the anniversary of the order, as I have described in relation to amendment 37.

Section 16 of the bill relates particularly to when a review is not triggered because an application that is made to the tribunal is then withdrawn by the patient. That can lead to substantial delays to the two-year review. Therefore, I invite Dr Simpson not to move amendment 99, given the benefits that will result from section 16.

I move amendment 37.

Dr Simpson: The issue in amendment 99 was raised with me by the Law Society of Scotland, which considers that any reference should be dealt with efficiently and effectively by the tribunal, thus avoiding any unnecessary delay in determining the reference. Patients should not be disadvantaged by delays in the tribunal process. They also should have a right to have their orders reviewed by reference every two years from the date on which the reference is made, in order to maintain consistency and to avoid confusion. To ensure that patients are not disadvantaged, reviews of all orders should be timetabled every two years in the same way.

If I am hearing the minister correctly, his amendments will deal with the issue. Subject to that, I will be content.

The Convener: I ask the minister to wind up and press or withdraw.

Jamie Hepburn: I have nothing to add, convener.

Amendment 37 agreed to.

Amendment 38 moved—[Jamie Hepburn]—and agreed to.

Amendment 99 not moved.

Section 16, as amended, agreed to.

Section 17—Recording where late disposal

The Convener: Amendment 101, in the name of Adam Ingram, is grouped with amendment 102.

Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP): Although there are few people who would challenge the powers to keep mentally ill patients in a place of safety or place of care, I believe that psychiatric drugs should not be the sole means of treating mental illness. However, that seems to be the prevailing situation in Scotland.

Many contend that, too often, physical health conditions that might underlie mental illness go untreated in mental hospitals. For example, 25 per cent of long-stay patients have no record of health checks. Similarly, people with behavioural issues such as those on the autism spectrum can be doubly disadvantaged, as treating people with autism spectrum disorders with psychiatric drugs has serious consequences that have been outlined and detailed by Autism Rights in its written evidence to the committee.

None of the current practice takes account of individual tolerance of such drugs, and little is known of the effects of polypharmacy. Let me give the committee one example: it is not current practice to record the prescription of drugs for epilepsy in mental health institutions. Many people with autism also have epilepsy, and it is not well known that seizure activity, even at sub-clinical level, can induce hallucinations, with the obvious dangers of misdiagnosis. As psychiatrists are not considered to be knowledgeable about autism, access to other professional expertise is essential, particularly for people who are on the autism spectrum.

Far greater care should be taken with psychotropic drugs, and amendment 101, in my name, seeks to promote that. Given that some people cannot tolerate such drugs at all or can tolerate them only in tiny doses over a short period of time, there must be a real choice of treatment...
options for them. I note that the National Institute for Health and Care Excellence guidance on ASD states that psychotropic drugs should be used only for six weeks and discontinued if there is no significant improvement. That is a major change from current psychiatric practice, and it needs to be applied and respected.

Amendments 101 and 102 are designed to address what appears to be the default position of psychotropic drug use in the treatment of mental illness in favour of a more holistic approach.

I move amendment 101.

11:30

Dr Simpson: I support Adam Ingram’s amendments on a very important matter. I would take issue with some of the things that he said about my psychiatric colleagues, and I remind members of my declaration of interests as a fellow of the Royal College of Psychiatrists. Nevertheless, the issues that Adam Ingram raises are important.

One of my major concerns at the moment is about the treatment with psychotropic drugs of people with dementia in acute hospitals. That is unacceptable, but it is not being ordered by psychiatrists; it is being ordered by those serving in acute hospitals, often without the use of liaison psychiatry. It is a matter of grave concern to me that that is happening.

In addition, there is the question of the use of psychotropic drugs in care homes, which the committee has looked at previously. Again, although the Care Inspectorate has looked at the matter, I do not believe that it has been examined as effectively as it might have been, despite the excellent reports by the Mental Welfare Commission for Scotland on such issues.

The general purpose of Mr Ingram’s amendments is extremely welcome and they are worthy of consideration.

Nanette Milne: I, too, speak in favour of Adam Ingram’s amendments. This is an opportunity to address something that has been a running sore for quite a long time. A lot of concerns have been expressed about the use of psychotropic drugs, both in acute hospitals and, as Richard Simpson said, in care homes, so I would happily support the amendments.

Jamie Hepburn: I recognise that Adam Ingram lodged amendments 101 and 102 to highlight strongly held concerns that have been raised by some individuals and organisations, and I am willing to meet Mr Ingram, Dr Simpson and other members to discuss specific concerns in greater detail. Let me say at the outset that the bill is very focused, and that the issue that Mr Ingram seeks to address goes slightly wider than the proposed legislation that we have before us.

The 2003 act is designed to improve the safeguards for patients. All medical practitioners who are giving treatment for a mental disorder must have regard to the principles that are set out in section 1 of the 2003 act, and to any advance statement that a patient makes. In particular, the code of practice already highlights the responsibilities that medical practitioners have, including that the views of the patient should be taken into account and that the patient should be given information and assisted to understand the treatment and its aims and effect. My view is that the 2003 act already makes adequate provision that treatment, including the use of psychoactive substances, has appropriate safeguards in place including that patients have the information that they need to understand the treatment and to make their views known.

It might be helpful if I highlight provisions from the Patient Rights (Scotland) Act 2011, which states:

“Health care is to—

(a) be patient focused: that is to say, anything done in relation to the patient must take into account the patient’s needs,

(b) have regard to the importance of providing the optimum benefit to the patient’s health and wellbeing,

(c) allow and encourage the patient to participate as fully as possible in decisions relating to the patient’s health and wellbeing.

(d) have regard to the importance of providing such information and support as is necessary to enable the patient to participate in accordance with paragraph (c) and in relation to any related processes, taking all reasonable steps to ensure that the patient is supplied with information and support in a form that is appropriate to the patient’s needs.”

I reiterate my willingness to meet Mr Ingram and others, if they request such a meeting, to discuss the issues, but I urge him not to press his amendments. If he does, I urge members to vote against them.

Adam Ingram: I would be more than happy to engage with the minister on the issue. Indeed, it would be helpful if Dr Simpson were to accompany me, as I have no doubt that he would keep me right about his psychiatric colleagues.

As both Dr Simpson and Nanette Milne have said, the use of psychotropic drugs has been a long-running issue, and it needs to be addressed. I hear what the minister says about the scope of the bill, but perhaps we could have a discussion with a view to revisiting the matter at stage 3. I would be grateful for that opportunity. On that basis, I seek leave to withdraw amendment 101.

Amendment 101, by agreement, withdrawn.
Amendment 102 not moved.

Section 18—Opt-out from having named person

The Convener: Amendment 103, in the name of Nanette Milne, is grouped with amendments 39 to 43, 105 and 108.

Nanette Milne: Amendment 103 relates to a patient’s ability to opt out of having a named person. It might seem odd that we are discussing opt-out provisions, as paragraph 90 of the policy memorandum states that

“an individual should only have a named person if they chose to have one”.

However, the bill retains the default provisions that in section 251 of the 2003 act.

The bill requires any opt-out from having a named person to be in writing but an opt-out should be able to be made by any means available. The Law Society states that amendment 103 would allow people to opt out, for example, by making an oral statement before the tribunal or by communicating that intention to an independent advocate.

I realise, of course, that had I lodged my amendment later, I would have seen that it was not relevant because the other amendments in the group remove my concerns by making it quite clear that a person does not have to have a named person unless they specifically say that they want one.

I move amendment 103.

Jamie Hepburn: The stage 1 debate highlighted the importance of ensuring that individuals have a named person only if they choose to have one. I noted that I was likely to lodge amendments to achieve that. The Government’s response to the committee’s stage 1 report recognised the need to provide protections for service users without capacity who have not been able to appoint a named person.

Amendment 39 works with amendment 40 to remove the default named person role. Specifically, amendment 39 removes section 18, which currently allows someone to opt out from having a named person but retains the default for those without capacity to make the decision. Amendment 40 removes the existing provisions for the default named person under the 2003 act.

The Government listened carefully to stakeholders’ concerns about the default named person. We have taken their view that it can cause considerable distress to patients and to their carers and relatives.

Amendment 40 and its related consequential amendments will mean that a service user will have a named person only if they want one. Amendment 41 is consequential to amendment 40; it removes a reference to section 251 of the 2003 act from section 19 of the bill. Section 251 of the act is repealed by amendment 40.

Amendment 42 relates to the provisions in section 20 of the bill, which repeals the section of the 2003 act that gives powers to the tribunal to appoint a named person when the patient does not have one. That is a consequential amendment to remove the right to appeal that decision, an omission that was picked up during scrutiny of the bill.

As already noted, amendment 40 removes the default named person provisions. As colleagues will be aware, the Government did not remove the default named person role when we introduced the bill because we had some concerns about protections for the most vulnerable service users. It would not be right to remove the default named person role without bringing in some form of right of appeal for those without capacity to either nominate a named person or initiate an application or appeal to the tribunal. Without an alternative appeal right, the patient would, in effect, not be able to appeal when they have no named person. In the case of a short-term detention certificate, they could be detained for 28 days with no automatic review or right of appeal, which might be of concern in relation to their rights under the European convention on human rights.

We have therefore introduced a limited right to initiate certain appeals and applications for the patient’s guardian, welfare attorney, primary carer or nearest relative. In the absence of a named person, they are the best-placed people to act. They are referred to in the amendments as “listed persons”. It is important to emphasise that they can act only when the patient does not have the capacity to do so. The amendments will also allow a patient’s guardian or welfare attorney to receive certain information or notifications that would otherwise have been given to a named person. In coming to that view, the Government has balanced a range of factors, including the need to protect vulnerable service users while also respecting patient autonomy and privacy. We believe that that solution best meets all those important considerations.

Certain provisions in amendment 43 are designed to address our policy of respecting patient autonomy and privacy. They include new section 257A(7) of the 2003 act, which will allow the patient to make a written declaration that they do not want their primary carer or nearest relative to be able to make applications and appeals on the patient’s behalf when the patient does not have capacity to do so. A patient may, for example, make such a declaration if they had...
made a decision that they did not want a named person.

New section 257A(6) of the 2003 act will protect privacy by ensuring that a guardian or welfare attorney will not automatically receive certain potentially sensitive information in the same way that a named person would at the sections referred to in subsection (6). For example, if a responsible medical officer determines that a compulsory treatment order is to be extended, the guardian or welfare attorney will receive notification of the determination, but not the full record setting out the reasons for the determination and any views expressed by the mental health officer.

It is important that I also put on record an additional provision, which is not covered by the bill. Our intention is that the listed person will only be able to initiate the application or appeal; a curator ad litem will take over at the hearing. With the agreement of the tribunal, we will also seek to amend tribunal rules so that the listed person will not automatically receive copies of papers, orders, records or certificates, as they could contain sensitive information.

We are continuing to work on the best solution to the issue, and I will be working closely with the tribunal and the commission. I am happy to take the views of committee members and stakeholders on the best way to do so, as this is a vital aspect of the bill that I am determined to get right.

In that regard, I refer back to what Dr Simpson said earlier about cross-border transfers. I am happy to look at anything that Dr Simpson would like the Government to consider in relation to that.

If, for any reason, we do not feel we can achieve a solution through the tribunal rules, I will look to lodge amendments at stage 3. I fully understand the concerns about sensitive information being received by carers and relatives who do not want to receive it and about breaching the service user’s privacy. Our policy intention is that that will not happen.

Amendment 103 relates to how a person who does not wish to have a named person makes such a declaration. In particular, it seeks to remove the requirement that that be done in writing. If the Government amendments to remove the default named person are accepted, amendment 103 will be redundant, as Nanette Milne has noted, so I ask her not to press it.

Amendment 105 would give the Mental Health Tribunal powers to appoint a person to provide independent advocacy services when the service user has no named person. It would also give ministers powers to make regulations to prescribe the functions of the independent advocate, as long as those powers did not give them access to medical records. The role of an advocate is different from that of a named person, and it should remain so. Amendment 105 would blur the lines around the role of an advocate, which is to express the wishes of the person they advocate for and not to make decisions for them.

Although I accept that its intent is positive, I do not support amendment 105. It seems to envisage that the Mental Health Tribunal might appoint a person to provide advocacy services to a patient. However, advocacy services have to be accepted voluntarily. Also, independent advocates are not a replacement for a named person, who has the right to initiate proceedings and take part in proceedings independently of the patient. On that basis, I ask Rhoda Grant not to move amendment 105.

The intention of amendment 108 is to put a right of appeal for named persons against cross-border transfers into the 2003 act. I cannot accept the drafting of the amendment, as it refers to section 290(1)(f) of the 2003 act, which does not exist. However, I agree with the policy intention, and I am happy to say on the record that I will ensure that a right of appeal for named persons against cross-border transfers will be covered by regulations on cross-border transfers. I have already made that commitment to Dr Simpson. I hope that that reassures Nanette Milne, and I ask her not to move amendment 108.

Rhoda Grant: I have listened carefully to what the minister said and I welcome the removal of the default named person in the bill. However, I do not think that we are there yet. Amendment 105 seeks to provide additional support for people who may not have capacity and are having to undertake compulsory treatment.

I have listened to what the minister and others have said and will not move amendment 105. However, there are issues with amendment 43, which also seeks to provide additional support to people who do not have a named person. I have concerns about that because it still puts a carer or a relative in that position and does not give them the opportunity to refuse to take action on behalf of a patient. It might also give the next of kin stronger rights than the carer.

11:45

Jamie Hepburn: Will Rhoda Grant give way?

The Convener: That might be helpful to the discussion.

Jamie Hepburn: I want to clarify something. Rhoda Grant expresses concerns about amendment 43 putting requirements on carers and those with the power of attorney. It should be clear
that no such requirement will be placed on them. The amendment gives them the right to initiate proceedings; they do not have to do so.

Rhoda Grant: That is really helpful, but the minister will be aware that SAMH has concerns about amendment 43. With the ranking between the primary carer and next of kin, people are concerned that patients might have issues with the next of kin who are being given rights over them. We should have further discussions about that. We certainly welcome the minister’s earlier discussions of the matter but we should ensure that we get it right because it is a crucial part of the bill. Although I welcome the steps that have been taken, we have a bit further to go before we satisfy everyone.

Dr Simpson: I welcome the Government’s amendments, which help, but they do not remove the matter that Nanette Milne raised in relation to leaving out the words “in writing” and inserting “by any means or in any way”.

I understand that the Government suggests that amendment 103 should not be pursued because it relates to capacity. What constitutes capacity remains my problem.

In the amendment, “incapable” has the same meaning as in section 250 of the 2003 act. I take it that a significantly impaired decision-making ability—or SIDMA—is involved, not the total loss of capacity, as under the Adults with Incapacity (Scotland) Act 2000, “incapable” means incapable of “acting; or ... making decisions; or ... communicating decisions; or ... understanding decisions; or ... retaining the memory of decisions”.

The differentiation between SIDMA and the 2000 act is at the nub of discussions that are taking place in civic Scotland among health professionals and patients.

In summing up, will the minister say whether, in referring to section 250 of the 2003 act, he can confirm—actually, he is not going to sum up—

Jamie Hepburn: Will Dr Simpson therefore give way?

Dr Simpson: I would be happy to do so, if the convener will allow it.

The Convener: Yes. We might be breaking new territory here, but I am sure that taking an intervention will help the debate. We all want to get it right.

Dr Simpson: That would be helpful.

Jamie Hepburn: To clarify, the concerns that Nanette Milne has raised, which Dr Simpson seems to be echoing, are no longer a consideration, because we want to delete section 18. Therefore, it would no longer be a requirement that someone would have to apply in writing.

Dr Simpson: But—

Jamie Hepburn: The point is that no one would have to apply at all.

The Convener: I am not extending the intervention to a conversation.

Dr Simpson: Okay. That is fine.

The Convener: The minister has made his point, and you will need to weigh it in your consideration.

Dr Simpson: Okay. I will continue.

I have slight concerns about passing the responsible medical officer’s report to the other listed persons. The responsible medical officer might or might not do that but it would depend on what they see as sensitive information. I am slightly concerned that, even if the patient’s advance statement indicates that it should be given to the listed persons, it remains the responsibility of the responsible medical officer to decide; it is not the patient’s decision even when that indication was given in full capacity in an advance statement. As I have said, I am slightly concerned about that. I realise that, as he is not summing up on this group of amendments, the minister cannot come back on the point, but I think that we might need to revisit the issue at stage 3.

On amendment 105, in the name of Rhoda Grant, which seeks to add advocacy, I know that we will be discussing this issue later and I fully understand that, although advocates should normally be notified and informed, they do not actually represent patients or make appeals on their behalf. I accept the minister’s view that that distinction needs to be maintained. However, there will still be individuals who have no guardian, no welfare attorney, no primary carer, no near relative or, indeed, no named individual at all and who will have no one to operate on their behalf. I believe that, in those circumstances, the Scottish Independent Advocacy Alliance would be prepared to allow advocates to be nominated to carry out such actions and, as a result, Rhoda Grant’s amendment might have some merit.

In short, although amendment 103 might not be pressed and amendment 105 not be moved, I believe that the issues that they raise require to be addressed before stage 3.

The Convener: I am going off-script here, I suppose, but I will give the minister a chance to respond to the discussion that we have just had before I ask Nanette Milne to wind up and indicate whether she wishes to press or withdraw amendment 103.
Jamie Hepburn: I will be very brief, convener. I have already intervened a couple of times to make clarifications—and I hope that they have been helpful—but I want to clarify one other point with regard to Dr Simpson’s concern about a mental health officer’s report being passed on to those identified as listed persons. As I made clear in my opening remarks, that is not quite the case: the mental health officer’s determination will be passed on, but the content of their report will not.

I accept Dr Simpson’s point about further safeguards for those who might not have anyone else to act on their behalf once the bill is passed. As Ms Grant has asked for further discussions, I commit to having further dialogue with her on the matter.

The Convener: I now ask Nanette Milne to wind up and indicate whether she wishes to press or withdraw amendment 103.

Nanette Milne: As I am happy to accept the minister’s explanation as to why amendment 103 is no longer necessary, I will not press it.

Amendment 103, by agreement, withdrawn.

Amendment 39 moved—[Jamie Hepburn]—and agreed to.

After section 18

Amendment 40 moved—[Jamie Hepburn]—and agreed to.

Section 19—Consent to being named person

Amendment 41 moved—[Jamie Hepburn]—and agreed to.

Section 19, as amended, agreed to.

Section 20—Appointment of named person

Amendment 42 moved—[Jamie Hepburn]—and agreed to.

Section 20, as amended, agreed to.

After section 20

Amendment 43 moved—[Jamie Hepburn]—and agreed to.

Amendment 105 not moved.

The Convener: Amendment 104, in the name of Rhoda Grant, is in a group on its own.

Rhoda Grant: Amendment 104 is intended to reflect the rights of carers and gives ministers the power to draw up a code of practice that gives “guidance on the role of carers and relatives”. However, it does not give them access to medical records, so it provides some balance against the next of kin not being involved but allows carers and relatives to have an input to a patient’s treatment.

That is most important when it comes to discharge planning. Many people have told me that, when a patient is being discharged from hospital, carers seldom have any information. Some carers have told me that that has led them to be unprepared and unable to support the patient. As discharge is a time of big suicide risk, it is really important that carers be involved in that planning so that they can support—and, indeed, decide whether they are able to support—the person through that process.

Amendment 104 gives ministers powers to create a code of practice so that those measures can be put in place. Giving ministers those powers rather than putting the role of carers into the bill demonstrates an understanding that that role might change and move on, and enables the guidance to be adapted.

I move amendment 104.

Bob Doris: I was inspired to speak on the amendment by listening to Ms Grant’s comments. Yesterday, the committee held an event in Glasgow at which we spoke to a variety of carers. One of the issues that was raised at that event—although not in relation to mental health—was carers not being routinely informed when patients are discharged from hospital, for example.

The issue might not be specific to mental health provision, but might be more connected to carers rights in general and communication with carers. I am open minded about whether the bill is the right place to address that, but it is important to put that point on the record.

Jamie Hepburn: The Government takes seriously the role of carers and our responsibility to support them better. That is why we have introduced the Carers (Scotland) Bill, which the committee is beginning to consider.

Involving carers and relatives in a patient’s care and treatment is important. It is one of the strong themes that emerged from the consultation on the mental health strategy and is raised with me in correspondence. I welcome the fact that Rhoda Grant’s amendment has allowed us to get the issue on the record.

The best care and treatment requires professionals to work with carers and patients collaboratively so that all are able to contribute. Making that work can be difficult and requires good professional judgment and skill about sharing information and involving carers while taking account of the patient’s views, which are sometimes in conflict.

I recognise that Rhoda Grant’s amendment is intended to reflect exactly that point—the concern
that patients might have about carers having access to information that they would not want shared—by emphasising that patient records cannot be shared. Indeed, other legislation already provides safeguards on the confidentiality of medical records.

In developing the revised code of practice, I intend to include guidance about the involvement of carers and relatives. I will ask the working group that is developing the revised code to do that and to reflect the good practice that exists. That does not need to be included in the bill, but I make a commitment on the record that it will be covered in the revised code of practice.

I would be happy to discuss with Rhoda Grant how we can do that. If she wants to pursue an amendment at stage 3 in the light of that discussion, I would be happy to work with her to try to develop a revised amendment that reflects how the code of practice supports good practice on involving carers and relatives.

On that basis, I urge Rhoda Grant not to press amendment 104.

**Rhoda Grant:** I welcome the minister’s commitment to ensure that the matter is covered in the revised code of practice. Because of that, I will withdraw the amendment and might come back at stage 3 if that is required.

Amendment 104, by agreement, withdrawn.

**The Convener:** Amendment 82, in the name of Richard Simpson, is grouped with amendments 83 and 84.

**Dr Simpson:** During the evidence taking, it became clear that there was a strong desire among those who are engaged in mental health to strengthen the role of independent advocacy. The series of amendments that I have lodged do that.

The first intention is to ensure that in all situations in which the patient or the patient’s named person, carer or other representative, such as a legal representative, is to be informed or notified, the independent advocate—if such a person is in place providing a service to the patient—should also be notified.

Matters of notification or informing aside, there are two roles that I propose the advocate may take on: they may make representations on behalf of a patient, or they may make an application on the patient’s behalf. As I mentioned when we considered an earlier amendment, those are not usual roles for an advocate to play, but in the absence of someone else being willing to undertake either of those roles, it seems to me appropriate that advocates should at least be asked whether they would wish to make representations or applications on a patient’s behalf, based on their knowledge of the patient. I recognise that those additional duties go beyond the more usual role of an advocate.

**Amendment 84:**

The purpose of amendment 84, which is supported more widely by the Scottish Independent Advocacy Alliance, SAMH and others, is to ensure that there is adequate monitoring of the availability and accessibility of advocacy services. There is considerable evidence that, despite the welcome advance in the deployment, availability and use of independent advocates, the picture is anything but uniform. I believe that we need to be aware of the situation, and I think that the monitoring and reporting that I suggest in amendment 84 would best be undertaken by the Mental Welfare Commission would help. Regular reports should be made by the local authorities and national health service boards that would allow the commission to determine the adequacy of independent advocacy services and to report to the Scottish ministers on that. I would expect that, thereafter, the Scottish ministers would wish to report from time to time to the Parliament or the Health and Sport Committee on the issue, which is certainly one that has concerned the committee over a number of years.

I move amendment 82.

**The Convener:** As no other members wish to speak on this group, I invite the minister to do so.

**Jamie Hepburn:** Some of my remarks will be similar to those that I made in relation to Rhoda Grant’s amendment 105 in group 11.

As drafted, Richard Simpson’s amendments 82 and 83 make provision for rights for advocates that are extensive and which go beyond the role that advocates normally play—advocates normally assist the patient to access their rights, rather than having rights to make representations, to have access to information and to lead and produce evidence at the tribunal.

However, I appreciate that the amendments might have been developed to fill the gap that is created by removing the default position of having a named person when a person has not appointed a named person and the person is not able to act on their own behalf. Our amendment 43, to which the committee has agreed, is intended to provide for that situation by including a limited list of people who, in limited circumstances, can act on behalf of a patient who does not have a named person and who is not able to act on their own behalf. I have committed to having dialogue with Ms Grant on the issue, and I would be happy to speak to Dr Simpson about it in advance of stage 3. On that basis, I urge members not to support amendments 82 and 83.
I recognise that ensuring that people can access advocacy is important to many of the people and organisations that offered their views to the committee during its consideration of the bill at stage 1; indeed, I met the Scottish Independent Advocacy Alliance to discuss some of these matters a couple of weeks ago. I understand, too, that some people have interpreted the fact that we did not include in the bill any specific provision on advocacy as an indication that it is not important. That is definitely not the case. My view is that the 2003 act already sets out duties to provide advocacy.

I accept that people’s experience of accessing advocacy does not always meet their expectations. It is important that we understand that and ensure that people are able to access services and their rights. The Mental Welfare Commission has indicated that it would be possible to develop reporting that is not overly resource intensive. If that proves to be the case for NHS boards and local authorities as well as the commission, I would be prepared to work with Dr Simpson to lodge an amendment at stage 3. On that basis, I urge him not to move amendment 84.

Dr Simpson: As the minister has quite rightly said, the issue is that given the possibility of there being no named person, individuals might be unrepresented. I believe that the advocacy role could be extended reasonably in those rather limited circumstances.

For me, the situation is complicated by the difference between the Adults with Incapacity (Scotland) Act 2000’s measurement of capacity and the bill’s measurement of capacity. That is a fundamental problem, to which we will return in later amendments. In situations in which capacity is very seriously impaired, individual patients might be left totally unrepresented. In those circumstances, it seems reasonable that the advocate, if they have previous knowledge of the patient—which they might well do—should be able, on that basis, to make an application or representation on their behalf. At the moment, however, I accept the minister’s view and will withdraw amendment 82 and not move amendments 83 and 84, on the basis that we will have further discussions and examine whether the role of the advocate needs to be enhanced either in the bill or in regulations to ensure that patients do not go unrepresented.

Amendment 82, by agreement, withdrawn.
Amendments 83 and 84 not moved.

Section 21—Registering of advance statements

The Convener: Amendment 44, in the name of the minister, is grouped with amendments 45, 46, 106 and 107. I point out that, if amendment 46 is agreed to, I cannot call amendments 106 or 107, because of pre-emption.

Jamie Hepburn: The Government’s intention with section 21 is to increase the uptake of advance statements. We had hoped that a central register of statements could be set up and that by providing reassurance that the statement could always be located there, but we have listened to stakeholder concerns that such a move could have an adverse effect and deter some service users from making an advance statement. I had also hoped that such a system would lead to advance statements being more readily available for relevant practitioners when they required them, but it is now clear that that might not be the case.

We have therefore worked with the Mental Welfare Commission to develop alternative proposals that will not require the statement to be sent but which will require certain information to be sent to the commission to help it monitor the numbers of advance statements made and to provide a central place where the existence and location of an advance statement are recorded but where the advance statement itself is not held.

Amendment 44 seeks to remove the provisions that required a health board to send a copy of the statement to the commission. Instead, it sets out the information that should be sent, which include that a statement or withdrawal document exists, where it is held, and any personal and administrative details that are essential to identify the record as the person’s advance statement.

Amendment 45 seeks to ensure that the commission keeps a central register of information about advance statements to provide a source of information if there is any uncertainty as to whether a statement exists for a particular patient or where it is held. Requiring the commission to mark the date of entry will ensure that there is no confusion if a subsequent statement is made or if a statement is withdrawn.

Amendment 46, which is consequential on amendments 44 and 45, replaces the reference to “anything kept in the register to be inspected at a reasonable time ... by the person to whom the thing relates” with “an entry in the register to be inspected at a reasonable time ... by the person whose medical records are referred to in the entry” to reflect the changes to the information kept in the register. I think that that should take care of the concerns about legislative terminology that I believe Nanette Milne’s amendments 106 and 107 are aimed at addressing.

Beyond that, there is a problem with amendments 106 and 107, as they would make
the provisions refer to only an “advance statement”, not to a document withdrawing one. Both things need to be covered. Given that no “thing” remains in the text and given the omission of a reference to any withdrawal document, I respectfully invite Nanette Milne not to move her amendments.

I move amendment 44.

Nanette Milne: As has been said, amendments 106 and 107 in my name are largely technical and seek to amend the language in section 21, which amends proposed new section 276C of the 2003 act.

The commission will keep a register of advance statements. Although the wording of the bill as it stands would allow “anything ... in the register to be inspected”,

I think that the context is clear that that can refer only to advance statements. I believe that the alteration of the language in section 21 as proposed in amendments 106 and 107—in other words, the replacement of “anything” and “thing” with “advance statement”—will provide additional clarity.

I appreciate that the terminology that the minister has set out in his amendment is not exactly the same, but I think that the meaning is the same.

The Convener: Minister, do you wish to wind up?

Jamie Hepburn: I have nothing to add.

Amendment 44 agreed to.

Amendment 45 moved—[Jamie Hepburn]—and agreed to.

Amendment 46 moved—[Jamie Hepburn].

The Convener: I remind members that, if amendment 46 is agreed to, I cannot call amendments 106 and 107.

Amendment 46 agreed to.

The Convener: Amendment 85, in the name of Dr Richard Simpson, is grouped with amendments 86 and 87.

Dr Simpson: I welcome the changes that the minister has made to the registration process. The issue of protecting confidentiality and privacy with regard to advance statements was raised in the evidence that the committee received.

I have lodged a number of amendments to seek to ensure that privacy and confidentiality is fully protected, and the provision for registration with the Mental Welfare Commission goes a long way towards addressing those concerns. However, the advance statement itself will now be held elsewhere.

My amendment 85 seeks to insert as section 276D in the 2003 act a requirement on ministers, by regulations, to set out the circumstances under which a person or persons may have access to advance statements. I believe that amendment 85 remains pertinent, although I am happy to hear from the minister whether or not that is the case.

Aside from my amendments 85 and 86, the other amendment in the group is amendment 87, in the name of Bob Doris, on promotion of advance statements, which I support.

I move amendment 85.

Bob Doris: I thank SAMH for its partnership work in drafting amendment 87, which would place a duty on health boards and local authorities to promote advance statements. The amendment has support from a wide range of stakeholders.

An advance statement is a powerful tool that allows people with mental health problems to state what treatment they do or do not wish to receive in the event that they are treated compulsorily under the 2003 act. Although those statements are not binding, medical staff must notify the person, that person’s named person and the Mental Welfare Commission in writing if the statement is overridden, setting out the reason for doing so.

No information is available at present on the number of advance statements that have been made, but the Mental Welfare Commission was notified of 31 overrides in 2013-14. Given the other provisions in the bill, we will start to get more robust data on the matter. SAMH’s research suggests that awareness of the right to make an advance statement is mixed. People feel that advance statements are often not well promoted, and, while there is strong support for the concept, people are sceptical about whether an advance statement will be taken seriously.

A duty to promote advance statements, coupled with stronger guidance in the code of practice about when and how promotion should take place, will potentially increase uptake and empower people to make it clear what they do and do not want to happen. The committee noted in its stage 1 report the Government’s preference to raise awareness of advance statements “from the grass-roots”. We asked the Government to consider placing a duty to promote statements in the bill, which is what my amendment seeks to do.

If the Government cannot support placing a duty in the text of the bill, I would need some additional assurance about how the four aims in the bill can be achieved by another means. I have worked in partnership with SAMH to ensure that advance statements are promoted.
Jamie Hepburn: I thank Dr Simpson for setting out his thinking on amendment 85. However, it remains unclear to me what he envisages might be set out in the proposed regulations beyond the requirement for access to an advance statement to relate to the exercise of functions under the 2003 act. The act already requires the designated medical practitioner to have regard to an advance statement before making a decision under sections 236(2)(c), 239(1)(c) or 241(1)(c) of the act.

I am mindful of the fact that, when an advance statement is lodged in a patient’s medical records, it should be treated as a medical record in terms of patient confidentiality. We should also ensure that service users have as much control as possible over who accesses their advance statement without there being too much bureaucracy governing how they share their information.

I am not convinced of the need for amendment 85, so I invite Dr Simpson not to press amendment 85 and not to move its consequential amendment 86.

12:15

On amendment 87, I am conscious that the committee recommended in its stage 1 report that the Scottish Government consider placing on health boards and local authorities a statutory duty to promote advance statements. As I said during the stage 1 debate, I very much agree with the committee’s belief that more can be done to promote advance statements. I was happy recently to meet SAMH, which Mr Doris mentioned, and the matter has been the subject of discussion between us.

I want to ensure that advance statements are promoted in the most meaningful way and a way that has the most impact, and I remain unconvinced that the use of legislation would necessarily achieve that. Given that there are other effective ways for service users to be supported and encouraged to make an advance statement, including peer support initiatives, and given the burden that such a duty might place on health boards and local authorities, I invite Mr Doris not to move his amendment 87. I will, of course, be happy to meet him to discuss the work that he has undertaken with SAMH thus far.

In asking Mr Doris not to move his amendment, I also make it clear that the Scottish Government will look to do more to promote advance statements as part of implementation of the bill, and we will of course be happy to have the committee’s input as part of that work.

Dr Simpson: I am not totally convinced that amendments 44 to 46, to which we have already agreed, cover the situation adequately. I still think that there need to be regulations—beyond the bill’s provisions—for the responsible medical officer to have regard to the advance statement and therefore to have access to it. There should be regulations that allow or do not allow other persons to have access.

My amendments 85 and 86 might not be perfect and the Government might wish to amend them further at the next stage but, if they were agreed to, it would make a statement about the need to ensure that there is clarity in the regulations about who should and should not access advance statements.

Amendment 87 also needs to be supported. Again, the Government could further amend it at stage 3 if it felt that that was necessary, but I feel that it should be moved and agreed to.

The Convener: The question is, that amendment 85 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 85 disagreed to.

The Convener: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 86 disagreed to.
The Convener: I ask Bob Doris whether he wishes to move amendment 87.

Bob Doris: In asking me not to move amendment 87, the minister raised the issue of the burden that it might place on health boards and local authorities. I am unconvinced about the extent of the burden that would be placed on them. Looking at the provisions in the bill, I cannot imagine why health boards and local authorities would not want to promote the existence and effectiveness of the provisions about advance statements, irrespective of whether there is a duty to do that in the bill. That said, I am happy to meet the minister to discuss what that burden may or may not be.

I am conscious that putting something in the bill does not necessarily mean that there will be good-quality and extensive promotion of advance statements. I intend to hold my position until stage 3 and the possibility of lodging a revised amendment, depending on the outcome of meetings with the minister.

I know that Richard Simpson is keen for me to move amendment 87; if he wishes to move it, it is his prerogative to do so. However, on the basis that the minister has agreed to meet me to consider the matter further, I will not move the amendment.

Amendment 87 moved—[Dr Richard Simpson].

The Convener: The question is, that amendment 87 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 87 disagreed to.

Section 21, as amended, agreed to.

After section 21

The Convener: Amendment 88, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: The committee will probably realise that, throughout our consideration of the bill, I have been wrestling with the differentiation between the definition of “incapacity” in the Adults with Incapacity (Scotland) Act 2000 and the lower test of capacity commonly known as SIDMA.

The conclusion that we reached when we debated the matter in 2003 was that it was appropriate, while modernising the Mental Health Act 1983, that the SIDMA test, not the incapacity test under the 2000 act, should be applied.

However, the significant impairment of decision-making ability is a lesser test for adults than is required under the 2000 act. Although, in the overwhelming majority of cases, that test serves the interests of the patient well, I believe that there are circumstances in which the patient’s right to refuse medical treatment, under the European convention on human rights, is being denied inappropriately.

Amendment 88 seeks in a very modest way to ensure that when a patient has made an advance statement while they have full capacity, their wishes are followed, and should be followed unless the patient’s capacity is so impaired that they meet the more stringent requirements of the test of incapacity under the 2000 act.

We must recognise that underuse of advance statements may in part be because there is a feeling—realistic or not—that the wishes that are expressed in them will not be fully respected, despite the fact that there is already a requirement that where and at what time treatment is given must be on the orders of the tribunal. Variation must be reported to the Mental Welfare Commission if it does not reflect the advance statement. Amendment 88 is a rather modest proposal pending what I believe to be a necessary, much fuller review of the legislation governing the whole issue of mental health and capacity, including protection of vulnerable adults.

Since lodging my amendments I have been asked whether amendment 88 would do exactly what I intend: it may need to be modified for stage 3. However, I believe that the amendment should be agreed to now, then modified at stage 3, unless the minister agrees in principle that the amendment is appropriate, and is willing to discuss its inclusion in modified form at stage 3.

I move amendment 88.

Jamie Hepburn: I share the Mental Welfare Commission’s concerns about the intended effect of proposed new subsection (3B) of section 276 of the 2003 act and what that proposal would mean for urgent cases. Tribunal hearings can take some time to arrange, and amendment 88 would mean that the patient could not be given treatment in the meantime—treatment that could be essential for their immediate wellbeing, long-term recovery and rehabilitation.
Furthermore, I am not sure of the need for amendment 88. Advance statements are written statements setting out how patients would wish to be treated, or not be treated, for their mental disorder should their ability to make decisions about treatment for it become significantly impaired as a result of that disorder. However, amendment 88 seems to relate to situations in which the patient is capable of consenting to treatment. In such situations—where a patient is judged to be capable in terms of the 2003 act—we would expect the patient’s consent to the treatment to be the primary consideration. In addition, from what I understand there is not a significant issue that needs to be addressed; the number of instances each year in which advance statements are being overridden is relatively small.

The current framework ensures that doctors and tribunals take account of advance statements and it requires them to set out the reasons why they are overridden, whenever that occurs.

On that basis I invite Dr Simpson not to press amendment 88.

Dr Simpson: The fundamental point remains that it is the right of any individual to refuse treatment if they have the capacity to do so. My proposal is that “significantly impaired decision-making ability” is not a total loss of capacity. Therefore, in those circumstances, patients should be entitled to choose to review their treatment, which they are not entitled to do under the 2003 act as it stands. Amendment 88 would therefore apply the more severe test of the Adults with Incapacity (Scotland) Act 2000, under which only when there is complete loss of capacity would treatment be allowed to proceed.

Moving forward from the original act, which I very much supported at the time, I do not believe that we have got the balance right. I think that this very modest provision—which will allow the advance statement that is given at a time of full capacity to be fully respected, unless the patient has lost capacity—is reflected in the 2000 act and not the 2003 act.

I press amendment 88.

The Convener: The question is, that amendment 88 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 88 disagreed to.

Section 22—Communication at medical examination etc

The Convener: Amendment 47, in the name of the minister, is grouped with amendments 48 and 49.

Jamie Hepburn: Amendment 47 seeks to amend an incorrect cross-reference that was inadvertently left in the version of the bill that was introduced to Parliament. A prior draft version of the bill had gone out to consultation. It contained a provision that would have inserted a new section 57A into the 2003 act. That related to a previous proposal on applications for compulsory treatment orders. However, the provision was removed following consideration of consultation responses. The amendment will therefore remove the reference to section 57A(2), which appears in proposed new section 261A(4) of the 2003 act.

Amendment 48 will insert a new section 291A into the Mental Health (Care and Treatment) (Scotland) Act 2003. It provides that there must be no conflict of interests in relation to certain medical examinations that are carried out for purposes that are covered in a variety of sections under the 2003 act. The amendment will also extend coverage of existing conflict of interests provisions in the 2003 act to include compulsion order and compulsion order with restriction order reviews. In addition, the proposed new section will confer on Scottish ministers a power to make regulations that may specify circumstances in which there is, or is not, taken to be a conflict of interests.

Amendment 48 has been lodged following concern among stakeholders that conflict rules apply in relation to, for example, the making of a compulsory treatment order but not to its extension. Stakeholders have also identified that such provision does not apply to reviews of compulsion orders, either. There is a strong feeling that conflict rules should apply and that, where a conflict exists, the responsible medical officer should be required to arrange for the examination to be carried out by an approved medical practitioner. That is something that can be considered under the proposed regulations.

Amendment 49 will amend section 245 of the Mental Health (Care and Treatment) (Scotland) Act 2003. It will add to the list of people who must be consulted in circumstances where certain certificates are granted in accordance with the 2003 act. It will provide additional protections for...
patients in the light of removal of the default named person, which has already been discussed under amendment 40.

I move amendment 47.

Amendment 47 agreed to.

Section 22, as amended, agreed to.

The Convener: That ends day 1 of stage 2 consideration of amendments to the Mental Health (Scotland) Bill. Day 2 will be at the committee’s meeting next Tuesday; we will start where we ended today. A further marshalled list and groupings will be issued on Wednesday.

Agenda item 3 will be held in private.
Mental Health (Scotland) Bill

2nd Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 51 Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

After section 22

Jamie Hepburn

48 After section 22, insert—

<Conflicts of interest to be avoided

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 291 there is inserted—

“Conflicts of interest to be avoided

291A Conflicts of interest to be avoided

(1) There must not be a conflict of interest in relation to a medical examination to be carried out for the purpose of section 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of this Act.
(2) Regulations may—

(a) specify circumstances in which, in the application of subsection (1) above—

(i) there is to be taken to be a conflict of interest,
(ii) there is not to be taken to be a conflict of interest,
(b) specify circumstances in which subsection (1) above does not apply.”.
(3) These provisions are repealed—

(a) in section 36 (emergency detention in hospital)—

(i) paragraph (a) of subsection (3),
(ii) subsection (9),
(b) in section 44 (short-term detention in hospital)—

(i) paragraph (a) of subsection (3),
(ii) subsection (8),
(c) in section 47 (extension of detention pending application for compulsory treatment order)—

(i) paragraph (a) of subsection (2),
(ii) subsection (5),

(d) in section 58 (medical examination: requirements), subsection (5).>

**Jamie Hepburn**

49 After section 22, insert—

*Safeguarding the patient’s interest*

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 245 (certificates under sections 235, 236, 239 and 241), in subsection (3)—

(a) the word “and” immediately preceding sub-paragraph (ii) of paragraph (a) is repealed,

(b) after sub-paragraph (ii) of paragraph (a) there is inserted—

“(iii) any guardian of the patient; and

(iv) any welfare attorney of the patient;.”>

**Section 23**

**Jamie Hepburn**

50 In section 23, page 16, line 8, leave out <, for the words “for post-natal depression,” in subsection (1)(d)> and insert—

<( ) in paragraph (d) of subsection (1), for the words “for post-natal depression,”>}

**Jamie Hepburn**

51 In section 23, page 16, line 11, at end insert—

<( ) after subsection (1) there is inserted—

“(1A) But a Health Board is required to provide services and accommodation under subsection (1) above only if it is satisfied that doing so would be beneficial to the wellbeing of the child.”.>

**Section 24**

**Nanette Milne**

108 In section 24, page 16, line 29, at end insert—

<( ) in paragraph (f) of subsection (1), after the word “patient” there is inserted “, or the patient’s named person,.”>

**Section 25**

**Bob Doris**

52 In section 25, page 17, line 14, leave out <some or all of> and insert <specific provisions in>
In section 25, page 17, line 14, leave out <some or all of Part 16> and insert <section 243>.

In section 25, page 17, line 18, leave out <that Part> and insert <section 243>.

In section 25, page 17, line 19, leave out <any of that Part> and insert <section 243>.

In section 25, page 17, line 21, at end insert <, or

( ) authorise medical treatment of the types mentioned in section 234(2) or 237(3) of this Act.”.>

In section 26, page 17, line 30, leave out from <subsection> to the end of line 33 and insert <paragraph (a) of subsection (3) there is inserted—

“(aa) that—

(i) a mental health officer has agreed to the making of the direction, or

(ii) it has been impracticable to obtain the agreement of a mental health officer;”.

After section 27

After section 27, insert—

<Meaning of “mental disorder”>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 328 (meaning of “mental disorder”)—

(a) paragraph (c) of subsection (1) is repealed together with the word “or” immediately preceding it,

(b) before paragraph (a) in subsection (2) there is inserted—

<“(za) learning disability;

(zb) autism spectrum disorder;”>
**Jackie Baillie**

56* After section 27, insert—

<Review of the meaning of “mental disorder”>

**Review of the meaning of “mental disorder”**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 328 there is inserted—

“328A Review of meaning of “mental disorder”

(1) The Scottish Ministers must carry out a review of the definition of mental disorder no later than one year after the Mental Health (Scotland) Act 2015 receives Royal Assent.

(2) The purpose of the review under subsection (1) is to consider whether “learning disability” should continue to be within the meaning of “mental disorder”.

(3) In carrying out a review under subsection (1) the Scottish Ministers must consult such persons as they consider appropriate.

(4) The Scottish Ministers must—

(a) publish a report—

(i) setting out the findings of the report under subsection (1),

(ii) making a recommendation as to whether “learning disability” should continue to be within the meaning of “mental disorder”,

(b) lay a copy of that report before the Parliament.

(5) The Scottish Ministers must make provision by regulations for the removal of “learning disability” from the meaning of “mental disorder” where a report under subsection (4) recommends that “learning disability” should not continue to be within the meaning of “mental disorder”.

(3) In section 326 (orders, regulations and rules), in subsection (4)(c) for the words “or 310” there is substituted “310 or 328A”.

**Adam Ingram**

109 After section 27, insert—

<The Commission: statistical information>

**Information on adverse incidents etc.**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 19, there is inserted—

“19A Statistical information: further provision

(1) The Commission must make arrangements for the collection of the statistical information mentioned in subsection (2) in respect of patients detained in hospital by virtue of—

(a) this Act; or

(b) the 1995 Act.
(2) That information is the annual number of—
   (a) deaths;
   (b) suicides;
   (c) assaults recorded against a patient;
   (d) recorded adverse incidents;
   (e) occasions on which restraints have been used in relation to a patient.

(3) The information mentioned in subsection (2) must be broken down by—
   (a) age;
   (b) gender;
   (c) diagnosis;
   (d) class of drug prescribed (where appropriate);
   (e) Health Board;
   (f) such other categories as may be prescribed by regulations.

(4) The Commission must in accordance with directions given to it by the Scottish Ministers, from time to time, and not less than once in every Parliamentary session, lay before the Parliament a report summarising the findings of the information collected under subsection (1) since the laying of the last report.

(5) Subsections (6) and (7) apply where—
   (a) the Parliament is dissolved before the period of 12 months has elapsed since the commencement of the session of Parliament, and
   (b) as at the date of dissolution a report under subsection (4) has not been published.

(6) The session in which the Parliament is so dissolved is not to be regarded as a session in which a report under subsection (4) is to be published.

(7) A report under subsection (4) must be published in the session of the Parliament which—
   (a) next follows the session in which the Parliament is so dissolved, and
   (b) is not itself a session in which the Parliament is so dissolved.

Dr Richard Simpson

110 After section 27, insert—

<Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

Scottish Ministers review of deaths in detention or otherwise in hospital for treatment for a mental disorder

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 4A, there is inserted—

"Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

4AA Review of deaths in detention or otherwise in hospital for treatment for a mental disorder
(1) The Scottish Ministers must carry out a review of the arrangements for investigating the death of a patient who was—

(a) detained in hospital by virtue of—

(i) this Act;

(ii) the 1995 Act; or

(b) admitted voluntarily to hospital for the purpose receiving treatment for a mental disorder.

(2) The review must be carried out within 2 years of this section coming into force.

(3) In carrying out a review under subsection (1) the Scottish Ministers must consult—

(a) the nearest relative of a patient within the meaning of subsection (1);

(b) such persons as they consider appropriate.

(4) The Scottish Ministers must—

(a) publish a report setting out the findings of the review under subsection (1);

(b) lay a copy of that report before the Parliament;

(c) notify those persons consulted under subsection (3) of the publication of the report.”.

After section 28

Jamie Hepburn

57 After section 28, insert—

<Detention under compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 57  (disposal of case where accused found not criminally responsible or unfit for trial), in subsection (2)—

(a) in paragraph (a), for the words “authorising the detention of the person in a hospital” there is substituted “(whether or not authorising the detention of the person in a hospital),”

(b) for paragraph (b) there is substituted—

“(b) subject to subsection (4A) below, make a restriction order in respect of the person (that is, in addition to a compulsion order authorising the detention of the person in a hospital);”.

Section 29

Dr Richard Simpson

111 In section 29, page 19, leave out lines 16 to 22
Section 35

Jamie Hepburn

58 In section 35, page 22, line 25, at end insert <, or

( ) a temporary compulsion order (see section 54(1)(c) of this Act).>

Jamie Hepburn

59 In section 35, page 22, line 26, leave out from beginning to <question,> in line 27

Before section 36

Jamie Hepburn

112 Before section 36, insert—

<Specification of unit>

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 61 there is inserted—

“61B Specification of hospital unit

(1) A reference in this Part to a hospital may be read as a reference to a hospital unit.

(2) In the operation of section 61A of this Act in relation to a transfer from one hospital unit to another within the same hospital—

(a) subsection (2) of that section applies by virtue of subsection (1) of that section where the order in question specifies the hospital unit in which the person is to be detained,

(b) in subsection (5) of that section—

(i) paragraph (b) is to be ignored,

(ii) in paragraph (c)(i), the reference to the managers of the other hospital is to be read as a reference to the managers of the hospital in which the person is detained.

(3) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”>

Section 36

Jamie Hepburn

61 Leave out section 36

Section 37

Jamie Hepburn

62 Leave out section 37
Section 38

Jamie Hepburn

63 Leave out section 38

After section 40

Dr Richard Simpson

92 After section 40, insert—

*Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons*

Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 63 (appeal by prosecutor in case involving insanity), there is inserted—

“Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

63A Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) Subsection (2) applies where a person—

(a) is charged with a relevant offence, and

(b) has prior to being charged with that relevant offence been—

(i) in receipt of care and treatment from a health board under the Mental Health (Treatment and Care) (Scotland) Act 2003 (“the 2003 Act”), or

(ii) referred to a Health Board for care and treatment under the 2003 Act.

(2) As soon as practicable after the person is charged with a relevant offence, the procurator fiscal must, where it appears to the procurator fiscal that the person meets the conditions specified in subsection (1), notify—

(a) the Health Board—

(i) which provided care and treatment to the mentally disordered person under the 2003 Act, or

(ii) to which the mentally disordered person was referred for care and treatment under the 2003 Act, and

(b) the Mental Welfare Commission,

that the mentally disordered person has been charged with a relevant offence.

(3) A Health Board which has been notified under subsection (2) must—

(a) undertake an inquiry into the mentally disordered person’s interaction with the Health Board,

(b) prepare and publish a report setting out the findings of the inquiry, and
(c) as soon as practicable after the publication of a report under paragraph (b), prepare an action plan responding to the findings of the report.

(4) As soon as practicable after the publication of a report and action plan under subsection (3), the Health Board must provide the report and action plan to—

(a) the Mental Welfare Commission,

(b) any natural person against whom a relevant offence has been perpetrated, provided that the Health Board has ascertained that the person to be given the information wishes to receive it.

(5) The Mental Welfare Commission must, in accordance with directions given to it by the Scottish Ministers, from time to time, and not less than once in every parliamentary session, lay before the Parliament a report summarising the findings of the reports received since the laying of the last such report.

(6) Subsections (7) and (8) apply where—

(a) the Parliament is dissolved before the period of 12 months has elapsed since the commencement of the session of Parliament, and

(b) as at the date of dissolution a report under subsection (5) has not been published.

(7) The session in which the Parliament is so dissolved is not to be regarded as a session in which a report under subsection (5) is to be published.

(8) A report under subsection (5) must be published in the session of the Parliament which—

(a) next follows the session in which the Parliament is so dissolved, and

(b) is not itself a session in which the Parliament is so dissolved.

(9) Health Boards must, in exercising any function under this section, have regard to any guidance issued by the Scottish Ministers.

(10) The Scottish Ministers must publish any guidance they issue for the purposes of this section.

(11) The Scottish Ministers may revise and revoke such guidance.

(12) For the purposes of this section, “relevant offence” means the committing of the offence of—

(a) murder,

(b) culpable homicide,

(c) such other offence as the Scottish Ministers may by regulations prescribe.

(13) For the purposes of this section, “referred” means referred to a Health Board by a medical practitioner, or such other person as the Scottish Ministers may by regulations prescribe.

(14) The Scottish Ministers may by regulations amend subsections (1) to (9), so as to—

(a) incorporate within the meaning of this section persons charged with a relevant offence who have been in receipt of care and treatment under the 2003 Act from a body other than a Health Board,
(b) to require that body to be notified of the charging of that person and to be subject to the requirements of subsections (3) to (6).

(15) Regulations under subsections (12) and (14) are subject to the affirmative procedure.

(16) Regulations under subsection (13) are subject to the negative procedure.

Before section 41

Dr Richard Simpson

113 Before section 41, insert—

<Referral by Tribunal to High Court

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 195 there is inserted—

‘Reference to High Court by Tribunal

195A Tribunal’s powers to make reference to High Court

(1) This section applies where—

(a) a person—

(i) was convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or

(ii) was remitted to the High Court by the sheriff under any enactment for sentence for such an offence;

(b) the person is subject to—

(i) a compulsion order; or

(ii) a compulsion order and a restriction order; and

(c) a determination or order is made under this Act changing the category of the patient’s mental disorder.

(2) If the conditions in subsection (3) apply, the Tribunal may refer the matter to the High Court.

(3) Those conditions are that—

(a) the Tribunal is satisfied that the category of the patient’s mental disorder has changed from that specified at the time at which the court made the compulsion order or compulsion and restriction order, as the case may be;

(b) it appears to the Tribunal that, given the change in category, it is appropriate for the patient to be remitted to the High Court for sentence for the offence for which the person was convicted; and

(c) the Tribunal considers that it is in the interests of justice and consistent with the principles of this Act that such a reference should be made.

(4) In determining whether a reference is in the interests of justice, the Tribunal must have regard to the need for finality and certainty in the determination of criminal proceedings.
(5) In considering whether or not to make a reference, the Tribunal may at any time refer to the High Court for the Court’s opinion on any point on which it desires the Court’s assistance; and on a reference under this subsection the High Court must consider the point referred and provide the Tribunal with its opinion on the point.

(6) A reference under subsection (2) may be made by the Tribunal under this Act—

(a) on the Tribunal’s own initiative;
(b) on application to the Tribunal by;
   (i) the patient;
   (ii) the responsible medical officer;
   (iii) the Commission;
   (iv) any other person mentioned in subsection (8).

(7) Before making a reference to the High Court under this section the Tribunal must—

(a) afford the persons mentioned in subsection (8) below the opportunity—
   (i) of making representations (whether orally or in writing); and
   (ii) of leading, or producing, evidence; and

(b) whether or not such representations are made, hold a hearing.

(8) Those persons are—

(a) the patient;
(b) the patient’s named person;
(c) the patient’s primary carer;
(d) any guardian of the patient;
(e) any welfare attorney of the patient;
(f) any curator ad litem appointed by the Tribunal in respect of the patient;
(g) the Scottish Ministers;
(i) the mental health officer;
(j) any other person appearing to the Tribunal to have an interest.”

(3) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(4) After section 61 there is inserted—

“Reference by the Tribunal to the High Court

61A Reference by the Tribunal to the High Court

(1) Where the Tribunal makes a reference to the High Court under section 195A of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Tribunal must—

(a) give to the Court a statement of its reasons for making the reference; and

(b) send a copy of the statement to every person who appears to them to be likely to be a party to any proceedings arising from the reference.
(2) The High Court must hear and determine the case, subject to any directions the High Court may make, as if it were an appeal under Part VIII or, as the case may be, Part X of this Act.

### 61B Further provision on reference

(1) The High Court may reject the reference if the Court considers that it is not in the interests of justice that any proceedings arising from the reference should proceed.

(2) In determining whether or not it is in the interests of justice that any proceedings should proceed, the High Court must have regard to the need for finality and certainty in the determination of criminal proceedings.

(3) On rejecting a reference under this section, the High Court may make such order as it consider necessary or appropriate.

### 61C Supplementary provision

(1) The Scottish Ministers may by order make such incidental, consequential, transitional or supplementary provisions as may appear to them to be necessary or expedient for the purpose of bring section 61A and 61B into operation.

(2) Regulations under subsection (1) are subject to the affirmative procedure.

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**Section 41**

Jamie Hepburn

**64** In section 41, page 25, line 12, leave out <165(2)> and insert <165(2)(a)>

**After section 42**

Jamie Hepburn

**65** After section 42, insert—

<Effect of revocation of restriction order>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 198 (effect of revocation of restriction order), for the words “Tribunal revoked the restriction order” there is substituted “order revoking the restriction order has effect in accordance with section 196 of this Act”.

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**Section 44**

Dr Richard Simpson

**114** In section 44, page 27, leave out line 17 and insert—

<((1) Where—->

Dr Richard Simpson

**115** In section 44, page 27, line 24, after <years> insert—
<e>there are no exceptional circumstances which, in the opinion of the Scottish Ministers, make it inappropriate to do so, the Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).</e>

Dr Richard Simpson

116 In section 44, page 27, leave out lines 25 to 33

Jamie Hepburn

120 In section 44, page 29, line 2, at end insert—

< ( ) the terms of any restrictions on things O may do which have been imposed on O as conditions on conditional discharge under section 193(7) or section 200(2) of the Mental Health Act (including under section 193(7) as applied by section 201(3) or 204(3) of that Act),>

Section 45

Jamie Hepburn

121 In section 45, page 29, line 32, after <granting> insert <for the first time>

Jamie Hepburn

122 In section 45, page 29, line 36, after <granting> insert <for the first time>

Jamie Hepburn

123 In section 45, page 30, line 10, leave out <paragraph (b) or (c) of section 17B(5)> and insert <section 17B(5)(b)>

Section 47

Jamie Hepburn

124 In section 47, page 31, line 30, at end insert—

< ( ) to such a certificate being granted for the first time is to such a certificate being granted for the first time—

(i) since the person was detained under the particular order or direction which authorises the person’s detention in a hospital (or would do, but for the certificate’s being granted), or

(ii) in a case where the person, while subject to that order or direction, has been recalled to hospital under section 202 of the Mental Health Act, since the person was so recalled (or most recently so recalled if it has happened more than once).”.

13
Section 49

Dr Richard Simpson

117 In section 49, page 32, line 20, at end insert—

<(  ) In paragraph (a) of subsection (2) of section 167 (powers of tribunal on application under section 149, 158, 161, 163 or 164) after “measures” there is inserted “, or any recorded matter”>.

Jamie Hepburn

125 In section 49, page 32, line 28, leave out <the decision> and insert <a decision about what (if any) conditions to impose on the patient’s conditional discharge under subsection (7)>.

Nanette Milne

118 In section 49, page 32, line 38, at end insert—

<(  ) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal)—

(a) after paragraph (b) of subsection (5) there is inserted—

“(ba) that person’s curator ad litem;”,

(b) after paragraph (b) of subsection (6) there is inserted—

“(ba) that person’s curator ad litem;”,

(c) after paragraph (b) of subsection (8) there is inserted—

“(ba) that person’s curator ad litem;”,

(d) after paragraph (b) of subsection (9) there is inserted—

“(ba) that person’s curator ad litem;”.

(  ) In section 322 (appeal to the Court of Session against certain decisions of the Tribunal)—

(a) after paragraph (b) of subsection (3) there is inserted—

“(ba) that person’s curator ad litem;”,

(b) after paragraph (b) of subsection (4) there is inserted—

“(ba) that person’s curator ad litem;”>.

Before section 50

Nanette Milne

119 Before section 50, insert—

<Interpretation

In section 329 (interpretation) of the 2003 Act, in the definition of “medical practitioner”, after the word “practitioner” where it second appears there is inserted “or practitioner psychologist”>.
2nd Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- a list of any amendments already debated;
- the text of amendments to be debated on the second day of Stage 2 consideration, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

Groupings of amendments

**Services and accommodation for mothers**
50, 51

**Absconding patients**
52, 89, 90, 91, 53

*Notes on amendments in this group*
Amendment 52 pre-empts amendment 89

**Agreement to transfer prisoners**
54

**Meaning of mental disorder**
55, 56

**Information on adverse incidents**
109

**Review of deaths in detention**
110

**Detention under compulsion orders**
57

**Period of assessment order**
111

**Transfer of patients to suitable hospital**
58, 59
Duty of Health Boards: homicide reporting
92

Referral to the High Court
113

Effect of restriction order
65

Victim notification: circumstances in which duty arises
114, 115, 116

Victim notification: information and representations etc
120, 121, 122, 123, 124, 125

Compulsion order: recorded matter
117

Involvement of curator ad litem: appeals
118

Practitioner psychologists
119

Amendments already debated

Compulsory treatment
With 1 - 64

Transfers and hospital units
With 93 - 112, 61, 62, 63

Named person
With 103 - 108

Support, conflicts of interest and safeguarding patients
With 47 - 48, 49
Present:
Bob Doris (Deputy Convener)     Rhoda Grant
Colin Keir                      Richard Lyle
Mike MacKenzie                  Duncan McNeil (Convener)
Nanette Milne                   Dennis Robertson
Dr Richard Simpson

Also present: Adam Ingram, Jackie Baillie

Mental Health (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 2).

The following amendments were agreed to (without division): 48, 49, 50, 51, 52, 53, 54, 57, 58, 59, 112, 61, 62, 63, 64, 65, 120, 121, 122, 123, 124 and 125.

The following amendments were moved and, no member having objected, withdrawn: 55, 109, 110, 111, 92, 113, 114, 117, 118 and 119.

Amendment 89 was pre-empted.

The following amendments were not moved: 108, 90, 91, 56, 115 and 116.

Sections 24, 27, 28, 29, 30, 31, 32, 33, 34, 39, 40, 42, 43, 46, 48, 50, 51 and the long title were agreed to without amendment.

The following provisions were agreed to as amended: sections 23, 25, 26, 35, 41, 44, 45, 47 and 49.

The Committee completed Stage 2 consideration of the Bill.
The Convener (Duncan McNeil): Good morning and welcome to the 17th meeting in 2015 of the Health and Sport Committee. We welcome to the committee Adam Ingram MSP, and we expect Jackie Baillie MSP to attend.

At this point, I usually ask everyone in the room to switch off mobile phones, as they can interfere with the sound system. I remind people that committee members and our support staff are using tablet devices instead of hard copies of our papers.

The first item on the agenda is day 2 of stage 2 consideration of the Mental Health (Scotland) Bill. I again welcome the Minister for Sport, Health Improvement and Mental Health and his officials. For the record, I remind members that the minister’s officials are here in a strictly supportive capacity and cannot speak during proceedings or be questioned by members. Everyone should have a copy of the bill as introduced, the second marshalled list of amendments and the second groupings of amendments.

There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment and to speak to all the other amendments in the group. I will then call the other members who have amendments in the group. Finally, the member who lodged the first amendment in the group will be asked to wind up the debate and to press or withdraw the amendment. Members who have not lodged an amendment in the group but who wish to speak should catch my attention in the usual way.

If a member wishes to withdraw their amendment after it has been moved, I must check whether any member objects to its being withdrawn. If any member objects, the committee will immediately move to the vote on the amendment. Any member who does not want to move their amendment when it is called should say, “Not moved.” Any other MSP can move the amendment, but I will not specifically invite other members to do so. If no one moves the amendment, I will call the next one.

After section 22
Amendments 48 and 49 moved—[Jamie Hepburn]—and agreed to.

Section 23—Services and accommodation for mothers

The Convener: Amendment 50, in the name of the minister, is grouped with amendment 51.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): In the development of my position on these issues, my policy intention has centred on the particular benefit for mothers and babies of maintaining and supporting that relationship in the first year of life. As part of that, it is important that our approach in the area is consistent with the Children and Young People (Scotland) Act 2014 in recognising the rights of the child and promoting, supporting and safeguarding a child’s wellbeing.

Amendment 51 amends the Mental Health (Care and Treatment) (Scotland) Act 2003 to provide that “a Health Board is required to provide services and accommodation ... only if it is satisfied that doing so would be beneficial to the wellbeing of the child.”

That would not preclude health boards from offering those services in other circumstances, without it being an express duty, for example in cases where the impact on the child may be judged to be neutral. I believe that that strikes the right balance, requiring that accommodation and services are provided where it is beneficial to the child, while providing flexibility for health boards to consider other circumstances.

Amendment 50 is a technical amendment, which restructures provisions in the 2003 act to accommodate the new provisions that are set out in amendment 51.

I move amendment 50.

Rhoda Grant (Highlands and Islands) (Lab): I have some concerns about amendment 51. I recognise that it is good and to be encouraged for mothers to have their babies with them. However, I wonder whether the catch-all of that being beneficial to the wellbeing of the child could give health boards an opt-out. I am wondering when it would not be beneficial to its wellbeing for a child to be with its mother. The provision is quite broad, but it seems to me that the range of situations in which a child would be away from its mother should be really narrow. I am a bit concerned that the amendment is very broadly drawn, which could give health boards the opportunity to opt out if they did not think that the facility was right, for instance. In what circumstances do you envisage that a parent and a child would be separated?
Jamie Hepburn: Rhoda Grant’s points are well made. The bill already improves circumstances for mothers with respect to the right to have their child with them at the early stages. I think that I am right in recalling that, at the moment, under the 2003 act, the only circumstances that apply are those of postnatal depression. We are widening those circumstances to cover other forms of mental health disorder. In that sense, we are taking on board concerns about ensuring that children are with their mother where that is appropriate. Of course, the bottom line is that the measures must be appropriate for the circumstances of the child, too.

I hear Rhoda Grant’s concern about a health board interpreting the circumstances as not being appropriate because of the structure of the facility and so on. That is certainly not the intention. I am happy to consider whether we need to finesse the provisions further, but I think that the principle that we have set out is the appropriate one. I believe that the committee should support amendment 51 at stage 2, and we will consider the matter further in advance of stage 3.

My instinct is that the concerns could be addressed by the guidance that we issue, but it is of course not the case that we want health boards to interpret the provisions on the basis of the facilities—this is a duty that they will have to adhere to.

Amendment 50 agreed to.

Amendment 51 moved—[Jamie Hepburn]—and agreed to.

Section 23, as amended, agreed to.

Section 24—Cross-border transfer of patients

Amendment 108 not moved.

Section 24 agreed to.

Section 25—Dealing with absconding patients

The Convener: Amendment 52, in the name of Bob Doris, is grouped with amendments 89 to 91 and 53. If amendment 52 is agreed to, I cannot call amendment 89, as amendment 52 will have pre-empted it.

Bob Doris (Glasgow) (SNP): Amendment 52 relates to section 25 of the bill, which amends section 309 of the 2003 act to allow regulations to be made “applying some or all of Part 16” of the 2003 act, relating to medical treatment, to patients who have absconded from jurisdictions outwith Scotland while they are held pending removal to their home jurisdiction. That section would allow medical treatment to be given to those patients in accordance with those regulations. The purpose of amendment 52 is to amend section 309 of the 2003 act so that, instead of allowing regulations to be made that apply “some or all of Part 16” to absconding patients, regulations would apply only “specific provisions in” that part of the act to such patients. The effect of the amendment is that the regulations would have to specify the particular provisions of that part of the act that are to apply to such patients, thereby authorising only specified treatments to be given in accordance with the provisions of that part only, rather than applying the part in its entirety.

Amendment 53 also relates to the regulation-making powers that are introduced in section 25 of the bill. The purpose of amendment 53 is to introduce a new exception to the power to make regulations applying the provisions of part 16 of the 2003 act to patients who have absconded to Scotland.

Amendment 53 would ensure that the regulations would not authorise medical treatment of the types mentioned in section 234(2) and section 237(3) of the 2003 act. The effect would be that no regulations could be made that would permit those treatments being given. It would—this comes to the nub of both amendments—preclude treatments such as surgical operations, other treatment specified in regulations made under section 234 and electroconvulsive therapy from being given to patients who have absconded to Scotland from other jurisdictions. The amendment would specifically preclude those forms of treatments, with other forms of treatments to be outlined in the regulations.

I have worked with the Scottish Association for Mental Health to look at alternative amendments, but we considered that the alternative proposals might preclude routine treatment that may be necessary for on-going medication to be given.

I hope that the two amendments reassure stakeholder groups that the rights of absconding patients will be protected, while allowing essential treatment to be given when it is needed. I hope that the committee will support amendments 52 and 53.

I move amendment 52.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have listened very carefully to Bob Doris. I welcome the fact that he has lodged amendments to section 25. The amendments in my name would go somewhat further than his proposals. He is proposing that certain treatments under part 16 of
the 2003 act would still be allowed, subject to regulations, whereas I am proposing that all treatment other than under section 243 of the 2003 act—that is, all treatment other than emergency treatment—should be precluded.

The bill as drafted will allow ECT and any surgical operations intended to destroy brain tissue, as well as treatments to reduce sex drive and to force nutrition. However, section 243 of the 2003 act, which is what the bill would refer to under my amendments, specifically authorises urgent treatment for the purposes of saving life, preventing serious deterioration, alleviating suffering and preventing violent behaviour. That fairly broad area protects patients. The question to the minister is whether, under the regulations under part 16 of the 2003 act, those other treatments would be excluded. Treatments should be excluded unless they are there to save life or prevent serious deterioration.

The Government has argued against the amendment. It has said that that is not the Government’s policy and that more invasive treatments should be permitted in accordance with part 16 of the 2003 and should be given to patients who have absconded to Scotland. However, the amendments in my name would strengthen the situation. I will wait to hear the minister’s reply and Bob Doris’s summing up to see whether we will get guarantees on the regulations before I decide whether to move amendments 89 to 91.

Jamie Hepburn: I thank Bob Doris and Richard Simpson for lodging their amendments. I know that a range of stakeholders have particular interests in this area, such as the Scottish Association for Mental Health, as Mr Doris mentioned.

As I said in the response to the stage 1 report, it has never been the Government’s policy that certain treatments for which part 16 of the 2003 act requires additional safeguards would be given to patients who have absconded to Scotland. However, it is important that we strike the right balance to allow absconding patients to receive the treatment that they need.

Amendments 89 to 91, in the name of Richard Simpson, would restrict treatment to urgent situations for the purposes of saving the patient’s life, preventing serious deterioration in the patient’s condition, and alleviating serious suffering and preventing the patient from behaving violently or being a danger to the patient or to others. Although I recognise and understand the sentiments, the amendments extend too widely. As Dr Simpson said, they are fairly broad and, as Bob Doris suggests, could restrict appropriate treatment for absconding patients, as they potentially do not allow for on-going or routine treatment that may be of benefit to the patient.

09:30

As Bob Doris set out, amendments 52 and 53 rule out certain treatments that require additional safeguards—electroconvulsive therapy, surgical operations and other treatments specified in regulations under section 234 of the 2003 act.

Turning to Dr Simpson’s question about what would be contained in the regulations, I note that the amendments will allow detailed consultation before the making of regulations to make specific provisions relating to other treatment for absconding patients. My commitment to Dr Simpson and the committee is that that will be a genuine consultation. It is important that we undertake such consultation to make sure that we get the right balance before we determine what would be in the regulations. The points by Dr Simpson are well made.

The amendments that have been lodged by Bob Doris strike the right balance, in advance of further consultation. I ask members to support amendments 52 and 53 and Dr Simpson not to move amendments 89 to 91.

The Convener: I call Bob Doris to wind up and press or withdraw his amendments.

Bob Doris: I will be very brief. I had written down three words in the course of that short debate: proportionality, balance and safeguards. The safeguards are for the patient in terms of when they would need treatment and when treatment should be precluded from being given to them. The amendments that I have lodged provide that balance, on the basis that the minister has agreed today to an open consultation in relation to what future regulations will be. I am sure that there will be such consultation. I press amendment 52 and will move amendment 53.

Amendment 52 agreed to.

Amendments 90 and 91 not moved.

Amendment 53 moved—[Bob Doris]—and agreed to.

Section 25, as amended, agreed to.

Section 26—Agreement to transfer of prisoners

The Convener: Amendment 54, in the name of the minister, is in a group on its own.

Jamie Hepburn: Section 26 amends section 136 of the 2003 act to provide that a prisoner may be transferred to a hospital for treatment under a transfer for treatment direction only when a mental health officer has agreed to that.
A number of stakeholders including the Mental Welfare Commission for Scotland, the Scottish Prison Service, and the Royal College of Psychiatrists do not believe that the requirement for mental health officer agreement should be mandatory in all cases, as that could lead to delays in transfer and treatment. In particular, the Royal College of Psychiatrists noted that

“It would be inequitable for an ill prisoner to have a delay in necessary urgent treatment because their need is to do with their mental health and not physical.”

Amendment 54 therefore amends section 26 to allow a transfer for treatment direction to be made if it has been impracticable to obtain the agreement of a mental health officer.

Appropriate guidance will be provided in the statutory code of practice to make clear that the presumption is that agreement should be received from a mental health officer before a transfer for treatment direction is made and that a mental health officer should be involved promptly after the transfer, where that has not been possible beforehand. That maintains the right balance of requiring mental health officer involvement while avoiding any delays in treating acutely unwell prisoners.

I move amendment 54.

**Dr Simpson:** I welcome amendment 54 because the practical situation is that we have fewer mental health officers than we had 10 years ago. Recruiting them is proving extremely difficult and, therefore, the absolute requirement that a mental health officer should be involved in transfer from prison would be impracticable on a number of occasions. That needs to be addressed, because their engagement and involvement is important in both the short and long term. Getting this right is important.

My experience of working in a prison is that trying to get a mental health officer caused delays that were not in the best interests of the prison, the prisoner, other prisoners or the prison staff. I very much welcome the amendment.

**Dennis Robertson (Aberdeenshire West) (SNP):** Can the minister tell us whether there is a timeline in the guidance to ensure that a mental health officer will be involved after transfer?

**Jamie Hepburn:** I thank Dr Simpson for his comments. In response to Dennis Robertson’s question, I say that there is not a timeline because the guidance has not been written yet, but we can certainly consider that when we draft the guidance. We want to strike a balance between having a reasonable timescale and taking account of the other concerns that have been raised in comments. The general principle is one that we hope will be backed by the committee, for the reasons that Dr Simpson has set out.

Amendment 54 agreed to.

Section 26, as amended, agreed to.

Section 27 agreed to.

After section 27

**The Convener:** Amendment 55, in the name of Richard Simpson, is grouped with amendment 56.

**Dr Simpson:** The inclusion of learning disabilities and autism spectrum disorder in mental health legislation was raised by a number of witnesses and in written submissions to the committee. Autism Rights and Psychiatric Rights Scotland called for the removal of people with learning disabilities and ASD from mental health law.

Inclusion Scotland commented that people with learning disabilities are concerned that they could be subject to compulsory treatment as a result of their learning disability alone. The committee received powerful testimony from Steve Robertson of People First, who questioned the appropriateness of the way in which people with learning difficulties are considered under mental health legislation. He said:

“We honestly believe that the time has come for a new piece of legislation that is just about people with learning disabilities. We think that it is only right and fair that learning disability is properly defined as an intellectual impairment rather than a mental disorder. With that definition, we would want recognition that additional time to learn and support to understand things, together with easy-read documents and support to make some decisions, are what we need. We need those things to help us take part in our communities, rather than restrictions, detentions and efforts to keep us apart from the world that we want to live in.”—[Official Report, Health and Sport Committee, 11 November 2014; c 39-40.]

I recognise that the Government’s document “The keys to life”, which came on top of the iconic and groundbreaking document “The same as you?” produced under Labour in 2000, moves things on for learning disability. However, we should recognise that, in 1999, recommendation 2 from the Millan committee said:

“In due course, mental health and incapacity legislation should be consolidated into a single Act.”

In 2009—six years ago—the McManus commission said that there was a need to review the Adults with Incapacity (Scotland) Act 2000 along with the Mental Health (Care and Treatment) (Scotland) Act 2003.

Northern Ireland has already begun the process of aligning incapacity and mental health legislation. In discussing previous amendments, I have raised my concern about the difference between SIDMA—significantly impaired decision-making ability—and lack of capacity, which must be looked at again. The need for alignment was
echoed by a raft of witnesses who called for a wholesale review of mental health and incapacity legislation for a further reason—because of new information on, and knowledge about, neurodevelopmental disorders.

I concur with the Mental Welfare Commission for Scotland, which said that while the 2003 act and the 2000 act “for a time ... genuinely led the world”.—[Official Report, Health and Sport Committee, 30 September 2014; c 27.]

there is a need to start thinking about the next wave and particularly about supported decision making in future plans.

Such views apply not just to amendment 55 but to other amendments that I have lodged. By continuing to include learning disability in the definition of mental illness, we are harking back to a bygone era. The inclusion of learning disability as a mental illness goes to the heart of issues of capacity.

The journey that we have taken from the lunacy acts of the 19th century, when we had idiot schools, through the asylum movement, the growth of huge institutions such as the Royal Scottish National hospital, Gogarburn house and Lennox Castle hospital, the shift to the community—which happened in my professional lifetime and was an excellent move with transitional and double funding—to the groundbreaking “The same as you?” report in 2000 and “The keys to life” in 2013 must now or in the very near future be matched by and fully reflected in our laws.

Colleagues, the simple truth is that, although people with learning disabilities are much more likely to have mental illness than the one in four of the general population who will have it, learning disability is not in and of itself a mental illness, and to continue to include it in the definition is an infringement of the human rights of those with such disabilities. Of course they need protection in law, but not in a law that could remove their human rights. As the Government’s second response to the committee’s stage 1 report said, a review would not be simple, but that should not prevent us from immediately commencing one.

In April 2014, the Committee on the Rights of Persons with Disabilities made a general comment on article 12 of the Convention on the Rights of Persons with Disabilities. Paragraph 38 of that general comment states:

“forced treatment by psychiatric and other health and medical professionals ... denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention.”

Learning disability is such a disability. Accordingly, it follows that states parties “must abolish policies and legislative provisions that allow or perpetrate forced treatment”.

We cannot ignore the fact that there have been occasions when patients have been deprived of their right to refuse treatment although they did not lack capacity and when the treatment and what those who were in power considered to be in the patient’s best interests might not, in fact, have been in their best interests. If necessary, a speedy application to the court should occur when there is a dispute.

The Government said in its initial response to our stage 1 report that it was not considering removing learning disabilities or autism spectrum disorder from the 2003 act or having a wider review. Its more recent, fuller response to the report was much more accommodating but still said that such an approach would be difficult.

I believe that the minister is sympathetic. I ask him to make a firm commitment on the record to an early review and to discussing with other parties and stakeholders the chair, membership and remit for such a review in the near future. Amendment 56 goes further than my amendment 55 in specifying that such a review must occur within a year. For me, a year is too long but, nevertheless, I will support Jackie Baillie’s amendment 56 if my amendment is disagreed to or if I do not press it.

On 19 May, the General Assembly of the Church of Scotland approved a report prepared by its church and society council that includes a section on human rights and mental health. That report strongly urges the Government to undertake the wider review for which I call. It also urges that the review should consider the issues that are raised in that report, which include matters relating to legal capacity and consent to treatment.

I seek from the minister an unequivocal commitment to an early review with a full commission similar to the Millan committee to examine the relevant acts: the Criminal Procedure (Scotland) Act 1995, the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007.

I will listen carefully to the minister’s response before deciding whether to press my amendment, because I realise that it might remove protections in the 2003 act for individuals with learning difficulties or autism spectrum disorder. Nevertheless, it is an important amendment that requires debate.

I move amendment 55.

Jackie Baillie (Dumbarton) (Lab): I thank the committee for allowing me the opportunity to speak to amendment 56. I support amendment 55,
but I am conscious that it seeks to remove learning disability and autism from the definition of mental disorder in the 2003 act. Amendment 56 calls for a review in the event that amendment 55 is lost. It reflects lengthy discussions held by the cross-party group on learning disability and would give effect to the group’s view that the inclusion of people with learning disabilities in the definition of mental disorder should be reviewed.

I absolutely acknowledge that unpicking complex legislation, much of which provides a passport to services and rights, is difficult to do. That is why I believe that amendment 56 is proportionate, because it calls for a review. Let us face it—a review is nothing new. The Millan committee first recommended it in 2001 and the McManus review recommended it in 2009. Both supported the idea of removing learning disability from the definition of mental disorder in existing legislation. I might be called a patient person but, 14 years on, it has still not happened, and it is now time to make that review happen.

Amendment 56 does not presuppose the outcome of any review. It would simply ensure that a review happened, that we got a chance to look at complex issues away from the urgency, if you like, and the process of a bill, and that we could consider the matter properly.

I hope that the minister will support amendment 56. Like Richard Simpson, I detect a change to a more welcoming tone. The previous comments from the Scottish Government were more negative. I hope that we will gain support for the amendment from the Scottish Government.

09:45

**Dennis Robertson:** I have a great deal of sympathy for Dr Simpson’s amendment 55 and, to some extent, for the patient Jackie Baillie. I echo the sentiments that they expressed. I hope that the Government can provide us with details as to when a review will take place, because the organisations and agencies that provide services for people with learning disabilities are asking for that. I will listen to the minister’s comments.

**Rhoda Grant:** I support amendments 55 and 56. We have had powerful evidence about the difficulties that the current situation causes. It is time that we moved on and came to a better settlement with people with learning disabilities and other conditions that are not mental illnesses.

**Jamie Hepburn:** I recognise the issues that Richard Simpson and Jackie Baillie raise in their amendments and the passion with which they argue their case. I have heard the concerns that a number of people and organisations have raised about the inclusion of learning disability and autism under the mental health legislation. I met representatives of People First just last week, when the issue was discussed.

The 2003 act provides people with learning disabilities and autism spectrum disorders with important protections, safeguards and access to care and treatment. In anything that we seek to do, we must ensure that that continues.

In the Scottish Government’s response to the committee’s stage 1 report, I indicated that we intend to review the inclusion of learning disability and autism in the mental health legislation. It is important that we undertake that review to ensure that the range of views is heard—the views of those who have been making the case that learning disability and autism should not be included and the views of those who make the case for the benefit of the protections, safeguards and access that the legislation provides. We also need to consider carefully the practicality and the implications of any review that concludes that learning disability and autism spectrum disorder should be removed from the 2003 act. The review process would clearly allow for that.

I do not support Richard Simpson’s amendment 55 as it would remove the protections and safeguards that exist for people with learning disability and autism who are treated under the 2003 act and would not replace them with anything. Dr Simpson referred to the request for new legislation specifically on learning disability, but his amendment would not achieve that in and of itself. I urge him to withdraw his amendment in the light of the Government’s commitment to carrying out a review.

I understand why Jackie Baillie’s amendment 56 requires ministers to carry out a review within a year of royal assent. There has been an expectation that a review will take place for a considerable time—since the 2003 act came into effect, and again following the McManus report. I note that Richard Simpson believes the timescale in Jackie Baillie’s amendment to be too long.

I understand the sentiment, but I observe that the timescale that amendment 56 would impose would mean carrying out the review at the same time as implementing the bill. The people who will be involved in implementation—in feeding into the secondary legislation, developing the code of practice and putting in place the required changes to services—will also be key to the carrying out of a review.

I want the review to be participative, to ensure that all voices have an opportunity to influence the process and to be heard. It is critical to include those who have learning disabilities and autism spectrum disorders. That takes time, and it sometimes means taking longer than expected for genuine reasons, as unexpected issues arise.
during the process. I do not want us to set out an expectation, least of all in legislation, that is not achievable.

I make a commitment to carrying out a review. I would be happy to speak in more detail about the issue to Jackie Baillie, Dr Simpson or any other member of the committee or Parliament. I urge Jackie Baillie not to move her amendment 56 and, if she moves it, I urge members not to support it.

My position is unequivocal. I support a review of the inclusion of learning disability and autism in mental health legislation and I am happy to discuss that further with Opposition members and the committee. In setting out that position, we have to be clear that the review must be genuine. I do not want us to set a timescale that could curb the review so that it is not full scale and proper.

Dr Simpson: I welcome the fact that the minister has committed to a review, although the time is uncertain. As I said when I moved amendment 55, the review has to commence pretty rapidly. The term “carry out” in Jackie Baillie’s amendment 56 might not be the right one, as it may imply that the review will be carried out and completed. My interpretation is that the review would at least have to commence within a year. As I said, it is reasonable to expect the Government to establish the review within months, rather than a year.

I am happy to seek to withdraw my amendment 55, which I lodged as a probing amendment to ensure that there would be a proper debate, as there has now been. I realised that it would remove certain protections from people with learning disability, which would not be appropriate, so I am happy to seek to withdraw it. However, I will support Jackie Baillie’s amendment 56, if she moves it, on the basis that the review must start within a reasonable period. At stage 3, we will have the opportunity to make minor modifications to ensure that the bill talks about starting the review, rather than completing it, which was the implication of the minister’s remarks.

Amendment 55, by agreement, withdrawn.

Jackie Baillie: I will not move amendment 56, on the basis that there will be a discussion with the minister about a firm timescale for a review. People expect that. However, I reserve my right to bring back the amendment at stage 3.

Amendment 56 not moved.

The Convener: Amendment 109, in the name of Adam Ingram, is in a group on its own.

Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP): Amendment 109 was inspired by my constituent Fiona Sinclair of the Autism Rights group. Her research, using freedom of information requests, has established that there are no published statistics on deaths, suicides or adverse events such as assaults or restraints in the mental health system in Scotland. There is no collation of any data for any of those categories, apart from deaths.

There are national statistics for suicides, but there is no separate collation of data for those in mental institutions or those who are subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003. Although pilot schemes are in place to collate some of that information, we as parliamentarians must ensure that scrutiny is thorough and systemic.

In addition, there appears to be little collation of evidence, other than randomised control trials that are funded by the pharmaceutical industry, on the efficacy and effectiveness of various drug treatments. It is therefore impossible to judge how those treatments compare with different forms of treatment.

Amendment 109 would assist the purposes of medical research as well as providing a useful check on human rights in the system.

I move amendment 109.

Jamie Hepburn: I thank Adam Ingram for lodging amendment 109, which raises the important issue of how we reduce harm to people who receive care and treatment and how information gathering can support such a reduction. Of course, that is an issue not just for mental health services but for all health services.

I absolutely recognise the importance of reducing harm to people who are subject to compulsory treatment, but I do not think that the amendment would deliver the improvements to services that it is intended to deliver. We have already put in place mechanisms to support improvements in patient safety in mental health services. Health boards already report the deaths of patients who are detained in hospital to the Mental Welfare Commission, which in 2014 produced a report entitled “Death in detention monitoring” that provides an analysis of the situation. Moreover, Healthcare Improvement Scotland runs a suicide reporting and learning system that shares learning from suicide reviews. I am sure that we will return to the matter when we debate amendment 110, in the name of Richard Simpson, on reviews of deaths in detention.

In 2012, we introduced the Scottish patient safety programme for mental health. That genuinely innovative work on mental health services, which is run by Healthcare Improvement Scotland and involves all health boards, aims to systematically reduce harm experienced by people receiving care from mental health services. It focuses on five areas: communication at
transitions; leadership and culture; medicines management; restraint and seclusion; and risk assessment and safety planning. Some of those areas—restraint and seclusion; risk assessment and safety planning; and medicines management—are exactly those that Adam Ingram’s amendment highlights.

The approach under the Scottish patient safety programme is powerful, because it allows services and front-line staff to focus resources, including those for collecting and analysing information, on the areas that need most attention locally, which will certainly change over time. Introducing a legislative requirement to always collect certain information or data would result in a lack of flexibility to do such work effectively. I argue that what we have in place and are continuing to develop is a more effective way of improving safety and reducing harm to patients, and it is more effective than introducing a new layer of statutory reporting and information collection requirements that would have substantial resource implications for health boards and front-line staff.

I urge Adam Ingram not to press amendment 109.

Dr Simpson: I very much support what Adam Ingram is trying to do. It is essential that boards collect such information if they are to learn anything. I heard what the minister said about the patient safety programme, which is important, but it is a matter of regret that we have no clear data on these matters.

I think that the issue can be covered in regulations and that the Government should give an undertaking on that if amendment 109 is not agreed to. It is essential that we have an appropriate understanding of such things. As I will indicate when I speak to amendment 110, I think that the time has come for further reviews, but I note that Adam Ingram’s amendment 109 goes further, as it deals with assaults, recorded adverse events and “occasions on which restraints have been used in relation to a patient.”

The public are concerned about such issues, and it is important that we have some understanding so that we can see variations between health boards, which I have gone on about at length in the Parliament. That information would allow us to understand when one board is performing well and another is not. Until that information is made available in a public and transparent way, we will not be serving the public in the way that we should be, despite all the excellent programmes that the Government has put in place.

Adam Ingram: To add to what Dr Simpson has just expounded, I think that we need to improve the level of information that is available. A couple of years ago, the Scottish Information Commissioner produced a report that criticised a health board’s recording of significant adverse incidents in its mental health services. There is a deficiency in practice across the country, and I very much support Dr Simpson’s suggestion of putting in place regulations to improve that practice.

I heard what the minister said about the level of bureaucracy that might be involved in the administration that would result from amendment 109, but I certainly want to pursue regulations. On that basis, I will seek to withdraw my amendment, but I want to return to the issue, perhaps with Dr Simpson and others. If the minister was willing to listen to us, I would appreciate that.

10:00

The Convener: I cannot speak on the minister’s behalf, but, throughout these days of considering the bill, he has been approachable and has been available to discuss any of the details.

Amendment 109, by agreement, withdrawn.

The Convener: Amendment 110, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 110 follows on from Adam Ingram’s amendment 109. The wording of amendment 110 has been lifted and redrafted from Patricia Ferguson’s proposal for a member’s bill on fatal accident inquiries. The reason for lodging it as an amendment to the Mental Health (Scotland) Bill arose from a suggestion at a recent Justice Committee evidence session on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill that scrutiny of deaths in mental health hospitals would be dealt with more suitably in a mental health bill. At present, there are serious incident reviews, but families with whom I have corresponded are of the view that those are insufficiently regulated. Amendment 110 will not prevent a fatal accident inquiry from taking place if the procurator fiscal deems that an FAI is appropriate. However, there are reasons to believe that, notwithstanding any decision by the fiscal not to have a FAI, the Health and Safety Executive should conduct investigations. Roger Livermore, with whom I have had considerable correspondence, has extensive experience and expertise in this field and is scathing of the failure by the Health and Safety Executive, and, indeed, ministers to undertake detailed investigations.

The situation is further confused by the role of the Mental Welfare Commission, which also has a duty in the area. From time to time, it has produced valuable reports proposing
improvements. In addition, as the minister mentioned in the debate on amendment 109, suicides in hospitals are reported to the confidential inquiry into homicides and suicides.

The fact that all those different organisations share responsibility for the situation is unsatisfactory. It is a complicated and confused area, which needs to be addressed. I will move amendment 110—as I will move an amendment on homicide later on—in the hope that it is accepted by the minister either in full or in principle. We need clarity of process, and families need transparency.

Amendment 110 would require the minister to establish a proper review of the arrangements for investigation of deaths, and it seeks to involve stakeholders in the process. If the minister opposes the amendment in principle, or supports the principle but opposes the amendment as it stands, I will seek to withdraw it and reconstruct it in order to lodge it at stage 3—with, I hope, the Government’s help.

I move amendment 110.

Jamie Hepburn: Richard Simpson’s amendment 110 is helpful in raising the issue. I am aware that in its report, “Death in detention monitoring”, the most important issue that the Mental Welfare Commission identified was the higher death rate in general among individuals with a history of mental health admission. However, it was not compulsory treatment that was associated with death; it was the presence of mental illness, learning disability and related conditions.

I have reflected on the issues that the report raises and on the point that the commission identifies about ensuring a more consistent and streamlined approach to reviewing deaths of patients in hospital. That approach should be focused on ensuring that services are able to both learn from reviews that are carried out and improve, so that they are more effective and safer. The approach should also ensure that relatives or carers are able to participate fully in the process.

I propose to ask the Mental Welfare Commission and Healthcare Improvement Scotland to consider how a more effective and consistent approach to investigating deaths could be developed. I expect them to take account of the views of relatives who have been affected by deaths in hospital. I will provide an update to the committee on those proposals, which would allow the committee to provide its views before we determine the action that will follow.

On that basis, I invite Dr Simpson to consider withdrawing amendment 110.

Dr Simpson: I am happy to withdraw amendment 110 on the basis of the minister’s helpful statement. However, I am concerned about the timeframe. If we do not see some strong progress soon, I expect to see, at stage 3, a requirement on ministers to produce regulations covering the issue, so that we have absolute clarity. I hope that the minister will make further comments on the developing discussions between the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland.

Amendment 110, by agreement, withdrawn. Section 28 agreed to.

After section 28

The Convener: Amendment 57, in the name of the minister, is in a group on its own.

Jamie Hepburn: Section 57(2) of the Criminal Procedure (Scotland) Act 1995 sets out the disposals available in cases where the accused has been acquitted on the ground of lack of criminal responsibility or where they have been found to be unfit for trial.

Section 57A of the 1995 act sets out equivalent provision for those who are convicted of an offence and meet the test for a compulsion order, and provides that a compulsion order may be made authorising treatment either in detention in hospital or in the community.

Amendment 57 is intended to clarify that a person who has been acquitted on the ground of lack of criminal responsibility or found to be unfit for trial may also be made subject to either a hospital-based compulsion order or a community-based compulsion order.

It is appropriate that such a person should be able to be treated in the community in the same way as someone who has been convicted of an offence, and the amendment achieves that intention, which is in keeping with the principles of the legislation in terms of being the least restrictive option. The amendment also allows the court to act on the recommendations of the psychiatrists and mental health officer who prepare the reports for the court.

Amendment 57 also makes a consequential amendment to make clear the current position, which is that a restriction order may be made only where a compulsion order authorising detention in hospital is also made.

I move amendment 57.

Rhoda Grant: In a case of a person who is found not fit to stand trial, what consideration is given to the victim of the crime that has been committed to ensure that they do not suffer any detriment and that the crime is not repeated? The
Jamie Hepburn: We are introducing the victim notification scheme in the bill to notify victims of certain pieces of information that they are not currently privy to or able to request. We are making a significant advance in victims’ rights, for the reasons that Rhoda Grant set out.

Having said that, it is important that we ensure that we give equal treatment to those who are treated in the mental health system, rather than sent through the criminal justice system. That is what amendment 57 seeks to achieve. Victims’ rights will always be paramount, and that is why we have introduced the victim notification scheme in the bill.

Amendment 57 agreed to.

Section 29—Periods for assessment orders

The Convener: Amendment 111, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: The effect of amendment 111 is to delete paragraphs (b) and (c) of section 29(4).

I note that no provision is made for cross-border transfers in section 52D of the Criminal Procedure (Scotland) Act 1995. I anticipate that problems may be encountered with respect to female and child patients who are on remand, who should be detained in a high-security facility, given that Scotland’s state hospital does not have provision for female or child patients.

Section 29(4)(c) allows the court to extend the assessment order to 14 days. I note that the consultation on the draft bill proposed extending the period to 21 days. Although I acknowledge that it is in the patient’s interests that as full an assessment as possible is made, I do not support the increase from seven to 14 days. Articles 5(4) and 6(1) of the European convention on human rights require a timely hearing, and I am not convinced that such an extension is necessary or proportionate.

Amendment 111 is supported by the Law Society of Scotland.

I move amendment 111.

Jamie Hepburn: Amendment 111, in the name of Richard Simpson, is on an issue that has generated considerable debate not only during the passage of the bill but when the proposals for the bill were consulted on. The committee also highlighted the issue in its stage 1 report.

As Dr Simpson said, our original proposal was to allow the court to extend an assessment order for a period of up to a maximum of 21 days, rather than the maximum of seven days that is permitted under the 1995 act. The proposal generated considerable comment. Respondents who supported it commented that it would allow for a more robust and informed assessment. However, not all respondents supported the proposal, and we acknowledged that by reducing the period of an extension to a maximum of 14 days.

The committee heard evidence at stage 1 from Dr John Crichton on the provisions extending the maximum period for the assessment order. He described how, in the most complex cases, that will allow the clinical team enough time to assess patients fully. In such cases, more time is needed than is presently available under the Mental Health (Care and Treatment) (Scotland) Act 2003 to determine whether the patient meets the treatability criteria and other criteria, as set out in the act.

Concern has been expressed that increasing from seven to 14 days the maximum period for an extension is, or may be, contrary to the rights, under the ECHR, of a person being assessed, particularly their rights under article 5, the right to liberty, and article 6, the right to a fair trial. Dr Simpson has just alluded to that.

However, I suggest that those concerns arise from a misunderstanding of how convention rights are secured in the context of an application for an extension of an assessment order. An extension can only be granted on application to the court, and then only for the period that the court permits. That is subject to a maximum period, which the bill provides is to be 14 days. I emphasise that that is the maximum; the court can, of course, determine a shorter period than the full 14 days.

When considering any application for an extension, the court has to comply with the Human Rights Act 1998. It can grant an extension only if, and to the extent that, to do so is compatible with the assessed person’s human rights. Therefore, the compatibility of any extension with the assessed person’s human rights is assured not by the statutory maximum period established by the legislation, but by the court’s scrutiny of each individual case to ensure that the period of extension granted is no longer than is justified by the particular circumstances of that case. I emphasise that an extension may be granted by the court only on the basis of a report from the patient’s responsible medical officer and will be determined on the basis of clinical need.

I ask Dr Simpson not to press amendment 111. If he presses the amendment, I ask members not to vote for it.

Dr Simpson: I thank the minister for his response. The fact that the court will determine the issue is very important, because that should protect the person’s rights under the ECHR. On
that basis I will withdraw the amendment at this stage. I will consult the Law Society as to whether we need to proceed with another amendment at stage 3.

Amendment 111, by agreement, withdrawn.

Section 29 agreed to.

Sections 30 to 34 agreed to.

Section 35—Transfer of patient to suitable hospital

The Convener: Amendment 58, in the name of the minister, is grouped with amendment 59.

Jamie Hepburn: Section 35(3) inserts new section 61A into the Criminal Procedure (Scotland) Act 1995, in order to close a gap identified in that act. New section 61A will allow for the transfer of persons who are awaiting trial and are subject to certain orders, described as remand orders, to a hospital that is suitable for their needs.

Amendment 58 extends that provision to cover patients who are subject to a temporary compulsion order. That will enable such patients to be moved to a hospital that is more suited to their needs, if it transpires that the hospital ordered by the court is unsuitable, and will ensure that they can be moved in the same way that patients on remand orders—that is, assessment orders, treatment orders and interim compulsion orders—can be moved.

Amendment 59 provides for the transfer of patients who are subject to assessment orders, treatment orders, interim compulsion orders and temporary compulsion orders to another hospital at any time during which the patient is subject to the order, and not only within the first seven days of admission to hospital, as proposed in the bill as introduced.

It is recognised that there might be situations where it does not become apparent until later that the hospital ordered by the court is not suitable or indeed that the patient’s mental condition and therefore treatment needs might change over time, necessitating a transfer to a different hospital.

I move amendment 58.

Amendment 58 agreed to.

Amendment 59 moved—[Jamie Hepburn]—and agreed to.

Section 35, as amended, agreed to.

10:15

Before section 36

Amendment 112 moved—[Jamie Hepburn]—and agreed to.

Section 36—Compulsion orders

Amendment 61 moved—[Jamie Hepburn]—and agreed to.

Section 37—Hospital directions

Amendment 62 moved—[Jamie Hepburn]—and agreed to.

Section 38—Transfer for treatment directions

Amendment 63 moved—[Jamie Hepburn]—and agreed to.

Sections 39 and 40 agreed to.

After section 40

The Convener: Amendment 92, in the name of Dr Richard Simpson, is in group on its own.

Dr Simpson: Amendment 92 has arisen from discussions with Hundred Families, which is an organisation that supports families who have been affected by homicide involving individuals with mental illness. In the past 10 years, 137 homicides have been committed by those with mental illness, but only two appear to have been the subject of published reports by the Mental Welfare Commission, and few appear to have been the subject of adverse incident reviews by health boards. Of course, that might not be the case, but, as we discussed in relation to amendment 109 in the name of Adam Ingram, we do not know what the situation is with any clarity, given the information that is available.

We should compare the situation with that in England, where, over the same period, 321 reviews were carried out for the 576 homicides that happened. Although they are not perfect, those English reviews suggest that 25 to 35 per cent of those homicides could have been prevented. The United Kingdom confidential inquiry, in which Scotland participates, is helpful, but Scotland might not be adequately fulfilling its duty to victims’ families if we do not require transparent reviews to be carried out in every case. Amendment 92 seeks to correct that failing.

The intention in amendment 92 is to provide, in primary legislation, clarity, consistency and accountability in the reviewing of and reporting on certain offences involving a person suffering from a mental illness who is already known to services. That provision is specified in proposed new section 63A(1) of the Criminal Procedure (Scotland) Act 1995, which amendment 92 would insert, and would apply, as proposed new section 63A(12) makes clear, to “murder, ... culpable homicide” and
“such other offence as the Scottish Ministers may by regulations prescribe.”

I would expect those other offences to include serious and violent assault and attempted murder.

At present, we have a dysfunctional reporting and review system that involves decisions by multiple organisations. The range includes the procurator fiscal deciding whether there should be an FAI; the confidential inquiry reports on homicide and suicide; the health board and the Mental Welfare Commission deciding whether to undertake reviews; and decisions by other organisations that might or might not have a role, including Healthcare Improvement Scotland and the Health and Safety Executive, especially in cases where a victim is a member of staff and the offence occurred in a workplace setting. Finally, the minister could require a review to be undertaken.

As I have said, the issue arose because of concerns expressed by Hundred Families, but for the record I make it clear that the number of murders, culpable homicides and serious assaults committed by persons with a mental illness, including those committed by persons with a severe and enduring mental illness, is tiny. My purpose in lodging amendment 92 is to ensure under proposed new section 63A(2) of the 1995 act that, if such a person is charged, the procurator fiscal will inform both the health board and the Mental Welfare Commission, and that, if the person in question has already been treated by that health board’s mental health services or those in another board area, the board will be obliged to make inquiries and prepare a report for the commission. The purpose of those reports and the Mental Welfare Commission summaries that are also proposed in amendment 92 is to ensure that the board in question and other boards learn from such incidents and amend procedures or practices to reduce the likelihood of a recurrence. The reports must also be given to the victim, if they are still alive, or their family—although I gather that, as drafted, the amendment does not ensure that the report goes to the next of kin, which will need to be addressed at stage 3. In any case, this is about improvement, not blame. It is also about protecting people with mental illness in future and ensuring that the procedures, wherever possible, prevent them from committing these offences.

Nevertheless, I am aware of two concerns about my proposals, the first of which is timing. How long ago should mental health services have been involved to require a board to conduct an inquiry and produce a report? Given that such cases are likely to involve mainly persons with a severe and enduring mental illness, I do not propose any time limit. If there were no follow-up in cases involving persons with such a mental illness, that might in itself be the problem that the boards need to face.

Secondly, as the minister mentioned in relation to a previous amendment, discussions are ongoing between the Mental Welfare Commission, Healthcare Improvement Scotland and health boards. That is, of course, welcome, but will the outcome be enshrined in law—perhaps in regulations—and will it cover all the points that I have made? I believe that victims, their families, those with a mental illness and society itself are all best served by putting the measure in primary legislation.

I move amendment 92.

**Jamie Hepburn:** I know that Dr Simpson has taken a considerable interest in the issue and has been working closely with victims’ organisations, and I thank him for that work. It is important—indeed, it is imperative—that the voices of victims and their representative organisations are heard.

I understand that Dr Simpson has also met the Mental Welfare Commission to hear about the work that it is proposing to undertake with Healthcare Improvement Scotland. I have considered the commission’s advice on how we can improve the reporting of homicides, which I agree should be improved. The commission is seeking a more streamlined system to ensure that lessons are learned and shared in order to provide comfort and reassurance to families in these tragic cases.

The commission already has a power under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to investigate cases of deficiency of care, and it has from time to time used that power to investigate homicides by patients. It has therefore proposed that, working with Healthcare Improvement Scotland and the Scottish Government, it should build on that to ensure that all cases are reviewed appropriately. In some cases, that would involve a review initiated by the local health board with oversight by the commission, but in cases in which there were serious concerns about the provision of care or reason to believe that significant opportunities to prevent a serious incident had been missed, the commission could conduct its own investigation. It would also be possible for a fatal accident inquiry, where appropriate, to be held. The commission is working with Healthcare Improvement Scotland to refine the proposal, which it hopes can be brought into effect soon. I propose to reflect on that proposal and, if it would help the committee, to write to the committee and update members in due course.

I have some concerns about whether amendment 92, as drafted, will achieve what is intended. The provision triggers the need for an
inquiry on a person’s being charged with an offence, which would therefore be prior to their conviction. That person could be acquitted, because they were not guilty or were found not criminally responsible for conduct constituting an offence by reason of mental disorder, and holding an inquiry at such an early stage would seem to cut across the criminal justice process and might be thought inappropriate prior to the final disposal of the case.

The publication of reports also raises potential confidentiality issues, especially in cases where a person is acquitted. Sensitive personal details related to mental ill health are not normally made public, and it is not clear how confidentiality is to be safeguarded.

In light of those concerns and, more significantly, in light of the work that is already under way, I urge Dr Simpson not to press amendment 92.

Dr Simpson: I very much welcome part 2 in general and the approach of trying to involve victims and their families in the process. I also welcome the on-going work between the Mental Welfare Commission and Healthcare Improvement Scotland to streamline the system. However, I have residual concerns that I do not think are being addressed, although it remains to be seen whether that is the case.

Those concerns are about the situation in which a health board does not deem an incident to be sufficiently problematic to justify an investigation or review, but the victim or their family feels that that is necessary. There must be a mechanism beyond going to the Mental Welfare Commission to ensure that, if a victim or their family raises an issue of concern, the health board is required to hold a review at an early stage.

I am not convinced that the matter does not need to be dealt with in primary legislation, but I accept that the minister raised important issues to do with charging a person with an offence and confidentiality. On that basis, I will seek to withdraw amendment 92 and consult those with whom I have been in discussion to see whether a further amendment should be lodged at stage 3. That might depend on the fuller information that we will receive from the minister, who has offered to update us on the issue before stage 3. I hope that that will at least give us an outline of where we are going. I fully understand that full regulations cannot be delivered but, if we get an outline of the principles involved, that will probably be sufficient for us not to require the measure in primary legislation, but I reserve my position on that.

Amendment 92, by agreement, withdrawn.

Before section 41

The Convener: Amendment 113, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 113 arises from discussions with the faculty of forensic psychiatry. I should declare an interest in that I am a fellow of the Royal College of Psychiatry.

The first piece of legislation that was passed by the new Scottish Parliament in 1999, with which I was personally involved, was to tackle the situation arising from an appeal made under the European convention on human rights by Noel Ruddle against his detention in the state hospital at Carstairs following serious offences. That arose because the ECHR had been incorporated into Scottish law.

The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 introduced the serious-harm test, under which patients who were convicted on indictment or complaint and subject to special restrictions by the court could be subject to indefinite hospital detention if a mental disorder was present and they were considered to pose a risk of serious harm to the public, irrespective of the appropriateness of the order or the treatability of the subject.

The legislative provisions in the 1999 act were subsequently extended in the Mental Health (Care and Treatment) (Scotland) Act 2003 to apply to all restricted patients in Scotland, who numbered about 250. Because of those provisions, there remained a small number of patients who became stuck in the forensic mental health system but who had been reclassified as personality disordered. In all likelihood, if the information regarding their mental disorder had been known at the time of sentence, they would not have been subject to a mental health disposal. In the case of Alexander Reid, the court of criminal appeal subsequently recognised that the change of diagnostic category could be considered as new evidence, and it allowed for a new disposal in his case. The process for raising his appeal took several years.

An alternative approach to the problem that is raised by cases such as that of Noel Ruddle is that there should be some mechanism by which the appropriateness of sentence can be reconsidered for patients whose diagnostic category has changed and whose detention in psychiatric hospital is consequently inappropriate. The whole approach in Scotland to personality disordered offenders was considered by a working group on services for people with personality disorder, which was chaired by Professor Thomson and which reported in May 2005. The report recommended that the Scottish Government consider whether a mechanism should be created to refer such cases to the Scottish Criminal Cases
Review Commission for consideration. That position was rearticulated in 2011, when the forensic network gave evidence to the commission on women offenders, which was chaired by the Rt Hon Dame Elish Angiolini.

Amendment 113 seeks to create a mechanism whereby patients whose diagnostic category has changed following sentence can have the appropriateness of that sentence reconsidered in the light of the current or revised diagnosis. It will affect those restricted patients who, having been admitted on a mental illness or learning disability diagnosis, are subsequently recategorised as having a personality disorder. The patients find themselves stuck within the mental health system, with their continued detention justified on the basis of their personality disorder and the risk of the harm that they pose.

The faculty of forensic psychiatry believes that individuals with personality problems are far better supported and managed within the prison system than the mental health system. The amendment will provide a mechanism that allows individuals similar to Alexander Reid to have the courts review their disposal. The current system is extremely cumbersome and costly, and it is not in the best interests of the patient, society or the victims.

10:30

The amendment allows for the Mental Health Tribunal for Scotland to review the appropriateness of the mental health disposal following a review of a compulsion order with or without restrictions. If the tribunal considers that the on-going compulsion order is inappropriate, depending on the clarity of the situation and bearing in mind the interests of justice and the principles of the 2003 act, then it may make reference to an appeal court to reconsider the sentence. This would probably apply to only a small number of individuals seeking to obtain a more appropriate disposal from the court.

Finally, the benefit of this amendment would be that, if even that small number of patients currently stuck within the mental health system were transferred to the Prison Service, there would be savings to the national health service of something in the region of £200,000 per patient.

I move amendment 113.

Jamie Hepburn: Dr Simpson’s amendment 113 opens up very complex issues in proposing new powers for the tribunal and courts that would revisit the decision of the court in its original sentencing and disposal. It also opens up what can be very complex, competing, clinical opinions about diagnosis.

I understand that the amendment is designed to address concerns among some psychiatrists that patients who are diagnosed—or indeed misdiagnosed—as having a mental illness or learning disability and, on that basis, made subject to a compulsion order or compulsion order and restriction order may later be diagnosed as having only a personality disorder. If the court had had full medical evidence based on the later diagnosis, that may have resulted in a prison sentence rather than a mental health disposal for the patient. Yet, once in the hospital system the patient cannot be released because they continue to satisfy the test for a compulsion order or compulsion order and restriction order because of the risk of serious harm that they pose.

It appears to me that the proposal would result in a significant shift in how mentally disordered persons are dealt with by the criminal justice system and, indeed, by the health service after conviction. The present position in the 2003 act is quite clearly that a patient who meets the conditions for a mental health disposal and requires to be detained may, in many cases, most appropriately be detained in hospital rather than in prison.

The 2003 act provides that “mental disorder” includes “personality disorder”, meaning that it is possible for a patient who has a personality disorder with no co-occurring mental illness to be detained in hospital. A more fundamental change to the definition of mental disorder in the 2003 act would be required to prevent that.

An amendment to the Criminal Procedure (Scotland) Act 1995 extended the time period for an interim compulsion order from six months to 12 months, to ensure that a full and rigorous assessment of the offender's mental disorder is undertaken before the final disposal is made. It is very unlikely that an offender would be misdiagnosed in those circumstances, making it much less likely now that a patient would receive a hospital disposal from the court that would create the scenario that Dr Simpson describes.

All patients subject to compulsion orders and restriction orders have the right to apply to the tribunal and to have the orders reviewed periodically. In addition, there is already a means for patients to have their cases considered on appeal. The same appeal route is used for those offenders who receive a prison sentence but who argue that they should have received a hospital disposal.

Amendment 113 is well intentioned. However, it deals with a major issue and, given the implications for the criminal justice system, not one that I believe we should sensibly be considering without thorough consultation. On that basis I urge Dr Simpson not to press his
amendment 113; if he does, I strongly urge members not to vote for it.

**Dr Simpson:** The numbers affected by my amendment 113 would actually be very small—the minister has almost conceded that in the statement that he has just made. I agree with him that, normally, a period of six to 12 months might seem long enough to ensure that there is not a misdiagnosis, but in practice there will still be a small number of individuals affected. Detention in a state hospital for such people is inappropriate and they will wish to be transferred to prison. At the moment, as is clear from the Alexander Reid case, the legal requirements to get the category changed by the court are cumbersome and costly.

Given that reports were made by Professor Thomson in 2005 and that evidence was submitted to the Angiolini committee in 2011, I am concerned that it is not a new problem that has just arisen in 2015 but yet another area in which the Government has had the opportunity to consider matters and come to a conclusion.

I will withdraw amendment 113 at the present time, but I reserve the right to have discussions with the faculty of forensic psychiatry and look at bringing the amendment back at stage 3, unless the Government wishes to consider introducing its own amendment or giving a guarantee at stage 3 that the wider review to which it has committed will include a review of that particular area.

We must resolve the situation, thus saving the individuals concerned from being detained for longer within the state hospital, which is not good for them, and also in order to ensure that the limited resources of forensic psychiatrists are appropriately applied to those who will benefit from them, rather than continuing to be applied to those who are detained inappropriately in the state hospital.

I hope that the minister will consider what I have said.

**Amendment 113, by agreement, withdrawn.**

**Section 41—Information on extension of compulsion order**

Amendment 64 moved—[Jamie Hepburn]—and agreed to.

Section 41, as amended, agreed to.

Section 42 agreed to.

**After section 42**

**The Convener:** I call amendment 65, in the name of the minister, which is in a group on its own.

**Jamie Hepburn:** Amendment 65 deals with an issue highlighted by the Mental Welfare Commission in relation to the revocation of a restriction order.

Part 10 of the Criminal Justice (Scotland) Act 2003 contains provisions in relation to compulsion orders and restriction orders. There are various provisions that allow for applications or references to be made to the Mental Health Tribunal for Scotland in respect of those orders. When the tribunal considers that it is necessary for a compulsion order and restriction order patient to remain subject to a compulsion order but that the restriction order is no longer necessary, it must make an order under section 193 revoking the restriction order.

Section 196 provides that the revocation does not take effect until the occurrence of certain events, including the expiry of the appeal period and the determination of any appeal lodged against the tribunal decision. Section 198 provides that, from the day on which the tribunal makes the revocation order, the patient is treated as being subject to a compulsion order. Accordingly, from the day on which the revocation order is made, the patient is subject to various review requirements.

That means that from the day of the tribunal hearing, the patient must be treated as though they are a compulsion order patient even if the tribunal’s revocation of the restriction order has not yet taken effect. That could lead to the registered medical officer being required to carry out a review of the compulsion order despite the patient continuing to be subject to a compulsion order and restriction order.

Amendment 65 ensures that the provisions work as they should. It has the effect that a patient whose restriction order is revoked should not be treated as being subject to a relevant compulsion order within the meaning given by section 137(1) of the 2003 act—and its attendant review requirements—until such time as the revocation takes effect.

I move amendment 65.

Amendment 65 agreed to.

Section 43 agreed to.

**Section 44—Right to information: compulsion order**

**The Convener:** Amendment 114, in the name of Dr Richard Simpson, is grouped with amendments 115 and 116.

**Dr Simpson:** Amendments 114, 115 and 116 stem from discussions with the Law Society, and the aim is to achieve simplification and clarity.
In the new section 16A proposed by the bill, the statutory language is somewhat cumbersome. Amendment 114 would have the effect of deleting reference to subsection (2) as a qualification of section 16A(1); amendment 115 adds a new subsection (4(e); and amendment 116 deletes the proposed subsections (2), (3) and (4). The effect of the amendments is to create a fully modified section 16A(1) of the Criminal Justice (Scotland) Act 2003, which the Law Society believes will be simpler and clearer.

I move amendment 114.

Jamie Hepburn: Amendments 114 to 116 in Dr Simpson’s name are intended to improve the clarity of the text that is to be inserted as new section 16A of the Criminal Justice (Scotland) Act 2003, but they seek to do that by taking three separate sentences and collapsing them into a single, very long sentence. I do not think that that makes the proposed new section clearer; it does quite the opposite. The choice between saying something one way or another comes down, in large part, to personal taste, but legislation is prepared carefully and just moving words around on the statutory page can change their legal effect, which is the case with amendments 114 to 116.

The amendments change the emphasis, which changes how readily victims’ rights to information arise. Under the bill as drafted, the default position is that information is to be given to a victim when the criteria in the new section 16A(1) are met. That right can only be disapplied in exceptional circumstances. The amendments change the emphasis by requiring exceptional circumstances to be ruled out before any entitlement to information ever arises.

The second problem is that the amendments would leave the new subsection (4) out of the proposed new section 16A. I am not clear why that is being proposed. New subsection 16A(4) is clearly important, because it states when a victim’s right to information about a patient comes to an end.

As I do not think amendments 114 to 116 will make the proposed new section 16A clearer and, more importantly, because they would change the proposed new section’s effect in unintended and unhelpful ways, I suggest that Dr Simpson should not press amendment 114 or move amendments 115 and 116; if he does, I urge members to vote against them.

Dr Simpson: I hear what the minister has said and I will go back and have some further discussions with the Law Society. I will not seek to press amendment 114 at this time.

Amendment 114, by agreement, withdrawn.

Amendments 115 and 116 not moved.

The Convener: Amendment 120, in the name of the minister, is grouped with amendments 121 to 125.

Jamie Hepburn: Amendments 120 to 125 are all amendments to part 3 of the bill, which provides for victims of mentally disordered offenders by introducing a statutory notification and representation scheme for victims of such offenders who are subject to certain orders. The intention is to develop a scheme that resembles as closely as possible the scheme that is available to victims under the Criminal Justice (Scotland) Act 2003.

In lodging the amendments, I have considered the work of the forensic network’s victims’ rights and victims of mentally disordered offenders guidance short-life group. The group includes representatives from the national health service, social work, Victim Support Scotland, Hundred Families, the Mental Health Tribunal for Scotland, Police Scotland and the Scottish Prison Service because of their expertise in operating the victim notification scheme under the 2003 act.

I have also taken into account the view that the committee set out in its stage 1 report that the scheme should not discriminate against mentally disordered offenders. The amendments reflect that concern and are intended to ensure that victims have rights to information and to make representations in a way that reflects as closely as possible the provisions for victims under the 2003 act.

Amendment 120 clarifies the information that will be relayed to victims when the Mental Health Tribunal directs conditional discharge under its powers in section 193(7) of the Mental Health (Care and Treatment) (Scotland) Act 2003, or when the Scottish ministers vary the conditions of discharge under section 200(2) of the 2003 act, which gives the Scottish ministers powers to recall a patient who has been conditionally discharged from hospital.

The effect of the amendment is that information may be provided about a patient and about any conditions have been made imposing restrictions on the things that the patient may do after his or her conditional discharge. In practice, the restrictions will commonly be about where the patient is prohibited from going and persons with whom the patient may not have contact.

10:45

Amendments 121 and 122, along with the whole approach to developing the victim notification scheme, have been proposed to mirror the criminal scheme as closely as possible so that victims of crimes have as comparable rights as possible. The policy aim that we are trying to
achieve is a proportionate position to ensure that the victim has information that is pertinent to them—in this case to know that the patient’s rehabilitation has reached the point at which they will be unescorted in the community.

The amendments will mean that a victim will be entitled to make representations on the first occasion that a decision is being made about granting the patient unescorted suspension of detention. The approach taken to granting unescorted suspension of detention is usually planned and, depending on the patient’s progress, that plan can be updated on multiple occasions during a year, ranging from very minor changes to larger ones when the patient progresses more quickly. It would be disproportionate for victims to be provided the opportunity to make representations on each occasion unescorted suspension of detention is granted. It would also potentially impede a patient’s rehabilitation. The amendments achieve the right balance.

Amendment 121 relates to offenders subject to hospital directions, and amendment 122 relates to cases in which offenders are subject to a compulsion order and restriction order. Amendment 123, which means that victims will provide representations to ministers in writing, has been proposed to mirror the position taken in the criminal justice scheme, in line with our approach to the victim notification scheme as a whole.

Amendment 124 provides for the situation in which a patient who is conditionally discharged is recalled to hospital by ministers. The amendment means that victims will have the right to make representations when a decision is being taken to grant unescorted suspension of detention for the first time after the patient is recalled.

Amendment 125 is intended to clarify how the tribunal will take into account representations that victims make when taking a decision about granting conditional discharge of a patient. The tribunal will be required to take into account the victim’s representations when considering what conditions to include when granting conditional discharge. That is intended to include conditions that would directly affect the victim, such as an exclusion zone that the patient cannot enter or a condition of no contact. Victims may make representations on how a decision might affect the victim or members of the victim’s family.

I move amendment 120.

Dr Simpson: I understand the purpose of amendments 121 and 122: to insert “for the first time”. I have some slight concerns, in that when someone is granted unescorted leave for the first time it might be for a brief period, which may be followed by a much longer period of unescorted leave—weekend leave, for example. If the provision is to apply just for the first time, it seems a little restrictive. Will the minister explain whether there would be a process of rehabilitation in which victims would be notified of a longer period of unescorted leave, if that was deemed to be appropriate and in the victim’s interest? Leaving it just as the first time is, as I understand it, overly restrictive.

Jamie Hepburn: The first thing to observe is that this is a new mechanism. It is not a reduction in victim’s rights, as it creates rights in the first instance. We should also be clear that victims organisations representatives have not been lobbying for the right to representation on each occasion. We constituted a working group to come up with the proposals and that group critically included victims organisations such as Victim Support Scotland and Hundred Families, with which Dr Simpson said that he had been working.

The amendments are about striking a balance and it is proportionate that victims should have the right of representation in the first instance, rather than on multiple occasions. Such a mechanism could be considered to place an onerous requirement on victims themselves, who may not welcome it in every circumstance. In addition, we want to reflect as closely as possible the victims’ rights process that is in place for the criminal justice system. The amendments reflect how things are set out in the criminal justice system.

We are trying to treat people on an equal basis and strike the right balance. The proposal, which is informed by representatives of victims organisations, is the correct way forward and I urge the committee to support the amendments.

Amendment 120 agreed to.

Section 44, as amended, agreed to.

Section 45—Right to make representations
Amendments 121 to 123 moved—[Jamie Hepburn]—and agreed to.

Section 45, as amended, agreed to.

Section 46 agreed to.

Section 47—Associated definitions
The Convener: You can hear the tone in my voice that says that we have witnesses waiting and we are trying to get through this.

Amendment 124 moved—[Jamie Hepburn]—and agreed to.

Section 47, as amended, agreed to.

Section 48 agreed to.

Section 49—Amendments to the 2003 Act
The Convener: Amendment 117, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: The effect of amendment 117 would be to ensure that recorded matters under section 64 of the Mental Health (Care and Treatment) (Scotland) Act 2003 are included in the orders that the tribunal may make when confirming the determining or varying of a compulsion order.

Section 65(4)(a) of the 2003 act sets out the definition of “recorded matter”. The tribunal can specify a recorded matter when making or reviewing a compulsory treatment order. In essence, a recorded matter is regarded as an essential element of the patient's care and treatment. If a recorded matter is not provided, the registered medical officer must refer the matter to the tribunal under section 96. That reflects the Millan principle of reciprocity.

Recorded matters are means of ensuring that patients get the essential elements of the care and treatment that they require, and can be used to secure care and treatment that might not otherwise be provided. That is a significant benefit to some patients.

Currently, recorded matters can be specified only in compulsory treatment cases. They cannot be specified in cases where the treatment is under a compulsion order or a compulsion order with a restriction order. The view of the Law Society is that patients with such orders would benefit from the inclusion of recorded matter provisions. Compulsory treatment orders are civil orders, whereas compulsion orders and compulsion orders with restriction orders are criminal justice orders. All patients should have the right to obtain the essential treatment that they require, regardless of their route into the mental health care and treatment system.

I move amendment 117.

Jamie Hepburn: I thank Dr Simpson for lodging his amendment. I have considered the case that exists for introducing provisions for the tribunal to specify a recorded matter in cases where the patient is under a compulsion order or a compulsion order with a restriction order. I am confident that the existing provisions in the 2003 act work well for patients who are subject to a compulsion order or a compulsion order with a restriction order. However, I am happy to consider whether improvements could be achieved by extending the use of recorded matters to those who are covered by such orders.

However, I am unsure why the amendment is for section 49. Section 49 is in part 3, which is exclusively about “Victims’ Rights”—that is its title. Section 49 contains amendments to the 2003 act in connection with victim notification only and is not at all suitable for unrelated topics, whether they involve the 2003 act or otherwise. Amendment 117 is not related to victim notification, therefore in my view it is extremely confusing to put it in part 3.

It seems to me that the amendment should be in part 1 of the bill, given that part 1 makes a large number of amendments to the 2003 act on a wide variety of topics apart from victim notification. I note, also, that the amendment on its own does not appear to do what it is intended to do and should perhaps have been accompanied by other consequential amendments.

I would be very willing to work with Dr Simpson to try to lodge an amendment or amendments at stage 3 that could better achieve the aims that are set out in amendment 117. On that basis, I ask Dr Simpson not to press his amendment.

Dr Simpson: I have no further comments, and I seek to withdraw amendment 117.

Amendment 117, by agreement, withdrawn.

Amendment 125 moved—[Jamie Hepburn]—and agreed to.

The Convener: Amendment 118, in the name of Nanette Milne, is in a group on its own.

Nanette Milne (North East Scotland) (Con): Amendment 118 was suggested by the Law Society of Scotland to deal with an omission—as the society sees it—from the 2003 act.

Section 320 of the 2003 act provides for a route of appeal to a sheriff principal against certain decisions of the tribunal. An appeal can be brought by the individual concerned or by a number of “relevant parties” as defined in section 320(5). Those include named persons; a guardian of the person; a welfare attorney; the mental health officer; or the person’s responsible medical officer. However, that fairly comprehensive list omits to mention a person’s curator ad litem where one is in place. Curators ad litem are people who are appointed by a court for people who lack the appropriate capacity to instruct a lawyer.

In the 2011 case of Brian Black as curator ad litem to the patient v the Mental Health Tribunal for Scotland and Scottish ministers, the inner house of the Court of Session found that curators ad litem did not have the statutory right of appeal to a decision by the tribunal. The Black case pointed to the power of curators ad litem to bring judicial review against a tribunal decision, but that is quite a different mechanism from an appeal and requires a virtually complete alienation of reasonableness in a public authority’s choices before its decision can be overturned.

The omission appears to be fairly straightforward but it leaves those often vulnerable people without an effective legal remedy against.
decisions of the tribunal. That puts those individuals at a considerable disadvantage, which is neither justifiable nor intended in the drafting of the 2003 act.

I move amendment 118.

Jamie Hepburn: Amendment 118 relates to an important issue that is linked to the debate that we had last week regarding the appointment of named persons. Nanette Milne’s amendment highlights concerns about the ability of patients who lack the capacity to instruct their own legal representation to exercise rights of appeal under the 2003 act.

The amendment would allow a curator who had been appointed to represent the patient at the tribunal or before the sheriff principal a right of appeal in those circumstances. Currently section 320(2) of the 2003 act entitles a relevant party to appeal to the sheriff principal against the decision. A relevant party includes

“the person to whom the decision relates ... that person’s named person ... any guardian of the person ... any welfare attorney of the person ... the mental health officer; and ... the person’s responsible medical officer.”

It is therefore not the case that the patient does not have effective remedies under the 2003 act.

My amendments on named persons included amendment 43—which was agreed to—to provide for a listed person to exercise rights to make an application or appeal, where the patient has no named person and does not have the capacity to initiate an application or appeal. A listed person is defined as any guardian or welfare attorney; the patient’s primary relative, if any; or the patient’s nearest relative. A listed person would be able to initiate an appeal under sections 320 to 322.

In my view, the provisions in the 2003 act and in the bill that we are considering ensure that patients without capacity are not disadvantaged. I am willing to consider the merits of the principle and the provisions that are set out in Nanette Milne’s amendment 118. However, as with amendment 117, I am unsure why the amendment seeks to amend section 49. As I said previously, section 49 is in part 3, which exclusively concerns victims’ rights, and I am therefore not sure that it is suitable for amendment in that way. It seems to me that the amendment should seek to amend part 1 of the bill, as part 1—as I said previously—makes a large number of amendments to the 2003 act on a wide variety of topics apart from victim notification.

On that basis, I urge Nanette Milne not to press amendment 18 so that we can discuss the matter in advance of stage 3. If Ms Milne presses her amendment, I urge members not to support it.

Nanette Milne: On the basis of what the minister has said, I seek to withdraw the amendment at this point.

Amendment 118, by agreement, withdrawn.

Section 49, as amended, agreed to.

Before section 50

The Convener: Amendment 119, in the name of Nanette Milne, is in a group on its own.

Nanette Milne: Amendment 119 makes provision for practitioner psychologists to be considered alongside medical practitioners for the purposes of the 2003 act, which would allow them to take on the statutory roles of approved medical practitioner and responsible medical officer. As members will be aware, the amendment follows extensive representations from the British Psychological Society.

At present, only medical doctors are registered as AMPs and only consultant psychiatrists perform duties as RMOs. The proposals for a greater role for psychologists aim to reflect the fact that the primary treatment for a number of mental health problems is psychological. In many situations, a psychologist may be the best-placed professional and the one who is most familiar with a particular patient’s case.

11:00

The situation is already quite different in England and Wales, as the equivalent roles were opened up to practitioner psychologists under the Mental Health Act 2007. The same high standards of learning and familiarity with mental health law are expected of all approved clinicians in England and Wales. The change has widely been seen as a success.

Practitioner psychologists are already recognised as having the skills to supervise people under the criminal procedures that are set out in section 135 of the 2003 act. There are a number of vulnerable individuals for whom psychological therapies are particularly relevant: people who have learning disabilities, people on the autistic spectrum, people with personality disorders and people with eating disorders. The contention is that the most appropriate person to undertake AMP and RMO roles in those cases will be the one who is most familiar with the individual’s treatment and care, and that there will be a positive impact on the patient’s rights from that measure.

Although that is a significant change, we can point to England and Wales for an example of a similar system adopting it and see evidence of how it has operated in practice. If the Scottish Government were minded to conduct further
investigation and consultation on the proposed change, there would be plenty of opportunity for that to be done after it was included in the bill. It will require further action from ministers to put the provisions into effect and have psychologists registered as AMPs and RMOs. The British Psychological Society has said that it does not expect uptake from psychologists to be high in the initial years, but making the change now would lay the groundwork for it to become far more commonplace in the future.

I move amendment 119.

Dr Simpson: The Royal College of Psychiatrists—my college—is not in favour of amendment 119, but its view is somewhat old-fashioned. The change is occurring in England.

The amendment would not apply to the totality of practitioner psychologists. We should achieve a mechanism whereby approved practitioners from psychology are enabled to support their colleagues in dealing with the limited number of cases in which they will have the primary role. The royal college’s view on the matter is out of date. In the 1980s, I was personally engaged in ensuring that all patients who were referred to psychologists no longer had to go through psychiatrists, which was the case at the time.

The amendment is helpful. Regulations might be required to determine which practitioner psychologists should be allowed to register as AMPs and RMOs, but it would be helpful to have the extension. It would also be helpful to understand how the change has worked in England. At the moment, I do not have any information on that but it would be useful to know about it. If it has worked well, the time has come for us to adopt a similar approach.

Dennis Robertson: There is a role for psychologists under the bill. I ask the minister to meet Nanette Milne and others on the committee to discuss further how we can include psychologists, but I will not support the amendment. I hope that the minister will agree to meet to determine how we can progress the amendment. I hope that the minister will agree to meet to determine how we can progress the amendment.

I am unsure why the amendment appears to be for the general provisions in part 4 of the bill. Although the proposed new section that the amendment would insert into the bill is headed “Interpretation”, it is not for the interpretation of the bill. Rather, it would insert material into section 329 of the 2003 act for the interpretation of the provisions of the 2003 act. Indeed, it would affect the legal and practical operation of the act as a whole. The amendment belongs more properly in part 1, as it would make a large number of amendments to the 2003 act for a wide variety of topics.

In addition, the amendment does not deal merely with some technical or formal matter of labelling or interpretation. It deals with the crucial issue of who is to be regarded as a medical practitioner under the 2003 act. Therefore, I suggest that it is unhelpful to the reader of the bill to put the measure under the innocuous heading “Interpretation” at all, as that conceals the true range and nature of the change to the operation of the 2003 act.

I do not support amendment 119, not because I do not think that there is merit in considering the duties that professionals other than doctors could
undertake but rather because proper consideration and consultation are needed before we change the legislation. The bill is intended to make technical changes to the operation of the 2003 act in light of the McManus review. I appreciate that there is a desire to take the opportunity to make other changes, but we should try to keep it fairly focused and consider other changes in due course.

I have already indicated the Government’s intention and willingness to review the inclusion of those with autistic spectrum disorder or a learning disability within mental health legislation. I am also very willing for us to consider the role of psychologists in mental health legislation, but only if we are fully and properly informed.

Dennis Robertson requested that I discuss the matter with anyone who wants to discuss it with me. I am happy to do that but I urge Nanette Milne not to press the amendment and, if she does, I urge members not to vote for it.

Nanette Milne: On the basis that the minister has indicated his willingness to have further discussions on an important subject that needs to be progressed at some point, I am willing to withdraw the amendment.

Amendment 119, by agreement, withdrawn.

Sections 50 and 51 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill.

I ask members to agree that, after a suspension, we move directly to agenda item 3 so that we do not delay our witnesses any further.

Members indicated agreement.

The Convener: I thank the minister and his officials.

11:08

Meeting suspended.
Mental Health (Scotland) Bill
[AS AMENDED AT STAGE 2]

CONTENTS

Section

PART 1

THE 2003 ACT

Procedure for compulsory treatment
1 Measures until application determined
2 Information where order extended
2A Transfer to another hospital

Emergency, short-term and temporary steps
3 Emergency detention in hospital
4 Short-term detention in hospital
5 Meaning of temporary compulsion

Suspension of orders and measures
6 Suspension of orders on emergency detention
7 Suspension of orders on short-term detention
8 Suspension of detention for certain purposes
9 Maximum suspension of particular measures

Specification of hospital units
9A Specification for detention measures
9B Transfer of prisoner to hospital unit
9C Transfer from specified unit

Orders regarding level of security
9D Requirement for medical report
10 Process for enforcement of orders
11 Orders relating to non-state hospitals
11A Meaning of hospital in sections 268 to 273 of the 2003 Act

Removal and detention of patients
13 Notifying decisions on removal orders
14 Detention pending medical examination

Periodical referral of cases
16 Periodical referral of cases
Representation by named persons

18A Named person not to be automatic
19 Consent to being named person
20 Appointment of named person
20A Ability to act if no named person

Advance statements, support and services

21 Advance statements to be registered
22 Communication at medical examination etc.
22A Conflicts of interest to be avoided
22B Safeguarding the patient’s interest
23 Services and accommodation for mothers

Cross-border transfers and absconding patients

24 Cross-border transfer of patients
25 Dealing with absconding patients

Arrangements for treatment of prisoners

26 Agreement to transfer of prisoners
27 Compulsory treatment of prisoners

PART 2

CRIMINAL CASES

Making and effect of disposals

28 Making certain orders in remand cases
28A Detention under compulsion orders
29 Periods for assessment orders
30 Periods for treatment orders
31 Periods for short-term compulsion
32 Periods for compulsion orders
33 Periods for hospital directions

Variation of certain orders

34 Variation of interim compulsion orders
35 Transfer of patient to suitable hospital

Specification of hospital units

35A Specification of unit
39 Transfer from specified unit
40 Consequential repeals

Miscellaneous amendments

41 Information on extension of compulsion order
42 Notification of changes to compulsion order
42A Effect of revocation of restriction order
PART 3

VICTIMS’ RIGHTS

Information and representations

43 Right to information: offender imprisoned
44 Right to information: compulsion order
45 Right to make representations

Additional provisions

46 Information sharing
47 Associated definitions
48 Power to make modifications
49 Amendments to the 2003 Act

PART 4

COMMENCEMENT AND SHORT TITLE

50 Commencement
51 Short title
Amendments to the Bill since the previous version are indicated by sidelining in the right margin. Wherever possible, provisions that were in the Bill as introduced retain the original numbering.

Mental Health (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

PART 1
THE 2003 ACT
Procedure for compulsory treatment

1 Measures until application determined

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 64 (powers of Tribunal on application under section 63: compulsory treatment order), after subsection (8) there is inserted—

“(8A) If the patient has been detained in hospital by virtue of section 47(4)(a) or 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 6 months referred to in subsection (4)(a)(i) above is to be regarded as reduced by the period during which the patient has been so detained under that section.

(8B) Subsection (8A) above is of no effect if the patient has been detained in hospital in accordance with an interim compulsory treatment order made in connection with the application by virtue of which this section applies.”.

(3) In section 65 (powers of Tribunal on application under section 63: interim compulsory treatment order), after subsection (6) there is inserted—

“(7) If the patient has been detained in hospital by virtue of section 47(4)(a) or 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 56 days referred to in subsection (3) above is to be regarded as reduced by the period during which the patient has been so detained under that section.”.
Information where order extended

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 87 there is inserted—

“87A Further information where order extended

Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 86 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 101(2)(a) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and

(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—

(i) a copy of the record, and

(ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—

(a) the name and address of the patient,

(b) if known by the mental health officer, the name and address of—

(i) the patient’s named person, and

(ii) the patient’s primary carer,

(c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 85 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),

(d) so far as relevant to the extension of the compulsory treatment order—

(i) the details of the personal circumstances of the patient, and

(ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),

(e) the views of the mental health officer on the extension of the compulsory treatment order, and

(f) any other information that the mental health officer considers relevant in relation to the extension of the compulsory treatment order.

(5) The matters referred to in subsection (2)(c) above are—
(a) whether the mental health officer is sending a copy of the record to the patient, and
(b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.

(6) For the purposes of subsection (2)(c) above, the persons are—
(a) the patient’s named person,
(b) the patient’s responsible medical officer, and
(c) the Commission.”.

2A Transfer to another hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 124 (transfer to other hospital)—
(a) in subsection (1), for the words “by a compulsory treatment order.” there is substituted “by—

(a) a compulsory treatment order, or
(b) an interim compulsory treatment order.”,
(b) in subsection (14), for the words “compulsory treatment order” there is substituted “order in question”.

Emergency, short-term and temporary steps

3 Emergency detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 36 (emergency detention in hospital), after paragraph (d) there is inserted—
“(da) section 113(5) of this Act;”.

(3) In section 38 (duties on hospital managers: examination, notification etc.)—
(a) in paragraph (b)(i) of subsection (3), for the words “persons mentioned in subsection (4) below” there is substituted “Commission of the granting of the certificate and”,
(b) after subsection (3) there is inserted—
“(3A) The managers of the hospital may, so far as they consider it appropriate, give notice of the matters notified to them under section 37 of this Act to the persons mentioned in subsection (4) below.”,
(c) in subsection (4)—

(i) in the text preceding paragraph (a), for the words “subsection (3)(a) and (b)(i)” there is substituted “subsections (3)(a) and (3A)”,

(ii) paragraph (d) is repealed together with the word “and” immediately preceding it.

(4) In subsection (2) of section 40 (revocation of emergency detention certificate: notification), after the word “inform” there is inserted “the Commission and”.


(5) In subsection (4) of section 42 (certificate under section 41: revocation), after the word “inform” there is inserted “the Commission and”.

4 Short-term detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 44 (short-term detention in hospital), after paragraph (c) there is inserted—

“(ca) section 113(5) of this Act;”.

(3) In section 46 (hospital managers’ duties: notification)—

(a) in subsection (3), the words “, and send a copy of it,” are repealed,

(b) after subsection (3) there is inserted—

“(4) When giving notice under subsection (2) or (3) above, the managers of the hospital are to send a copy of the certificate to each recipient of the notice.”.

5 Meaning of temporary compulsion

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 230 (appointment of patient’s responsible medical officer), in paragraph (c) of the definition of “appropriate act” in subsection (4), the words “under section 54(1)(c) of the 1995 Act” are repealed.

(3) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—

“‘temporary compulsion order” means an order made under section 54(1)(c) of the 1995 Act;”.

6 Suspension of orders and measures

Suspension of orders on emergency detention

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 43 (effect of subsequent emergency detention certificate on compulsory treatment order)—

(a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,

(b) in subsection (2), for the words “The compulsory treatment order” there is substituted “A relevant order”,

(c) in subsection (3)—

(i) after the word “Act” there is inserted “or (as the case may be) section 57A(8)(b) of the 1995 Act”,

(ii) for the words “compulsory treatment order” in each place where they occur there is substituted “relevant order”,

(d) after subsection (3) there is inserted—

“(4) In this section, the references to a relevant order are to—
Mental Health (Scotland) Bill
Part I—The 2003 Act

(a) a compulsion order, or
(b) a compulsory treatment order or an interim compulsory treatment order.”.

(3) In relation to section 43—
(a) its title becomes “Effect of emergency detention certificate on certain earlier orders”,
(b) the italic heading immediately preceding it becomes “Effect of emergency detention certificate on certain orders”.

Suspension of orders on short-term detention

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 56 (effect of subsequent short-term detention certificate on compulsory treatment order)—

(a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,
(b) for subsection (2) there is substituted—

“(2) A relevant order shall cease to authorise the measures specified in it for the period during which the patient is subject to—

(a) the short-term detention certificate, or
(b) an extension certificate.”,

(c) after subsection (2) there is inserted—

“(3) In this section, the references to a relevant order are to—

(a) a compulsion order, or
(b) a compulsory treatment order or an interim compulsory treatment order.”.

(3) In relation to section 56—

(a) its title becomes “Effect of short-term detention certificate etc. on certain earlier orders”,
(b) the italic heading immediately preceding it becomes “Effect of short-term detention certificate etc. on certain orders”.

Suspension of detention for certain purposes

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 127 (suspension of measure authorising detention)—

(za) in subsection (1), the words “not exceeding 6 months” are repealed,
(zb) after subsection (1) there is inserted—

“(1A) A certificate under subsection (1) above may specify—

(a) a single period not exceeding 200 days, or
(b) a series of more than one individual period falling within a particular 6 month period.”,
(zc) after subsection (3) there is inserted—

“(3A) A certificate under subsection (3) above may specify—
(a) a single period, or
(b) a series of more than one individual period.”,

(a) subsection (4) is repealed,
(b) after subsection (4) there is inserted—

“(4A) The purpose for which a certificate under subsection (1) or (3) above is granted must be recorded in the certificate.”.

(3) In section 221 (assessment order: suspension of measure authorising detention)—

(za) after subsection (2) there is inserted—

“(2A) A certificate under subsection (2) above may specify—
(a) a single period, or
(b) a series of more than one individual period.”,

(a) after subsection (3) there is inserted—

“(3A) Subsection (3) above does not require the consent of the Scottish Ministers if the granting of the certificate is for the purpose of enabling the patient to—
(a) attend a hearing in criminal proceedings against the patient, or
(b) meet a medical or dental appointment made for the patient.”,

(b) subsection (4) is repealed,
(c) after subsection (4) there is inserted—

“(4A) The purpose for which a certificate under subsection (2) above is granted must be recorded in the certificate.”.

(4) In section 224 (patients subject to certain other orders and directions: suspension of measure authorising detention)—

(a) in subsection (1), after paragraph (b) there is inserted—

“(ba) a temporary compulsion order;”,

(aa) In subsection (2), the words “not exceeding 3 months” are repealed,

(ab) after subsection (2) there is inserted—

“(2A) A certificate under subsection (2) above may specify—
(a) a single period not exceeding 90 days, or
(b) a series of more than one individual period falling within a particular 3 month period.”,

(b) after subsection (3) there is inserted—

“(3A) In the case of a treatment order, an interim compulsion order or a temporary compulsion order, subsection (3) above does not require the consent of the Scottish Ministers if the granting of the certificate is for the purpose of enabling the patient to—
(a) attend a hearing in criminal proceedings against the patient, or
(b) meet a medical or dental appointment made for the patient.”,

(c) subsection (5) is repealed,

(d) after subsection (5) there is inserted—

“(5A) The purpose for which a certificate under subsection (2) above is granted must be recorded in the certificate.”.

9 Maximum suspension of particular measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 127 (suspension of measure authorising detention)—

(aa) for subsection (2) there is substituted—

“(2) The total period that an order does not, by reason of certification under subsection (1) above, authorise the measure mentioned in section 66(1)(a) of this Act must not exceed 200 days (or a higher total by virtue of subsection (10) below)—

(a) in the 12 month period beginning with the day on which the order is made, or

(b) in each subsequent period of 12 months.”,

(ab) after subsection (2) there is inserted—

“(2A) For the purpose of subsection (2) above—

(a) a day does not count towards the total period if the measure is (by reason of such certification) not authorised for a period of 8 hours or less in that day,

(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”,

(c) after subsection (9) there is inserted—

“(10) The total of 200 days referred to in subsection (2) above is increased in the patient’s case to a higher total if it is approved by an order of the Tribunal on an application by the patient’s responsible medical officer under this subsection.

(11) Where the patient’s responsible medical officer makes an application under subsection (10) above, that officer must inform the Commission of the application and the result of it once determined (including any order made in connection with it under subsection (11B) below).

(11A) Where the Tribunal receives an application under subsection (10) above, the Tribunal must inform the patient and the patient’s named person—

(a) that they may make representations (oral or written), and

(b) of the result of the application once determined (including any order made in connection with it under subsection (11B) below).
(11B) If the Tribunal decides not to make an order approving a higher total on an application under subsection (10) above, the Tribunal may make an order varying the compulsory treatment order to which the patient is subject so that it no longer authorises the measure mentioned in section 66(1)(a) of this Act.

(12) A higher total by virtue of subsection (10) above must not exceed 300 days.”.

(2A) In section 128 (suspension of other measures), in each of subsections (1) and (2), for the words “3 months” there is substituted “90 days”.

(3) In section 224 (patients subject to certain other orders and directions: suspension of measure authorising detention)—

(aa) for subsection (4) there is substituted—

“(4) The total period that an order or direction does not, by reason of certification under subsection (2) above, authorise the detention of a patient in hospital must not exceed 200 days (or a higher total by virtue of subsection (11) below)—

(a) in the 12 month period beginning with the day on which the order or direction is made, or

(b) in each subsequent period of 12 months.”,

(ab) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above—

(a) a day does not count towards the total period if the detention is (by reason of such certification) not authorised for a period of 8 hours or less in that day,

(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”,

(c) after subsection (10) there is inserted—

“(11) The total of 200 days referred to in subsection (4) above is increased in the patient’s case to a higher total if it is approved by an order of the Tribunal on an application by the patient’s responsible medical officer under this subsection.

(12) Where the patient’s responsible medical officer makes an application under subsection (11) above, that officer must inform the Commission of the application and the result of it once determined.

(12A) Where the Tribunal receives an application under subsection (11) above, the Tribunal must inform the patient and the patient’s named person—

(a) that they may make representations (oral or written), and

(b) of the result of the application once determined.

(13) A higher total by virtue of subsection (11) above must not exceed 300 days.”.

(4) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal), in subsection (1), after paragraph (l) there is inserted—

“(la) a decision to make an order under section 127(11B) of this Act arising by virtue of an application under section 127(10) of this Act;”.
**Specification of hospital units**

### 9A Specification for detention measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 36 (emergency detention in hospital), after subsection (12) there is inserted—

“(13) A reference in this section to a hospital may be read as a reference to a hospital unit.

(14) For the purpose of subsection (13) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(3) In section 44 (short-term detention in hospital), after subsection (11) there is inserted—

“(12) In this section and sections 46 to 49 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(13) For the purposes of subsection (12) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(4) After section 71 there is inserted—

“71A Compulsory treatment in hospital unit

(1) In sections 62 to 68 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(2) For the purposes of subsection (1) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

### 9B Transfer of prisoner to hospital unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after subsection (10) there is inserted—

“(11) A reference in this section to a hospital may be read as a reference to a hospital unit.

(12) For the purpose of subsection (11) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

### 9C Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 124 there is inserted—

“124A Transfer to other hospital unit

(1) Subsection (2) below applies where—

(a) the detention of a patient in hospital is authorised by—

(i) a compulsory treatment order, or

(ii) an interim compulsory treatment order, and

(b) that order specifies the hospital unit in which the patient is to be detained.
(2) The managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) In relation to a transfer or proposed transfer under subsection (2) above, section 124(4) to (14) of this Act applies subject to the following modifications—

(a) a reference to section 124(2) is to be read as a reference to subsection (2) above,

(b) subsection (10)(a) is to be ignored,

(c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,

(d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.

(4) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Orders regarding level of security

9D Requirement for medical report

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 264 (detention in conditions of excessive security: state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—

(a) states that in the practitioner’s opinion the patient does not require to be detained under conditions of special security that can be provided only in a state hospital, and

(b) sets out the practitioner’s reasons for being of that opinion.”.

(3) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—

(a) states that in the practitioner’s opinion the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, and

(b) sets out the practitioner’s reasons for being of that opinion.”.

Process for enforcement of orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Section 266 (order under section 265: further provision) is repealed.

(3) In section 267 (orders under sections 264 to 266: recall)—

(a) in subsection (1), for the words “, 265(3) or 266(3)” there is substituted “or 265(3)”,

40
(b) in subsection (3), for the words “, 265(4) to (6) or 266(4) to (6)” there is
substituted “or 265(4) to (6)”.

(4) The title of section 267 becomes “Order under section 264 or 265: recall”.

(5) Section 270 (order under section 269: further provision) is repealed.

(6) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), for the words “, 269(3) or 270(3)” there is substituted “or
269(3)”,

(b) in subsection (3), for the words “, 269(4) to (6) or 270(4) to (6)” there is
substituted “or 269(4) to (6)”.

(7) The title of section 271 becomes “Order under section 268 or 269: recall”.

(8) In section 272 (proceedings for specific performance of statutory duty)—

(a) in subsection (1), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 264(2) of this Act, or
(c) an order under section 268(2) of this Act;”,

(b) in subsection (2), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 265(3) of this Act, or
(c) an order under section 269(3) of this Act.”.

Orders relating to non-state hospitals

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 268 (detention in conditions of excessive security: hospitals other than state
hospitals)—

(a) in subsection (1), the word “qualifying” in the first place where it occurs is
repealed,

(b) in subsection (2), for the words from “detention” to “patient’s case” there is
substituted “the test specified in regulations made under section 271A(2) of this
Act is met in relation to the patient”,

(c) in subsection (5), for the words from “to the managers” to the end there is
substituted “of the name of the hospital so identified to the managers of the
hospital in which the patient is detained”,

(d) in subsection (6), the word “qualifying” in each place where it occurs is repealed,

(e) in subsection (10)—

(i) except in paragraph (e), the word “qualifying” in each place where it occurs
is repealed,

(ii) in paragraph (e), for the words “qualifying hospital” there is substituted
“hospital in which the patient is detained”,

(f) subsections (11) to (14) are repealed.

(3) In section 269 (order under section 268: further provision)—

(a) in each of subsections (1) and (2), the word “qualifying” is repealed,
(aa) in subsection (3), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”,

(c) in subsection (6), for the words from “to the managers” to the end there is substituted “of the name of the hospital so identified to the managers of the hospital in which the patient is detained”.

(4) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), the word “qualifying” is repealed,

(aa) in subsection (2)(a), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is not met in relation to the patient”.

(4A) After section 271 there is inserted—

“Process for orders: further provision

“271A Regulation-making powers

(1) A hospital is a “qualifying hospital” for the purposes of sections 268 to 271 of this Act if—

(a) it is not a state hospital, and

(b) it is specified, or is of a description specified, in regulations.

(2) Regulations may specify the test for the purposes of sections 268(2), 269(3) and 271(2)(a) of this Act.

(3) Regulations under subsection (2) above specifying the test—

(a) must include as a requirement for the test to be met in relation to a patient that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient’s case, and

(b) may include further requirements for the test to be met in relation to a patient.

(4) Regulations may make provision about when, for the purposes of—

(a) any regulations made under subsection (2) above, and

(b) sections 268 to 271 of this Act,

a patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case.

(5) Regulations may modify sections 264 and 268 of this Act so as to provide that a person must meet criteria besides being a medical practitioner in order to prepare a report for the purpose of subsection (7A) in each of those sections.”.

(5) In section 273 (interpretation of Chapter), for the definition of “relevant patient” there is substituted—

““relevant patient” means a patient whose detention in hospital is authorised by—

(a) if the patient is also subject to a restriction order, a compulsion order,

(b) a hospital direction, or
(c) a transfer for treatment direction.”.

(6) In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “268(11) to (14)” there is substituted “271A”.

11A Meaning of hospital in sections 268 to 273 of the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 273 (interpretation of Chapter)—

(a) the words up to the end of the definition of “relevant patient” become subsection (1),

(b) after that subsection there is inserted—

“(2) In this Chapter, a reference to a hospital may be read as a reference to a hospital unit.

(3) For the purposes of this Chapter, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Removal and detention of patients

13 Notifying decisions on removal orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 295 there is inserted—

“295A Notification of decision under section 293 or 295

(1) Subsection (2) below applies in relation to a decision of a sheriff or a justice of the peace under section 293 of this Act making, or refusing to make, a removal order.

(2) As soon as practicable after the decision is made, the mental health officer who made the application for the removal order must notify the Commission of the decision.

(3) Subsection (4) below applies in relation to a decision of a sheriff under section 295 of this Act making, or refusing to make, an order recalling or varying a removal order.

(4) As soon as practicable after the decision is made, the mental health officer specified in the removal order must notify the Commission of—

(a) the decision, and

(b) any additional order made under subsection (6) of section 295 of this Act.”.

14 Detention pending medical examination

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 299 (nurse’s power to detain pending medical examination)—

(a) in subsection (2)—

(i) paragraph (b) is repealed together with the word “and” immediately preceding it,
(ii) in the text following paragraph (b), for the words from “subject” to the end there is substituted “be detained in the hospital for a period not exceeding 3 hours (“holding period”) for the purpose of enabling the carrying out of a medical examination of the patient by a medical practitioner”,

(b) in paragraph (c) of subsection (3), for the words “to carry out a medical examination of the patient” there is substituted “for a medical examination of the patient to be carried out by a medical practitioner”,

(d) subsection (4) is repealed.

16 Periodical referral of cases

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(1A) In subsection (3)(c) of section 101 (Tribunal’s duty to review determination under section 86), for the words “made to” there is substituted “determined by”.

(2) In section 189 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2), for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(3) In section 213 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2), for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(4) In Schedule 2 (the Mental Health Tribunal for Scotland), paragraph 13A is repealed.

18A Named person not to be automatic

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Sections 251 and 253 are repealed.

(3) In subsection (2) of section 318 (false statements), sub-paragraph (ii) of paragraph (b) is repealed.

19 Consent to being named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 250 (nomination of named person)—

(a) in subsection (1), for the words “(3) and (6)” there is substituted “(2A), (3) and (6)”;

(b) after subsection (2) there is inserted—

“(2A) A nomination under subsection (1) above is valid only if—

(a) a docket to the nomination states that the person nominated has consented to the nomination,

(b) the docket is signed by the nominated person, and

(c) the nominated person’s signature is witnessed by a prescribed person.”,

(c) in subsection (6), for the words “may decline” there is substituted “ceases”.

(4) In section 257 (named person: Tribunal’s powers)—

(a) in subsection (3), after the word “(4)” there is inserted “or (5)”;

(b) after subsection (4) there is inserted—

“(5) An order under this section appointing a person to be a patient’s named person may be made only if—

(a) a document, signed by the person, states that the person has consented to being the patient’s named person, and

(b) the person’s signature is witnessed by someone.

(6) A person appointed by an order under this section to be a patient’s named person ceases to be the patient’s named person by giving notice to that effect to—

(a) the Tribunal,

(b) the patient, and

(c) the local authority for the area in which the patient resides.”.

20 Appointment of named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 255 (named person: mental health officer’s duties etc.)—

(a) subsections (3) to (5) are repealed,

(b) in paragraph (b) of subsection (7), sub-paragraph (i) is repealed together with the word “or” immediately following it.

(3) In section 256 (named person: application by patient etc.)—

(a) paragraph (a) of subsection (1) is repealed,

(b) in paragraph (b) of subsection (1), for the words “the applicant” there is substituted “a person mentioned in subsection (2) below (“the applicant”)”.

(4) In section 257 (named person: Tribunal’s powers)—

(a) subsection (1) is repealed,

(b) in subsection (2), for the words from “declaring” to the end there is substituted “as allowed by subsection (3A)”,

825
(c) after subsection (3) there is inserted—

“(3A) For the purpose of subsection (2), this subsection allows an order—

(a) in any case, to declare that the acting named person is not the named person,

(b) if the patient has not attained the age of 16 years, to appoint the person specified in the order to be the patient’s named person in place of the acting named person.”.

(5) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal), paragraph (1) of subsection (1) is repealed.

20A Ability to act if no named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 257 there is inserted—

“Ability to act if no named person

257A Ability to act if no named person

(1) This section applies if—

(a) a patient does not have a named person,

(b) the patient has attained the age of 16 years, and

(c) the patient is incapable in relation to a decision as to whether to initiate an application or appeal in the patient’s case.

(2) In subsection (1)(c) above, “incapable” has the same meaning as in section 250 of this Act.

(3) Each of the persons listed in subsection (9)(a) to (d) below has authority to initiate an application or appeal that may be made by the patient under section 50(1), 99(1), 100(2), 120(2), 125(2), 126(2), 163(1), 164(2), 192(2), 201(1), 204(1), 214(2), 219(2), 220(2), 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act.

(4) Each of the persons listed in subsection (9)(a) and (b) below has authority to obtain any notice or information that is to be provided under section 54(3), 60(1), 87(2)(c), 124(4) or (6), 127(7) or (11A)(b), 128(3), 129(3) or (4), 200(3), 218(4), (6) or (10)(b), 218A(4), 224(8) or (12A)(b) or 226(3) of this Act.

(5) The reference in subsection (3) above to section 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act does not apply in relation to a guardian or a welfare attorney of the patient (as that person is already entitled to make an application or appeal under that section).

(6) In the application of subsection (4) above—

(a) the reference to section 87(2)(c) relates only to notice of the determination mentioned in that section (and not also to a copy of the record mentioned in that section),
(b) the reference to section 128(3) or 129(4) relates to a responsible medical
officer’s reasons only if that officer is satisfied that it is appropriate to
give notice of them to a guardian or a welfare attorney of the patient
(having regard to the need to ensure the patient’s wellbeing and
confidence).

(7) Neither of the persons listed in subsection (9)(c) or (d) below has authority to
act in relation to a patient by virtue of this section if the patient has made a
written declaration precluding the person (or all persons) from so acting.

(8) Subsections (2) to (5) and (7) of section 250 of this Act apply to a declaration
mentioned in subsection (7) above as they apply to a nomination to which
subsection (1) of that section relates (with that section to be read accordingly).

(9) The listed persons are—

(a) any guardian of the patient,
(b) any welfare attorney of the patient,
(c) the patient’s primary carer (if any),
(d) the patient’s nearest relative.”.

Advance statements, support and services

21 Advance statements to be registered

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 276 there is inserted—

“276A Advance statements to be put with medical records

(1) Subsection (2) below applies where a Health Board receives a copy of an
advance statement, or a copy of a document withdrawing an advance
statement, from—

(a) the person who made the statement, or
(b) any individual acting with the person’s authority in relation to the
statement.

(2) The Health Board must—

(a) place a copy of the statement or document with the person’s medical
records, and
(b) inform the Commission—

(i) that a copy of the statement or document is held with the person’s
medical records, and
(ii) of the premises at which the medical records are kept (and the
personal and administrative details essential for identifying the
records as the person’s).

276B Advance statements to be registered by the Commission

(1) Subsection (2) below applies where the Commission receives information by
virtue of section 276A(2) of this Act.
(2) The Commission must enter the information in a register of advance statements maintained by it (and mark the date on which the entry is made).

276C Entitlement to inspect register of advance statements

(1) Subsection (2) below makes provision as to the register of advance statements maintained by the Commission in accordance with section 276B(2) of this Act.

(2) The Commission must allow an entry in the register to be inspected at a reasonable time—

(a) by the person whose medical records are referred to in the entry,

(b) with respect to treatment of the person for mental disorder, by any individual acting on the person’s behalf,

(c) for the purpose of making decisions or taking steps with respect to the treatment of the person for a mental disorder, by—

(i) a mental health officer dealing with the person’s case,

(ii) the person’s responsible medical officer,

(iii) the Health Board responsible for the person’s treatment.”.

22 Communication at medical examination etc.

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 261 there is inserted—

“261A Help with communication at medical examination etc.

(1) Subsection (2) below applies where—

(a) a medical examination or interview referred to in subsection (4)(a) or (b) below is to be carried out, and

(b) the subject of it—

(i) has difficulty in communicating, or

(ii) generally communicates in a language other than English.

(2) The appropriate person must take all reasonable steps to secure that, for the purpose of enabling the subject of the medical examination or interview to communicate during it—

(a) arrangements appropriate to the subject’s needs are made, or

(b) the subject is provided with assistance, or material, appropriate to those needs.

(3) As soon as practicable after taking any steps under subsection (2) above, the appropriate person must make a written record of the steps.

(4) This subsection refers to—

(a) a medical examination by virtue of section 36(1)(a), 44(1)(a), 57(2) or 136(2) of this Act,

(b) an interview by virtue of—

(i) section 45(1)(a) or 61(2)(a) of this Act, or

(ii) section 59B(2)(a) or 57C(2)(a) of the 1995 Act.
(5) In subsections (2) and (3) above, “the appropriate person” means—
(a) in relation to a medical examination by virtue of section 136(2) of this Act, the Scottish Ministers,
(b) in relation to a medical examination by virtue of any of the other sections of this Act mentioned in subsection (4)(a) above—
(i) if it is to be carried out at a hospital, the managers of the hospital,
(ii) if it is to be carried out elsewhere, the medical practitioner carrying it out,
(c) in relation to an interview referred to in subsection (4)(b) above—
(i) if it is to be carried out at a hospital, the managers of the hospital,
(ii) if it is to be carried out elsewhere, the mental health officer carrying it out.”.

22A  Conflicts of interest to be avoided

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 291 there is inserted—

“Conflicts of interest to be avoided

291A  Conflicts of interest to be avoided

(1) There must not be a conflict of interest in relation to a medical examination to be carried out for the purpose of section 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of this Act.
(2) Regulations may—
(a) specify circumstances in which, in the application of subsection (1) above—
(i) there is to be taken to be a conflict of interest,
(ii) there is not to be taken to be a conflict of interest,
(b) specify circumstances in which subsection (1) above does not apply.”.
(3) These provisions are repealed—
(a) in section 36 (emergency detention in hospital)—
(i) paragraph (a) of subsection (3),
(ii) subsection (9),
(b) in section 44 (short-term detention in hospital)—
(i) paragraph (a) of subsection (3),
(ii) subsection (8),
(c) in section 47 (extension of detention pending application for compulsory treatment order)—
(i) paragraph (a) of subsection (2),
(ii) subsection (5),
(d) in section 58 (medical examination: requirements), subsection (5).
Safeguarding the patient’s interest

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 245 (certificates under sections 235, 236, 239 and 241), in subsection (3)—
   (a) the word “and” immediately preceding sub-paragraph (ii) of paragraph (a) is repealed,
   (b) after sub-paragraph (ii) of paragraph (a) there is inserted—
      “(iii) any guardian of the patient; and
      (iv) any welfare attorney of the patient;”.

Services and accommodation for mothers

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 24 (provision of services and accommodation for certain mothers with post-natal depression)—
   (a) in paragraph (d) of subsection (1), for the words “for post-natal depression,” there is substituted “for—
      (i) post-natal depression; or
      (ii) a mental disorder (other than post-natal depression),”,
   (b) after subsection (1) there is inserted—
      “(1A) But a Health Board is required to provide services and accommodation under
      subsection (1) above only if it is satisfied that doing so would be beneficial to
      the wellbeing of the child.”.

(3) The title of section 24 becomes “Services and accommodation for mothers”.

Cross-border transfers and absconding patients

Cross-border transfer of patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 289 (cross-border transfer: patients subject to requirement other than detention), in paragraph (b) of subsection (1)—
   (a) the words from “a person” to the end become sub-paragraph (i),
   (b) after that sub-paragraph (as so numbered) there is inserted—
      “(ii) a person subject to corresponding requirements in a member State of the
      European Union (apart from the United Kingdom) and removed from
      that State.”.

(3) In section 290 (cross-border transfer: patients subject to detention requirement or otherwise in hospital), in paragraph (c) of subsection (1)—
   (a) the words from “a person” to the end become sub-paragraph (i),
   (b) after that sub-paragraph (as so numbered) there is inserted—
“(ii) a person subject to corresponding measures in a member State of the 
European Union (apart from the United Kingdom) and removed from 
that State.”.

(4) In section 309A (cross-border visits: leave of absence), in subsection (1)—

(a) the words from “a person” to the end become paragraph (a), 

(b) after that paragraph (as so numbered) there is inserted—

“(b) a person who is subject to a corresponding suspension of detention in a 
member State of the European Union (apart from the United 
Kingdom).”.

25 Dealing with absconding patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In paragraph (a)(iii) of subsection (3) of section 303 (taking into custody and return of 
absconding patients), after the words “compulsory treatment order” there is inserted “or 
an interim compulsory treatment order”.

(3) In section 309 (patients from other jurisdictions)—

(a) in subsection (1)—

(i) the words from “persons” to the end become paragraph (a), 

(ii) after that paragraph (as so numbered) there is inserted—

“(b) persons in Scotland who are subject to corresponding requirements or 
corresponding measures in a member State of the European Union (apart 
from the United Kingdom).”,

(b) in subsection (2), for the words “Those regulations” there is substituted 
“Regulations under subsection (1) above”,

(c) after subsection (2) there is inserted—

“(2ZA) Regulations may make provision applying specific provisions in Part 16 of this 
Act to persons to whom sections 301 to 303 of this Act apply by virtue of 
subsection (1) above.

(2ZB) Regulations under subsection (2ZA) above may make such modifications of 
that Part in that application as the Scottish Ministers think fit.

(2ZC) But regulations under subsection (2ZA) above may not—

(a) apply any of that Part to persons who are subject to requirements or 
measures corresponding only to detention in hospital in accordance with 
an emergency detention certificate, or 

(b) authorise medical treatment of the types mentioned in section 234(2) or 
237(3) of this Act.”.

(4) In section 310 (regulations as to absconding by other patients), after subsection (3) there 
is inserted—

“(3A) In making provision as described in paragraphs (a) and (b) of subsection (1) 
above, regulations under that subsection may specify persons who are 
authorised by patients’ responsible medical officers.”.
Arrangements for treatment of prisoners

26 Agreement to transfer of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after paragraph (a) of subsection (3) there is inserted—

“(aa) that—

(i) a mental health officer has agreed to the making of the direction, or

(ii) it has been impracticable to obtain the agreement of a mental health officer;”.

27 Compulsory treatment of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In schedule 2 (the Mental Health Tribunal for Scotland), in paragraph 7—

(a) in sub-paragraph (4), for the words “(other than proceedings relating solely to an application under section 255 or 256 of this Act)” there is substituted “(other than excepted proceedings)”,

(b) after sub-paragraph (4) there is inserted—

“(4A) For the purpose of sub-paragraph (4) above, the following are excepted proceedings—

(a) proceedings relating solely to an application under section 255 or 256 of this Act, or

(b) proceedings relating to an application for a compulsory treatment order in respect of a patient subject to—

(i) a hospital direction, or

(ii) a transfer for treatment direction.”.

(3) In schedule 3 (application of Chapter 1 of Part 7 to certain patients), after paragraph 1 there is inserted—

“1A In the case of a patient subject to a hospital direction or a transfer for treatment direction, section 60(1) of this Act shall have effect as if, after paragraph (b), there were inserted—

“(ba) to the Scottish Ministers;”.

PART 2

CRIMINAL CASES

Making and effect of disposals

28 Making certain orders in remand cases

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In each place where they occur as follows, before the words “in custody” there is inserted “remanded”—

(a) in section 52B (prosecutor’s power to apply for assessment order), in subsection (3)(c),

(b) in section 52C (Scottish Ministers’ power to apply for assessment order), in subsection (1)(c),

(c) in section 52D (assessment order), in subsection (10)(d),

(d) in section 52F (assessment order: supplementary), in subsection (1)(a),

(e) in section 52K (prosecutor’s power to apply for treatment order), in subsection (3)(c),

(f) in section 52L (Scottish Ministers’ power to apply for treatment order), in subsection (1)(c),

(g) in section 52M (treatment order), in subsection (9)(d)(i) and (ii),

(h) in section 52P (treatment order: supplementary), in subsection (2)(a) and (b)(ii).

28A Detention under compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 57 (disposal of case where accused found not criminally responsible or unfit for trial), in subsection (2)—

(a) in paragraph (a), for the words “authorising the detention of the person in a hospital” there is substituted “(whether or not authorising the detention of the person in a hospital),”

(b) for paragraph (b) there is substituted—

“(b) subject to subsection (4A) below, make a restriction order in respect of the person (that is, in addition to a compulsion order authorising the detention of the person in a hospital);”

29 Periods for assessment orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 52D (assessment order)—

(a) in subsection (6)—

(i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”,

(ii) in each of paragraphs (b) and (c), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (6A) below”,

(b) after subsection (6) there is inserted—

“(6A) For the purpose of subsection (6)(b) and (c) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring at the end of the 28 days following that day.”.
(3) In section 52F (assessment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 52G (review of assessment order)—
   (a) in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”,
   (b) in subsection (4), for words from “7 days” to the end there is substituted “the relevant period given by subsection (4A) below”,
   (c) after subsection (4) there is inserted—
      “(4A) For the purpose of subsection (4) above, the relevant period is the period—
      (a) beginning with the day on which the order would otherwise cease to authorise the detention of the person in hospital,
      (b) expiring at the end of the 14 days following that day.”.

(5) In section 52H (early termination of assessment order)—
   (a) in subsection (1)—
      (i) in paragraph (a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,
      (ii) in paragraph (b), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,
   (b) after subsection (1) there is inserted—
      “(1A) For the purpose of subsection (1)(a) and (b) above, the relevant period is the period—
      (a) beginning with the day on which the order is made,
      (b) expiring—
      (i) as regards subsection (1)(a) above, at the end of the 7 days following the day mentioned in paragraph (a) of this subsection,
      (ii) as regards subsection (1)(b) above, at the end of the 28 days following the day mentioned in paragraph (a) of this subsection.”.

30 Periods for treatment orders
   (1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
   (2) In section 52M (treatment order)—
      (a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”,
      (b) in subsection (6)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.
   (3) In section 52P (treatment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.
   (4) In section 52R (termination of treatment order)—
(a) in subsection (1)(a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,
(b) after subsection (1) there is inserted—

“(1A) For the purpose of subsection (1)(a) above, the relevant period is the period—

(a) beginning with the day on which the order is made,
(b) expiring at the end of the 7 days following that day.”.

31 Periods for short-term compulsion

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 53 (interim compulsion order)—

(a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”;
(b) in subsection (8)—

(i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”;
(ii) in paragraph (b), for the words “12 weeks beginning with the day on which the order is made” there is substituted “the relevant period given by subsection (8A) below”,
(iii) in paragraph (c), for the words “period of 12 weeks beginning with the day on which the order is made” there is substituted “relevant period given by subsection (8A) below”,
(c) after subsection (8) there is inserted—

“(8A) For the purpose of subsection (8)(b) and (c) above, the relevant period is the period—

(a) beginning with the day on which the order is made,
(b) expiring at the end of the 12 weeks following that day.”.

(3) In section 53A (interim compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 53B (review and extension of interim compulsion order)—

(a) in subsection (4), for the words “(not exceeding” to “not made)” there is substituted “not exceeding the relevant period given by subsection (4A) below”,
(b) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above, the relevant period is the period—

(a) beginning with the day on which the order would cease to have effect if it were not extended,
(b) expiring at the end of the 12 weeks following that day.”,
(c) in subsection (5), for the words “12 months beginning with the day on which the order was first made.” there is substituted “the period—

(a) beginning with the day on which the order was first made,
(b) expiring at the end of the 12 months following that day.”.

(5) In section 54 (unfitness for trial: further provision), in subsection (2B)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

32 Periods for compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 57A (compulsion order)—
   (a) in subsection (2), for the words “period of 6 months beginning with the day on which the order is made” there is substituted “relevant period given by subsection (2A) below”,
   (b) after subsection (2) there is inserted—
       “(2A) For the purpose of subsection (2) above, the relevant period is the period—
       (a) beginning with the day on which the order is made,
       (b) expiring at the end of the 6 months following that day.”,
   (c) in subsection (5)(b), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 57B (compulsion order authorising detention in hospital or requiring residence at place: ancillary provision), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 57D (compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

33 Periods for hospital directions

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 59A (hospital directions)—
   (a) in subsection (4)(b), for the words “expiry of the period of” there is substituted “end of the day following the”,
   (b) in subsection (7)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 59C (hospital direction: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

34 Variation of certain orders

Variation of interim compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 53B (review and extension of interim compulsion order)—
   (a) in subsection (4)—
       (i) the words from “if satisfied” to the end become paragraph (a),
       (ii) after that paragraph (as so numbered) there is inserted “, and
       (b) if it seems appropriate to do so, direct that the offender be admitted to the hospital specified in the direction.”,
(b) in subsection (6), after the word “order” there is inserted “or make a direction specifying a hospital”;

(c) after subsection (7) there is inserted—

“(7A) Where a direction is made under subsection (4) above, the interim compulsion order has effect as if the hospital specified in the direction were the hospital specified in the order.”.

35 Transfer of patient to suitable hospital

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) The italic heading immediately preceding section 61 becomes “Miscellaneous provision”.

(3) After section 61 there is inserted—

“61A Transfer of person to suitable hospital

(1) Subsection (2) below applies in relation to a person who is subject to—

(a) an assessment order,

(b) a treatment order,

(c) an interim compulsion order, or

(d) a temporary compulsion order (see section 54(1)(c) of this Act).

(2) The person’s responsible medical officer may transfer the person from the specified hospital to another hospital.

(3) The responsible medical officer may transfer the person only if satisfied that, for the purpose for which the order in question is made—

(a) the specified hospital is not suitable, and

(b) the other hospital is suitable.

(4) In considering the suitability of each hospital, the responsible medical officer is to have particular regard to the specific requirements and needs in the person’s case.

(5) As far before the transfer as practicable, the responsible medical officer must—

(a) inform the person of the reason for the transfer,

(b) notify the managers of the specified hospital, and

(c) obtain the consent of—

(i) the managers of the other hospital, and

(ii) the Scottish Ministers.

(6) As soon after the transfer as practicable, the responsible medical officer must notify—

(a) any solicitor known by the officer to be acting for the person, and

(b) the court which made the order in question.

(7) A person may be transferred under subsection (2) above only once with respect to the order in question.
(8) Where a person is transferred under subsection (2) above, the order in question has effect as if the other hospital were the specified hospital.

(9) In this section—

“managers” has the meaning given by section 329(1) of the Mental Health (Treatment and Care) Scotland) Act 2003,

“responsible medical officer” has the meaning given by section 329(4) of that Act,

“specified hospital” means hospital to which the person is admitted by virtue of the order in question.”.

35A Specification of hospital units

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 61 there is inserted—

“61B Specification of hospital unit

(1) A reference in this Part to a hospital may be read as a reference to a hospital unit.

(2) In the operation of section 61A of this Act in relation to a transfer from one hospital unit to another within the same hospital—

(a) subsection (2) of that section applies by virtue of subsection (1) of that section where the order in question specifies the hospital unit in which the person is to be detained,

(b) in subsection (5) of that section—

(i) paragraph (b) is to be ignored,

(ii) in paragraph (c)(i), the reference to the managers of the other hospital is to be read as a reference to the managers of the hospital in which the person is detained.

(3) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

39 Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 218 there is inserted—

“218A Transfer of patient from specified hospital unit

(1) Subsection (2) below applies where—

(a) a patient is subject to—

(i) a compulsion order and a restriction order,

(ii) a hospital direction, or

(iii) a transfer for treatment direction, and
(b) that order or (as the case may be) direction specifies the hospital unit in which the patient is to be detained.

(2) If the condition in subsection (3) below is satisfied, the managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) The condition is that the Scottish Ministers consent to the transfer.

(4) In relation to a transfer or proposed transfer under subsection (2) above, section 218(4) to (14) of this Act applies subject to the following modifications—

(a) a reference to section 218(2) is to be read as a reference to subsection (2) above,

(b) in subsection (10)(a), a reference to section 218(3) is to be read as a reference to subsection (3) above,

(c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,

(d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.

(5) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

40 Consequential repeals

The following enactments are repealed—

(a) section 9 of the Crime and Punishment (Scotland) Act 1997,

(b) paragraph 66 of schedule 7 to the Criminal Justice and Licensing (Scotland) Act 2010.

Miscellaneous amendments

41 Information on extension of compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 153 there is inserted—

“153A Further information on extension of compulsion order

(1) Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 152 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 165(2)(a) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and
(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—
   (i) a copy of the record, and
   (ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—
   (a) the name and address of the patient,
   (b) if known by the mental health officer, the name and address of—
      (i) the patient’s named person, and
      (ii) the patient’s primary carer,
   (c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 151 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),
   (d) so far as relevant to the extension of the compulsion order—
      (i) the details of the personal circumstances of the patient, and
      (ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),
   (e) the views of the mental health officer on the extension of the compulsion order, and
   (f) any other information that the mental health officer considers relevant in relation to the extension of the compulsion order.

(5) The matters referred to in subsection (2)(c) above are—
   (a) whether the mental health officer is sending a copy of the record to the patient, and
   (b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.

(6) For the purposes of subsection (2)(c) above, the persons are—
   (a) the patient’s named person,
   (b) the patient’s responsible medical officer, and
   (c) the Commission.”.

Notification of changes to compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 157 (application for extension and variation of compulsion order: notification), paragraph (f) is repealed together with the word “and” immediately preceding it.
(3) In section 160 (application for variation of compulsion order: notification), for the word “(f)” there is substituted “(e)”.  

42A Effect of revocation of restriction order
(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In subsection (2) of section 198 (effect of revocation of restriction order), for the words “Tribunal revoked the restriction order” there is substituted “order revoking the restriction order has effect in accordance with section 196 of this Act”.  

PART 3
VICTIMS’ RIGHTS

Information and representations

43 Right to information: offender imprisoned
(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.
(2) In section 16 (victim’s right to receive information concerning release etc. of prisoner), in subsection (3)—
(a) in paragraph (e)—
(i) for the words “or young” there is substituted “, young”,
(ii) after the word “institution” there is inserted “or hospital”,
(b) the word “and” immediately preceding paragraph (f) is repealed,
(c) in paragraph (f)—
(i) for the words “or young” there is substituted “, young”,
(ii) after the word “institution” there is inserted “or hospital”,
(d) after paragraph (f) there is inserted—
“(g) where the convicted person is liable to be detained in a hospital under a hospital direction or transfer for treatment direction—
(i) that a certificate has been granted, for the first time, under the Mental Health Act which suspends the person’s detention and does not impose a supervision requirement,
(ii) that the certificate mentioned in sub-paragraph (i) has been revoked.”.
(3) In section 16, in subsection (4)—
(a) the word “or” immediately preceding paragraph (b) is repealed, and
(b) at the end of paragraph (b) there is inserted “; or
(c) modify section 18A, by adding, amending or repealing definitions of terms used in the descriptions of information in subsection (3) of this section.”.
Right to information: compulsion order

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 16 there is inserted—

"16A Victim’s right to receive information concerning offender subject to compulsion order

(1) Subsection (2) applies where—

(a) an offence has been perpetrated against a natural person,

(b) another person ("O") has been made subject to a compulsion order and a restriction order in proceedings in respect of that offence,

(c) a person has asked to be given information about O under this section and that person is, or was at the time of asking, a person entitled to ask to be given the information (see section 16B), and

(d) O has attained the age of 16 years.

(2) The Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).

(3) But the Scottish Ministers need not give a person information under this section if they consider there to be exceptional circumstances which make it inappropriate to do so.

(4) If the compulsion order or the restriction order mentioned in subsection (1)(b) is revoked, subsection (2) ceases to apply when the Scottish Ministers give the person mentioned in subsection (1)(c) the information that the order has (or both orders have) been revoked.

16B Person entitled to ask to be given information under section 16A

(1) The reference in section 16A(1)(c) to a person entitled to ask to be given information under that section is to—

(a) the natural person ("V") against whom the offence mentioned in section 16A(1)(a) ("the relevant offence") was perpetrated,

(b) if V is dead—

(i) any or all of the four qualifying persons highest listed in section 14(10), and

(ii) if V died before attaining the age of 16 years, any other person who cared for V immediately before the relevant offence was perpetrated, or

(c) if V has attained the age of 12 years and is incapable for the purposes of this section, the qualifying person highest listed in section 14(10).

(2) If a person (including V) who would be entitled to ask to be given information by virtue of subsection (4) has not attained the age of 12 years—

(a) the person is not entitled to ask to be given the information, and

(b) someone who cares for the person is entitled to ask to be given it instead.

(3) For the purposes of this section—

(a) the references to a qualifying person are to a person—
(i) whose relationship to V is listed in subsection (10) of section 14 (read with the other subsections of that section),

(ii) who is not incapable for the purposes of this section, and

(iii) who is not a person accused of, or reasonably suspected of being the perpetrator of, or having been implicated in the perpetration of, the relevant offence,

(b) when determining who is the qualifying person highest listed in section 14(10), if two or more persons have the same relationship to V they are to be listed according to age with the eldest being the highest listed of them,

(c) the expressions “cared for” and “cares for”, are to be construed in accordance with the definition of “someone who cares for” in paragraph 20 of schedule 12 to the Public Services Reform (Scotland) Act 2010,

(d) a person is to be considered incapable for the purposes of this section if the person would be considered incapable of making a victim statement by virtue of section 14(6)(b)(i) and (7).

16C  Information to be given under section 16A

(1) This section sets out the information that is to be given under section 16A about the person referred to in that section as O.

(2) The following information is to be given in any case—

(a) that the compulsion order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(b) that the restriction order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(c) the date of O’s death,

(d) that the compulsion order has been varied by way of a modification of the measures specified in it,

(e) that O has been transferred to a place outwith Scotland,

(f) that the Mental Health Tribunal has made an order under section 193(7) of the Mental Health Act conditionally discharging O,

(fa) the terms of any restrictions on things O may do which have been imposed on O as conditions on conditional discharge under section 193(7) or section 200(2) of the Mental Health Act (including under section 193(7) as applied by section 201(3) or 204(3) of that Act),

(g) that the Scottish Ministers have recalled O to hospital under section 202 of the Mental Health Act.

(3) The following information is to be given in a case where the compulsion order authorises O’s detention in hospital—

(a) that O is unlawfully at large from hospital,

(b) that O has returned to hospital having been unlawfully at large,
(c) that a certificate has been granted, for the first time, under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,

(d) that the certificate mentioned in paragraph (c) has been revoked.”.

45 Right to make representations

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17A there is inserted—

“17B Mentally-disordered offender: victim’s right to make representations

(1) A person (“V”) who is to be given information about another person (“O”) under section 16 or 16A, must be afforded an opportunity to make representations—

(a) in a case where O is subject to a hospital direction or a transfer for treatment direction, before a decision of a type described in subsection (4) is taken in relation to O,

(b) in a case where O is subject to a compulsion order and a restriction order, before a decision of a type described in subsection (5) is taken in relation to O.

(2) Representations under this section must be about how the decision in question might affect V or members of V’s family.

(3) Subsection (1) does not apply unless V has intimated to the Scottish Ministers a wish to be afforded an opportunity to make representations about O under this section.

(4) For the purpose of section (1)(a), the type of decision is a decision by O’s responsible medical officer about granting for the first time a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement.

(5) For the purpose of subsection (1)(b), the types of decision are a decision—

(a) by O’s responsible medical officer about granting for the first time a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,

(b) by the Mental Health Tribunal under section 193 of the Mental Health Act (including a decision under that section as applied by section 201(3) or 204(3) of that Act),

(c) by the Scottish Ministers under section 200 of the Mental Health Act about varying conditions in a way which may have an effect on V or members of V’s family.

(6) The Scottish Ministers need not afford V an opportunity to make representations before taking a decision of the type described in subsection (5)(c) if it is not reasonably practicable to afford V that opportunity.

17C Making representations under section 17B

(1) Representations under section 17B—
Part 3—Victims’ rights

(a) may be made orally in relation to a decision of a type described in section 17B(5)(b), but
(b) otherwise, must be made in writing.

(2) The Scottish Ministers are to issue guidance as to how—
(a) written representations under section 17B should be framed, and
(b) oral representations under that section should be made.

17D Right to information after section 17B decision

(1) Subsection (2) applies where—
(a) before a decision was taken, a person (“V”) was afforded an opportunity
  to make representations under section 17B,
(b) the decision has since been taken,
(c) the Scottish Ministers are not required under section 16A to give any
  information to V as a result of the decision, and
(d) V has intimated to the Scottish Ministers a wish to receive information
  under this section.

(2) The Scottish Ministers must, unless they consider that there are exceptional
  circumstances which make it inappropriate to do so, inform V that the decision
  has been taken.”.

Additional provisions

46 Information sharing

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17D there is inserted—

“17E Information sharing in respect of mentally-disordered offenders

(1) Where the Scottish Ministers are subject to a duty under section 16 or 16A to
give a person (“V”) information about another person (“O”), they must give
notice to—
(a) O’s responsible medical officer, and
(b) if O is subject to a compulsion order, the Mental Health Tribunal.

(2) A notice under subsection (1) is to request that the recipient of the notice
provide the Scottish Ministers with information in such circumstances as may
be specified in the notice.

(3) The information that the Scottish Ministers may request in a notice under
subsection (1) must be information about O which they will require in order to
fulfil their duty to give information to V under section 16, 16A or 17D.

(4) The recipient of a notice under subsection (1) must provide the Scottish
Ministers with the information requested in the notice in the circumstances
specified in it.

(5) If the Scottish Ministers cease to be required to give anyone information about
O under section 16 or 16A—
(a) they must intimate that fact to anyone to whom they sent a notice in relation to O in accordance with subsection (1), and
(b) on receiving that intimation, subsection (4) ceases to apply to the person who received the intimation.”.

47 Associated definitions

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18 there is inserted—

“18A Interpretation of Part

(1) In this Part—

“Mental Health Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003,

“Mental Health Tribunal” means the Mental Health Tribunal for Scotland,

“transfer for treatment direction” means a direction made under section 136 of the Mental Health Act.

(2) A reference in this Part—

(a) to a certificate under the Mental Health Act which suspends a person’s detention and does not impose a supervision requirement is to a certificate under subsection (2) of section 224 of that Act, which does not include a condition under subsection (7)(a) of that section,

(b) to such a certificate being granted for the first time is to such a certificate being granted for the first time—

(i) since the person was detained under the particular order or direction which authorises the person’s detention in a hospital (or would do, but for the certificate’s being granted), or

(ii) in a case where the person, while subject to that order or direction, has been recalled to hospital under section 202 of the Mental Health Act, since the person was so recalled (or most recently so recalled if it has happened more than once).”.

48 Power to make modifications

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18A there is inserted—

“18B Power to modify Part

(1) The Scottish Ministers may by order amend—

(a) sections 16A and 16B, by substituting for any age for the time being specified in those sections a different age,

(b) section 16C, by adding descriptions of information,

(c) section 18A, by adding, amending or repealing definitions of terms used in the descriptions of information in section 16C.

(2) The Scottish Ministers may by order amend—
(a) section 16A, so that information may be given under that section in some or all cases where a person has been made subject to a compulsion order and either—

(i) the person has not been made subject to a restriction order, or

(ii) the restriction order to which the person was made subject has been revoked,

(b) section 17B, to specify types of decision in respect of which representations under that section may be made by persons who have a right to be given information under section 16A as amended by virtue of paragraph (a).

(3) In an order under subsection (2) which amends section 16A or 17B, the Scottish Ministers may make any amendment to the following enactments which they consider necessary or expedient in consequence of the amendment to section 16A or 17B—

(a) sections 16C, 17E and 18A,

(b) the Mental Health (Care and Treatment) (Scotland) Act 2003.”.

(3) In section 88 (orders), after “16(4)” there is inserted “, 18B”.

49 Amendments to the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 193 (powers of Tribunal on reference or application under certain sections), after subsection (9) there is inserted—

“(9A) Where—

(a) a person (“V”) is entitled to make victim’s representations before the Tribunal makes a decision under this section, and

(b) V has not been afforded the opportunity of making representations under subsection (8),

before making a decision about what (if any) conditions to impose on the patient’s conditional discharge under subsection (7), the Tribunal must have regard to any victim’s representations made by V.”.

(3) In section 200 (variation of conditions imposed on conditional discharge), after subsection (2) there is inserted—

“(2A) Before varying any conditions under subsection (2), the Scottish Ministers must have regard to any victim’s representations.”.

(4) In section 224 (patients subject to certain orders and directions: suspension of measure authorising detention), after subsection (6) there is inserted—

“(6A) Before deciding what conditions such as are mentioned in subsection (7) below to include in a certificate under subsection (2) above (if any), the responsible medical officer must have regard to any victim’s representations.”.

(5) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—
“victim’s representations” means representations made under section 17B of the Criminal Justice (Scotland) Act 2003 in relation to the matter being considered;”.

PART 4

COMMENCEMENT AND SHORT TITLE

50 Commencement

(1) This Part comes into force on the day after Royal Assent.

(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.

(3) An order under subsection (2) may include transitional, transitory or saving provision.

51 Short title

The short title of this Act is the Mental Health (Scotland) Act 2015.
Mental Health (Scotland) Bill
[AS AMENDED]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Introduced by: Alex Neil
Supported by: Michael Matheson
On: 19 June 2014
Bill type: Government Bill
INTRODUCTION

1. As required under Rule 9.7.8A of the Parliament’s Standing Orders, these Revised Explanatory Notes are published to accompany the Mental Health (Scotland) Bill (introduced in the Scottish Parliament on 19 June 2014) as amended at Stage 2. Text has been added or deleted as necessary to reflect the amendments made to the Bill at Stage 2 and these changes are indicated by sideling in the right margin.

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

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

THE BILL

4. The Bill’s overarching objective is to help people with a mental disorder to access effective treatment quickly and easily. The on-going monitoring to which the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) was subject to identified some aspects of the legislation which were not operating as efficiently and effectively as had been intended. To address these matters this Bill amends provisions within the 2003 Act and some related provisions in the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”). The Bill also makes provision, through amendments to the Criminal Justice (Scotland) Act 2003, for the introduction of a notification scheme for victims of mentally disordered offenders.

5. A more detailed explanation of the Bill’s purpose can be found in the Policy Memorandum, this also explains the thinking and policy intentions that underpin it.

THE STRUCTURE & A SUMMARY OF THE BILL

6. The Bill is structured in the following Parts:
This document relates to the Mental Health (Scotland) Bill as amended at Stage 2 (SP Bill 53A)

- **Part 1** amends the 2003 Act\(^1\) in respect of a number of issues relating to compulsory treatment for patients, including procedures for compulsory treatment, suspension of detention, removal of patients and timescales for referrals and disposals. Part 1 also amends provisions relating to representation by named persons and advance statements.

- **Part 2** amends the 1995 Act in respect of treatment for mentally disordered offenders. It amends timescales for assessment and treatment orders for such patients and provides for variation of certain orders.

- **Part 3** creates a new notification scheme for victims of mentally disordered offenders.

- **Part 4** sets out general provisions on coming into force and modification of enactments.

**Glossary of terms used**

AMP – approved medical practitioner  
AO – Assessment Order  
CO - compulsion order  
CORO – compulsion order and a restriction order  
CTO – compulsory treatment order  
EDC – emergency detention certificate  
HD – hospital direction  
MHO – mental health officer  
RMO – responsible medical officer  
STDC – short term detention certificate  
The 2003 Act – The Mental Health (Care and Treatment) (Scotland) Act 2003  
The Commission – the Mental Welfare Commission for Scotland  
The Tribunal – the Mental Health Tribunal for Scotland  
TTD – transfer for treatment direction

**PART ONE – THE 2003 ACT**

**Section 1: Measures until application determined**

**Amendment of sections 64 and 65**

7. Compulsory treatments orders (CTO) are orders made by the Mental Health Tribunal for Scotland (the Tribunal). A CTO can authorise detention and/or medical treatment in hospital or it can impose compulsory measures in the community. The arrangements for the application for and making of CTOs are contained in Part 7 of the 2003 Act (sections 57 to 129). Section 64 of the 2003 Act sets out powers of the Tribunal when considering an application for a CTO under section 63 of the 2003 Act. If the Tribunal is satisfied that the conditions for a CTO are met, then

\(^1\) Asp13
it may authorise for a period of up to 6 months, measures listed in section 66 of the 2003 Act. Section 65 of the 2003 Act empowers the Tribunal to grant an interim compulsory treatment order where an application has been made for a CTO. A patient can be made subject to measures under an interim CTO for a total period of no more than 56 days.

8. Short term detention certificates (STDC) can be granted in certain circumstances to authorise the detention of a patient in hospital, for 28 days under section 44 of the 2003 Act and for a further 3 days if an extension certificate is granted under section 47.

9. For patients who are already subject to an STDC (or an extension certificate), section 68 provides that once an application for a CTO has been made under section 63, the patient’s detention in hospital under authority of the certificate is automatically extended for a further five working days. This is to enable the Tribunal to have sufficient time to come to a decision on the application.

10. Section 1 of the Bill provides that if the Tribunal is making a CTO under section 64 or an interim CTO under section 65 and the patient subject to the orders has been detained in hospital under a STDC or an extension certificate under section 44 or 47 of the 2003 Act, the 6 month period, in the case of section 64, or 56 days under section 65 must be reduced by the length of time the patient has been detained under section 47(4)(a) or 68(2)(a).

Section 2: Information where order extended

11. Section 87 of the 2003 Act sets out the steps that a responsible medical officer (RMO) must take when he or she has determined that a CTO is to be extended without change. In such cases an RMO must prepare a record setting out the reasons for the determination and whether the Mental Health Officer (MHO) agrees, disagrees or has not expressed a view. Also required to be recorded are, in the case of a disagreement the reasons for the disagreement, the type of mental disorder suffered by the patient and whether that has changed from the disorder in the original CTO.

12. This record must be submitted to the Tribunal and a copy sent to the patient (unless the RMO considers there would be significant risk to the patient in doing so), the patient’s named person, the MHO and the Mental Welfare Commission for Scotland (the Commission). The Tribunal must be told if the RMO is sending a copy or not to the patient and, if not, the reasons for that decision.

New section 87A

13. Section 2 of the Bill inserts new section 87A which sets out new duties for the MHO when the Tribunal is required by section 101(2)(a) of the 2003 Act to review the determination. That is, when the determination states that there is a difference between the type of mental disorder that the patient has and that recorded in the original CTO, or the MHO disagrees with the determination, or has failed to express a view.

14. When section 101(2)(a) applies, section 87A requires the MHO to prepare and submit a record to the Tribunal with the patient’s name and address and that of the patient’s named person and primary carer (if known), details of what the MHO has done in compliance with section 85
of the 2003 Act (and if the MHO has not interviewed the patient, the reasons for that), and so far as relevant to the extension of the CTO, the details of the personal circumstances of the patient, any advance statement of the patient (if known by the MHO, and not withdrawn), the views of the MHO on the extension of the CTO and any other information the MHO considers relevant in relation to the extension of the CTO. A copy of this record must also be sent to the patient, the patient’s named person, RMO and the Commission. The MHO need not send a copy of the record to the patient if the MHO considers so doing would carry a significant risk of harm to the patient or others. The Tribunal must be told if the patient is not receiving the report, and the reasons for this decision.

Section 2A: Transfer to another hospital

Amendment of section 124

15. Section 124 of the 2003 Act makes provision for patients who are detained in hospital on the authority of a CTO to be transferred by the managers of that hospital to a different hospital, including to a state hospital. Various conditions and requirements, set out in subsections (3) to (13), apply in respect of any transfer.

16. Section 2A of the Bill amends section 124 to include reference to interim compulsory treatment orders (ICTOs) in order to allow the transfer between hospitals of patients who are subject to ICTOs, as well as patients who are subject to CTOs.

Section 3: Emergency detention in hospital

Amendment of sections 36, 38, 40 and 42

17. Part 5 (sections 36 to 43) of the 2003 Act makes provision for removal to and emergency detention in hospital by means of an emergency detention certificate (EDC). Section 36 sets out the procedure for the granting of an EDC authorising the detention of a patient in hospital for a period of 72 hours. An EDC cannot be granted in respect of a patient if the patient is subject to detention by virtue of the provisions listed in section 36(2).

18. Section 3(2) of the Bill adds short term detention under section 113(5) of the 2003 Act (non-compliance with a CTO or interim CTO) to that list.

19. Section 38 of the 2003 Act at present provides that in the case of an emergency detention, a hospital manager must inform the following persons that the certificate has been granted: the patient’s nearest relative; if the patient’s nearest relative doesn’t reside with the patient any person who does reside with the patient; the patient’s named person (if known); and the Commission. The hospital manager must also notify those persons of the matters notified to them under section 37, i.e. the reason for granting the certificate, whether the MHO consented to it, if not then why an MHO was not consulted, the alternatives to emergency detention that were considered by the medical practitioner and the reason that any such alternative was decided to be inappropriate.

20. Section 3(3) of the Bill amends section 38 so that hospital managers will still be required to inform those persons that an emergency detention certificate has been granted, but will have discretion as to whether the patient’s nearest relative, person residing with the patient and
patient’s named person are notified of the matters in section 37. Those matters will still require to be notified to the Commission. Section 3(4) and 3(5) of the Bill make consequential amendments in respect of the revocation of EDCs in sections 40 and 42 of the 2003 Act.

Section 4: Short term detention in hospital

Amendment of sections 44 and 46

21. Periods of short term detention in hospital are provided for in section 44 of the 2003 Act. In a similar way to section 36(2) of the 2003 Act, section 44(2) lists certain orders, which if in place in respect of a patient, mean that a short term detention certificate (STDC) cannot be granted in respect of the patient. Section 4(2) of the Bill adds a detention under section 113(5) of the 2003 Act to the list of orders in section 44(2) of the 2003 Act.

22. Section 46 of the 2003 Act provides that hospital managers must send a copy of a STDC to the Tribunal and the Commission. Section 4(3) of the Bill amends section 46 to provide that a copy of the certificate must now be sent to all those who are required to be notified of its granting (i.e. the patient, the patient’s named person and any guardian or welfare attorney of the patient). It also provides that the Tribunal and Commission are no longer to receive a copy of the STDC but are still to be given notice of it being granted.

Section 5: Meaning of temporary compulsion

Amendment of section 329

23. Section 5(3) of the Bill inserts a definition of “temporary compulsion order” into section 329 (interpretation) of the 2003 Act. In consequence of this, the reference to section 54(1)(c) in the definition of ‘appropriate act’ in paragraph (c) of section 230(4) of the 2003 Act is repealed.

Section 6: Suspension of orders on emergency detention

Amendment of section 43

24. Section 43 of the 2003 Act deals with the effect of subsequent emergency detention certificates (EDCs) on compulsory treatment orders (CTO). At present where a patient is subject to a CTO and an EDC is granted (for example because a patient’s condition has perhaps deteriorated suddenly to the extent that detention in hospital is required), any measures authorised by the CTO cease to have effect whilst the patient is subject to the EDC (with the exception of any measures authorised under section 66(1)(b) of the 2003 Act, i.e., the giving of medical treatment, in accordance with Part 16 of the 2003 Act).

25. Section 6 of the Bill amends section 43 of the 2003 Act to make equivalent provision as regards patients subject to a compulsion order or an interim CTO, and who then become subject to an EDC. The result of the amendments in such cases is that any measures authorised by a CO, interim CTO or CTO will cease to have effect for the duration of the EDC, with the exception of the giving of medical treatment in accordance with Part 16 of the 2003 Act (as authorised under section 66(1)(b) of the 2003 Act as regards CTOs and interim CTOs, or section 57A(8)(b) of the 1995 Act as regards compulsion orders).

26. Subsection (3) makes consequential changes to the title and heading of section 43.
Section 7: Suspension of orders on short term detention

Amendment of section 56

27. Section 56 of the 2003 Act makes provision for the effect of subsequent short term detention certificates (STDC) on compulsory treatment orders (CTO). At present where a patient is subject to a CTO and a STDC is granted (because a patient’s condition has perhaps deteriorated suddenly to the extent that hospital treatment is required), any measures authorised by the CTO cease to have effect whilst the patient is subject to the STDC.

28. Section 7 of the Bill amends section 56 to provide that if a patient is subject to a CTO, CO, or an interim CTO, and that patient becomes subject to a STDC, any measures authorised by the CO, interim CTO or CTO cease to have effect for the duration of the STDC. Subsection (3) makes consequential changes to the title and heading of section 56.

Section 8: Suspension of detention for certain purposes

29. Section 221 of the 2003 Act makes provision for the suspension of detention for patients subject to an assessment order (AO) made under the 1995 Act. At present, the consent of the Scottish Ministers is required for suspending the AO for any period of time. Section 8(3) of the Bill provides that consent of the Scottish Ministers will no longer be required if the suspension of detention is required to enable the patient to attend either a hearing in criminal proceedings against the patient or a medical or dental appointment.

30. Section 224 of the 2003 Act makes provision for the suspension of detention for patients subject to a treatment order, interim compulsion order, compulsion order and a restriction order, hospital direction or transfer for treatment direction. The consent of the Scottish Ministers is required for any period of suspension. Section 8(4) of the Bill amends section 224 to provide that the consent of the Scottish Ministers will no longer be required when suspension of detention is necessary for such patients to attend either a hearing in criminal proceedings against the patient, or a medical or dental appointment.

31. Section 127 of the 2003 Act makes provision for the suspension of detention for patients who are subject to a CTO or interim CTO. That section also applies in relation to patients who are subject to relevant compulsion orders, by virtue of section 179 of the Act. Sections 127, 221 and 224 of the 2003 Act are also amended by section 8 of the Bill to provide that a certificate suspending detention must record the purpose for which the certificate has been granted. Sections 127, 221 and 224 are also amended to make clear that a certificate granted under these sections can specify either a single period of suspension of detention, or a series of more than one individual period.

32. Section 127(1) of the 2003 Act provides that in relation to a CTO a certificate granted under this section must not exceed 6 months. Section 8(2) of the Bill amends that provision so that the certificate can specify a single period of suspension of detention not exceeding 200 days, or a series of more than one individual period within an overall 6 month period.

33. Section 224 of the 2003 Act provides that a certificate granted under this section must not exceed 3 months. Section 8 of the Bill amends section 224 so that the certificate can specify a
single period of suspension of detention not exceeding 90 days, or a series of more than one individual period within an overall 3 month period.

Section 9: Maximum suspension of detention measures

34. A patient who is subject to a CTO or an interim CTO can have measures authorising the detention under those orders suspended in terms of section 127 of the 2003 Act. At present, a patient’s responsible medical officer (RMO) can grant a certificate suspending detention, as an important part of the patient’s rehabilitation process, allowing patients extended time out of hospital, but still subject to conditions imposed by the RMO. The power is exercised at the RMO’s discretion. Under the current provisions, an RMO can suspend measures authorised by a CTO for up to 6 months in a single certificate. More than one certificate can be granted but the total period of suspension cannot exceed 9 months in any 12 month period. For the purposes of this provision, section 127(4) provides that a period may be expressed as the duration of an event or a series of events and any associated travel.

Amendment of section 127

35. Section 9 of the Bill amends section 127 of the 2003 Act by providing that the maximum period of suspension of detention for a CTO may not exceed 200 days in a 12 month period; however, any period of suspension authorised by the RMO of 8 hours or less is not to be counted towards that total. For the purpose of calculation, any period of more than 8 hours and less than 24 hours is counted as one day towards the total period. Section 9 further amends section 127 by providing that the total of 200 days may be increased by up to a further 100 days in a set 12 month period, if the Tribunal approves an application for an extension. In response to such an application, the Tribunal may make an order granting the extension of up to a further 100 days or may vary the order to a community-based order under the power now conferred on it by section 127(11B). Where an RMO makes an application to the Tribunal for an increase of the 200 day limit, the RMO must notify the Commission of the application and its outcome. The Tribunal must inform the patient and the patient’s named person that they may make written or oral representations to the Tribunal and must also inform them of the result of the Tribunal’s determination. The amendments made to section 127 will also apply to patients subject to a compulsion order (CO) by virtue of section 179 of the 2003 Act.

Amendment of section 224

36. Section 9 further amends section 224, by making similar amendments to those made to section 127 referenced above. As is the case with section 127, a patient’s RMO can, with the consent of the Scottish Ministers, grant suspension of detention for a maximum of 9 months in a 12 month period. Section 9 amends this to provide that suspension of detention can now be granted for a maximum of 200 days in a set 12 month period. Any period of suspension authorised which is 8 hours or less is not to be counted towards the maximum of 200 days, and periods of more than 8 hours but less than 24 hours are to be counted as one day. The total of 200 days can be increased on application to the Tribunal, to a maximum of 300 days in a set 12 month period, but cannot be varied to a community-based order. When an application for an increase in the period of suspension is made to the Tribunal, the RMO is required to notify the Commission of the making of the application and its outcome. The Tribunal must inform the patient and the patient’s named person that they may make written or oral representations to the Tribunal and must also inform them of the result of the Tribunal’s determination.
Amendment of section 320

37. Section 9(4) amends section 320 of the 2003 Act to allow an appeal to the sheriff principal against a decision of the Tribunal under section 127(11B) to vary an order to a community-based order. By virtue of section 321 of the Act, the decision of the sheriff principal may subsequently be appealed to the Court of Session.

Section 9A: Specification for detention measures

Amendment of section 36 and 44 and new section 71A

38. Section 36 of the 2003 Act allows a medical practitioner to grant an emergency detention certificate which authorises the removal of a patient to a hospital or different hospital, and the detention of the patient in hospital for a period of 72 hours.

39. Section 44 of the 2003 Act allows an approved medical practitioner to grant a short-term detention certificate which authorises the removal of a patient to a hospital or different hospital, the detention of the patient in hospital for a period of 28 days, and the giving to the patient of medical treatment in accordance with Part 16 of the Act.

40. Sections 62 to 68 of the 2003 Act relate to compulsory treatment orders and interim compulsory treatment orders.

41. Section 9A of the Bill amends sections 36 (emergency detention in hospital) and 44 (short-term detention in hospital) of the 2003 Act and adds a new section 71A which relates to sections 62 to 68 (compulsory treatment orders). The amendments and new section provide that references in sections 36, 44, 46 to 49 and 62 to 68 to a ‘hospital’ may be read as references to a ‘hospital unit’. This allows emergency detention orders, short-term detention orders, interim compulsory treatment orders and compulsory treatment orders to authorise detention in a specified hospital unit. It also makes clear that a mental health officer’s proposed care plan under section 62 of the 2003 Act may propose that a patient is detained in a specified hospital unit. In addition, the amendments will enable the removal of patients who are subject to emergency or short-term detention certificates to a particular hospital unit or to a different unit within the same hospital (where the patient is in hospital at the time that the order is granted).

Section 9B: Transfer of prisoner to hospital unit

Amendment of section 136

42. Section 136 of the 2003 Act provides for the Scottish Ministers to authorise the transfer of prisoners to hospital for treatment for mental disorder.

43. Section 9B provides that references in section 136 of the 2003 Act to a “hospital” may be read as references to a “hospital unit”, and defines “hospital unit” as meaning any part of a hospital which is treated as a separate unit. This makes clear that a transfer for treatment direction may authorise the transfer of prisoners to, and their detention in, specific hospital units.
Section 9C: Transfer from specified unit

New section 124A

44. Section 124A of the 2003 Act (as introduced by section 9C of the Bill) applies to patients subject to compulsory treatment orders (CTOs) and interim compulsory treatment orders (ICTOs) and enables the managers of the hospital in which the patient is detained to transfer the patient to another unit within the same hospital. This power will be available only where the order specifies that the patient is to be detained in a particular hospital unit, as provided for by section 9A, described above.

45. The effect is that patients subject to CTOs and ICTOs which require their detention in a particular hospital unit may be transferred to another unit within the same hospital. The provisions of section 124(4) to (14), which apply to transfers of those patients between hospitals, will apply with such modifications as are set out at subsection (3), being those necessary to reflect the fact that the transfer is within a hospital.

46. These provisions will also apply to patients subject to compulsion orders (made without a concurrent restriction order) by virtue of section 178 of the 2003 Act.

Section 9D: Requirement for medical report

47. Chapter 3 of Part 17 of the 2003 Act is concerned with appeals against detention in conditions of excessive security.

48. Section 264 of the 2003 Act provides at present that a patient detained in a state hospital by virtue of a compulsory treatment order (CTO), a compulsion order (CO), a hospital direction (HD) or a transfer for treatment direction (TTD) can apply to the Tribunal for an order declaring that the patient is being detained in conditions of excessive security. Similar provision is made at section 268 for patients detained in hospitals other than a state hospital. Where the Tribunal is satisfied that the conditions of security are excessive, the Tribunal can make an order declaring that the patient is being detained in conditions of excessive security and specifying a period of three months or less for the relevant Health Board to identify another hospital where the patient could be detained in conditions which would not involve an excessive level of security. By virtue of sections 265 (state hospital) and 269 (non-state hospital), if a suitable alternative hospital has not been identified, a further period of between 28 days and 3 months can be given to the relevant Health Board to identify such a hospital. After that, by virtue of section 266 (state hospital) and 270 (non-state hospital), another 28 days can be given to the relevant Health Board to identify such a hospital.

49. Where the patient is a relevant patient (defined in section 273 as a patient who is subject to a compulsion order and restriction order, a hospital direction or transfer for treatment direction), the Health Board is required to obtain the agreement of the Scottish Ministers that the alternative hospital identified is one in which the patient could be detained in conditions which would not involve an excessive level of security.
Amendment to section 264 and 268

50. Section 9D amends sections 264 and 268 of the 2003 Act to introduce a new requirement for a report by a medical practitioner to accompany an application to the Tribunal under those sections for an order declaring that a patient is being detained in conditions of excessive security and requiring the Health Board to identify a hospital in which the patient could be detained in appropriate conditions. The report must state that, in the practitioner’s opinion, the test set out in regulations is met in relation to the patient, and set out the reasons for that opinion. The regulations referred to are those made under section 271A of the 2003 Act, inserted by section 11 of the Bill.

Section 10: Process for enforcement of orders

Amendment of sections 266, 267, 270, 271 and 272

51. Section 10(2) of the Bill repeals section 266 so that, where the Tribunal determines that a patient is being detained in a state hospital but does not require to be detained under conditions of special security that can only be provided in such a hospital, the Health Board now has a maximum of six months in which to identify a suitable alternative hospital. Subsections (3) and (4) make changes consequential to this amendment.

52. Section 10(5) repeals section 270. This repeal has the same effect as repealing section 266, but in respect of orders relating to detentions in conditions of excessive security for patients in non-state hospitals. Subsections (6) and (7) make changes consequential to this amendment.

53. Section 10(8) reflects the repeal of section 266 and 270 in section 272 of the 2003 Act (proceedings for specific performance of statutory duty).

Section 11: Orders relating to non-state hospitals

Amendment of section 268

54. Section 268 of the 2003 Act provides patients in non-state hospitals with a right of appeal against conditions of excessive security. At present, that right extends to “qualifying patients” in “qualifying hospitals”, with the definition of what constitutes a qualifying patient or hospital to be provided in regulations. If the Tribunal is satisfied that a patient is being held in conditions of excessive security, then it may make a declaration to that effect and require the relevant Health Board to identify a hospital where the patient could be detained in conditions which would not involve the patient being subject to a level of security which is excessive in the patient’s case.

55. Section 11 of the Bill makes a number of amendments to the provisions relating to appeals against excessive security for patients detained in a hospital other than a state hospital. Section 11 removes references to “qualifying” in respect of patients who may appeal under this section. Instead, any patient in a “qualifying hospital” will be able to appeal, with the meaning of “qualifying hospital” to be set out in regulations under new section 271A (inserted by subsection (4A) of this section).

56. This section also adjusts sections 268 and section 269 so that notification of the proposed hospital, or hospital unit (section 11A provides that references to ‘hospital’ can include a
‘hospital unit’) to which the patient is to be moved, is given to the managers of the hospital or unit where the patient is currently resident. This is a slight change from the current requirement (to notify the managers of the ‘qualifying hospital’) to recognise the fact that notification that a patient is moving between units in a hospital may need to be given to the managers of the units as opposed to simply the overall manager of the hospital.

57. Subsections (11) to (14) of section 268, relating to the definition of qualifying patients are repealed and re-enacted (with adjustments) in section 271A. A revised definition of a relevant patient is inserted at section 273 of the 2003 Act by section 11(5) of the Bill in consequence of the amendments which remove the term “qualifying” in respect of patients. The definition of “relevant patient” applies to the provisions requiring the Health Board to obtain the agreement of the Scottish Ministers to the hospital identified following an order of the Tribunal.

58. Subsections (2)(ba), (3)(aa) and (4)(aa) of section 11 of the Bill provide that the Tribunal may make an order under section 268 or 269 of the 2003 Act (as applicable) where the test specified in regulations under section 271A(2) is met, and must make an order under section 271 of the 2003 Act (recalling an order under section 268 or 269) where the Tribunal is satisfied that the test specified in regulations is not met.

New section 271A

59. Section 11(4A) of the Bill inserts new section 271A into the 2003 Act. Subsection (1) of inserted section 271A provides that a qualifying hospital is a hospital which is not a state hospital and which is specified or is of a description specified in regulations. Only patients who are detained in qualifying hospitals within the meaning set out in regulations made under subsection (1) will have the right to make an application to the Tribunal under section 268.

60. Subsection (2) of section 271A provides that regulations may also set out the test for the purposes of the Tribunal’s consideration of whether to make an order under sections 268, 269 and 271 of the Act. The test must, by virtue of subsection (3)(a), include a requirement that the Tribunal is satisfied that detention of the patient in the hospital in question involves the patient being subject to a level of security that is excessive in the patient’s case. In addition it may, by virtue of subsection (3)(b), include other requirements.

61. Subsection (4) of section 271A includes a power for Ministers to make provision in regulations about when, for the purposes of regulations made under subsection (2) and sections 268 to 271 of the Act, a patient’s detention in a hospital is taken to involve the patient being subject to a level of security that is excessive in the patient’s case.

62. Subsection (5) of new section 271A provides that regulations may make provision requiring that a person meet criteria besides being a medical practitioner in order to prepare a report in support of a patient’s excessive security appeal for the purposes of the new requirements introduced by section 9D of the Bill. This applies both in relation to a patient making an application to the Tribunal in respect of detention in a state hospital (under section 264 of the 2003 Act) or another hospital (under section 268 of the 2003 Act).
Section 11A: Meaning of hospital in sections 268 to 273 of the 2003 Act

Amendment to section 273

63. Section 11A provides that in Chapter 3 of Part 17 of the 2003 Act, a reference to a hospital may be read as a reference to a hospital unit and that “hospital unit” means any part of a hospital which is treated as a separate unit.

Section 13: Notifying decisions on removal orders

New section 295A

64. Under section 293 or 294 of the 2003 Act a mental health officer (MHO) can apply for a removal order if he or she considers that a person over 16 who has a mental disorder, is at risk of significant harm and that certain circumstances are met. These circumstances are that the person is being subject or exposed to ill treatment or neglect, or that the person’s property is suffering loss or damage, or at risk of such loss or damage and the person is living alone or without care and unable to look after him or herself. Application is made to the sheriff, or justice of the peace, in urgent cases, for the removal of the person at perceived risk, and detention of that person for a maximum of 7 days.

65. Section 13 of the Bill inserts new section 295A into the 2003 Act which places a new duty on MHOs to notify the Commission of the decision of the sheriff or justice, and any subsequent recall or variation of the removal order.

Section 14: Detention pending medical treatment

Amendment of Section 299

66. Under section 299 of the 2003 Act a nurse has the power to detain certain patients for a period of up to two hours to enable a medical examination to be carried out, with an extension of one hour after the arrival of the medical practitioner, if the medical practitioner does not arrive within the first hour. Section 14 of the Bill amends section 299 to clarify that a nurse will now be able to detain a patient for a maximum of 3 hours, for the purpose of enabling the carrying out of a medical examination of the patient by a medical practitioner.

Section 16: periodical referral of cases

Amendment of section 101, 189 and 213

67. Section 101 of the 2003 Act ensures that the Tribunal reviews a compulsory treatment order (CTO) at least once every 2 years. It does this by requiring a review to be carried out where, during the relevant 2-year period, the Tribunal has not been required to review the CTO by virtue of subsection (2)(a) and none of the following references or applications have been made to the Tribunal; namely, a reference under section 92 or 95 by a responsible medical officer or an application under section 99 or 100 by the patient or patient’s named person.

68. Section 189 of the 2003 Act requires the Scottish Ministers to refer the case of a patient who is subject to a compulsion and restriction order (CORO) to the Tribunal for review every 2 years. The requirement applies where during the relevant 2-year period none of the following
This document relates to the Mental Health (Scotland) Bill as amended at Stage 2 (SP Bill 53A)

references or applications have been made to the Tribunal; namely, a reference under section 185 or 187 or an application under section 191 or 192.

69. Section 16 of the Bill amends sections 101 and 189 to provide that an order has to be reviewed under section 101 if a reference or application under sections 92, 95, 99 or 100 has not been determined by the Tribunal, rather than the requirement being based upon when a reference or application has been made. Similarly, it provides that an order has to be referred under section 189 if a reference or application under section 185, 187, 191 or 192 has not been determined by the Tribunal. This is different from the current position which is based upon whether a reference or application has been made, whether or not it has been determined. Requiring that a case has to be reviewed if a reference or application has not been determined by the Tribunal rather than the requirement being based upon when a reference or application has been made will avoid situations where a review is not triggered because an application has been made to the Tribunal and then withdrawn by the patient. Paragraph 13A of schedule 2 of the 2003 Act is repealed in consequence of these changes.

Section 18A: Named person not to be automatic

70. Chapter 1 of Part 17 of the 2003 Act makes provision for the appointment and duties of named persons. Under section 250 of the 2003 Act, a person who is 16 years or over is entitled to nominate another person, over the age of 16 to act as a named person. A named person has a similar role to that of a safeguarder and represents the interests of the patient, but does not necessarily represent the patient. The named person should be involved in discussions about care options for the patient and may take part in any legal proceedings relating to compulsory measures.

71. At present, if a person has not appointed a named person then in the absence of a declaration to the contrary, the person’s primary carer becomes the named person, or the person’s nearest relative where there is no primary carer by virtue of section 251 of the 2003 Act. An individual can decline to be a named person, and a person can make a declaration that a particular person or persons shall not be a named person. The Tribunal also has the authority to appoint a named person in certain cases under section 257.

Amendment to section 251, 253 and 318

72. Section 18A repeals section 251 and 253 so that the carer or relative does not become a named person by virtue of those sections if the patient does not nominate a named person. Therefore a patient aged 16 or over will only have a named person if they choose one. A consequential amendment is made to section 318 of the 2003 Act.

Section 19: Consent to being named person

Amendment to sections 250 and 257

73. At present, an individual may become a named person under section 251 of the 2003 Act without necessarily consenting to that role, albeit that he or she may decline to act. Section 19 of the Bill makes provision for a person to be appointed as a named person by virtue of section 250 or 257, only if he or she has agreed to act as the person’s named person and signed a docket to that effect. If no such signed and witnessed docket exists, the appointment of the named person is null and void.
Section 20: Appointment of named person

Amendment of sections 255, 256, 257 and 320.

74. The Tribunal currently has power to appoint a named person, in the absence of an existing named person. Section 20(4) of the Bill removes this power from the Tribunal, together with associated amendments to section 255 and 256 of the 2003 Act which currently allow the Mental Health Officer and certain persons listed in section 256(2) (including the patient) to apply to the Tribunal to have a named person appointed. A consequential amendment is made to section 320.

New section 257(3A)

75. Subsection (4) of section 20 adds subsection (3A) to section 257. Subsection (3A) makes provision for the Tribunal to remove an existing person if they are considered inappropriate to act as a named person and, if the individual appearing before the Tribunal is under 16, substitute another person to act as named person.

Section 20A: Ability to act if no named person

New section 257A

76. Section 20A of the Bill introduces a new section 257A to the 2003 Act which makes provision about who will have the ability to act in relation to a patient, over the age of 16, who does not have a named person and who is incapable in relation to a decision about whether to make a decision to initiate an appeal or application. This ability to act does not apply to the extent that the patient has made a declaration under subsection (6)(b) that they would not wish their primary carer or nearest relative to act in relation to them if they became incapable. Such a declaration must be in writing and can be made in relation to specific persons or all persons.

77. The section allows listed persons to initiate applications or appeals, to the Mental Health Tribunal for Scotland, the Sheriff Principal and the Court of Session, under various sections of the 2003 Act. The listed persons are the patient’s guardian, welfare attorney, primary carer or nearest relative. The sections of the 2003 Act under which these listed persons will now be able to initiate an application or appeal are 50(1), 99(1), 100(2), 120(2), 125(2), 126(2), 163(1), 164(2), 192(2), 201(1), 204(1), 214(2), 219(2), 220(2), 264(2), 268(2), 320(2), 321(1) and 322(2). Under section 257A(5), guardians and welfare attorneys are excluded from the application of certain of these provisions where there is an overlap with their existing functions.

78. The section also extends the effect of various sections of the 2003 Act so that certain of the listed persons (the patient’s guardian or welfare attorney) will now be entitled to obtain certain information in respect of a decision about the patient’s treatment. The information which they will be entitled to is any notice or information that is provided under sections 54(3), 60(1), 87(2)(c), 124(4) or (6), 127(7) or (11A)(b), 128(3), 129(3) or (4), 200(3), 218A(4), (6) or (10)(b), 218A(4), 224(8) or (12A)(b) or 226(3) of the 2003 Act. For these sections of the 2003 Act, which are included by virtue of subsection (4), notice is only given under the particular subsections listed. Exemptions are also included in new section 257A(6) so that the guardian or welfare attorney does not receive a copy of the record of a determination to extend a compulsory treatment order (CTO) under section 87(2)(c) of the 2003 Act and only receives information about the reasons for a Responsible Medical Officer’s (RMO) in relation to decisions about
suspension of detention under sections 128(3) or 129(4) if the RMO is satisfied it is appropriate for them to do so.

Section 21: Registering of advance statements

New sections 276A, 276B and 276C

79. An advance statement is a statement which may be made by a person at any time provided the person making the statement has capacity to make such a statement. The statement must be in writing and witnessed. The advance statement should set out how a person wishes to be treated for mental disorder and the ways in which a person wishes not to be so treated. Section 275 and 276 of the 2003 Act make provision for advance statements.

80. Section 21 of the Bill inserts sections 276A, 276B and 276C to the 2003 Act. Section 276A requires health boards to place a copy of any statement or document withdrawing a statement, with the person’s medical records and send certain information to the Commission. This information is that a copy of the statement, or a document withdrawing the statement, is held with the person’s medical records; the premises at which the medical records are kept; and personal and administrative details essential for identifying the records as the person’s.

81. Section 276B places a duty on the Commission, on receipt of this information relating to an advance statement or a document withdrawing the statement, to enter this information in a register to be maintained by the Commission, and make a note of the date on which the entry is made.

82. Section 276C details who may inspect the register (at a reasonable time): namely the person who made the advance statement and whose medical records are mentioned in the entry; with respect to treatment for a mental disorder, any individual acting on the person’s behalf; and for the purposes of making decisions or taking steps with respect to the treatment of the person for mental disorder – a mental health officer dealing with the person’s case, the person’s responsible medical officer, or the relevant health board responsible for the person’s treatment.

Section 22: Communication at medical examination etc.

New section 261A

83. Sections 260 and 261 of the 2003 Act place certain duties on hospital managers, known as appropriate persons for the purposes of these provisions, with regard to the provision of information to patients, and assistance to patients with communication difficulties.

84. Section 22 of the Bill inserts section 261A to the 2003 Act, which places additional duties on appropriate persons, in respect of help with communication at certain medical examinations and interviews specified in subsection (4)(a) and (b).

85. If the subject of a medical examination has difficulty in communicating or generally communicates in a language other than English, all reasonable steps must be taken to make arrangements to ensure the subject of the medical examination can communicate during the examination. A written record must be made of the steps taken to facilitate this. Section 22 concludes by defining appropriate person for the purposes of this section; namely the Scottish
Ministers in respect of a medical examination under section 136(2) of the 2003 Act (which is a medical examination for medical disordered prisoners) and otherwise, for examinations or interviews held in a hospital, the managers of that hospital, for examinations held elsewhere, the medical practitioner carrying it out, or for interviews, the mental health officer.

**Section 22A: Conflicts of interest to be avoided**

**New section 291A**

86. Section 22A of the Bill inserts a new section 291A into the 2003 Act which provides that there must be no conflict of interest in relation to certain medical examinations carried out for the purpose of certain sections under the 2003 Act. In addition, the new section confers a power upon Scottish Ministers to make regulations which may specify circumstances in which there is to be taken, or not to be taken to be a conflict of interest, and to specify circumstances in which the requirement to have no conflict of interest does not apply. The sections of the 2003 Act to which these provisions apply are sections 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) and 182(2).

**Amendments to sections 36, 44, 47 and 58**

87. Section 22A also removes the existing equivalent provisions from sections 36, 44, 47 and 58, as they are now covered by new section 291A.

**Section 22B: Safeguarding the patient’s interest**

**Amendment of section 245**

88. Section 245 of the 2003 Act provides that before giving a certificate which allows treatment to proceed under sections 235 (certain surgical operations etc. where the patient is capable of consenting), 236 (certain surgical operations etc. where the patient is incapable of consenting), 239 (electro-convulsive therapy etc.) and 241 (treatments given over period of time etc.), the certifying medical practitioner must consult the patient, the patient’s named person (where practicable) and those persons appearing to have the primary responsibility for the patient’s medical treatment.

89. Section 22B of the Bill amends section 245 to add any guardian or welfare attorney to the people who must be consulted before a certificate is granted.

**Section 23: Services and accommodation for mothers**

**Amendment of section 24**

90. Section 24 of the 2003 Act places a duty on health boards to provide services and accommodation for certain mothers with post natal depression, to enable those mothers to care for their child in hospital. Section 23 of the Bill amends this provision to extend the duty to provide services for mothers with a mental disorder other than post-natal depression, in addition to provision of services for mothers with post-natal depression. Section 23 of the Bill also amends section 24 of the 2003 Act so that the duty that the Health Board must provide these services applies only where the Health Board is satisfied that doing so would be beneficial to the wellbeing of the child.
Section 24: Cross-border transfer of patients

Amendment of sections 289, 290 and 309A

91. Section 24 of the Bill makes a number of small changes to provisions relating to cross-border transfer of patients.

92. Sections 289 and 290 of the 2003 Act give the Scottish Ministers power to make regulations allowing, respectively, for the cross-border transfer of patients subject to measures other than detention, and the cross-border transfer of patients subject to detention. Section 24(2) amends section 289 of the 2003 Act by extending the power to make regulations in respect of the cross-border transfer of patients subject to requirement other than detention, to include persons subject to equivalent requirements in a member state of the European Union. Section 24(3) amends section 290 in the same way in respect of cross-border transfer for patients subject to detention requirements or otherwise in hospital.

93. Section 309A of the 2003 Act allows the Scottish Ministers to make regulations for and in connection with the keeping in charge of a person who is subject to escorted leave of absence authorised under legislation in force in another part of the UK, or in the Isle of Man or the Channel Islands. Regulations made under that section may make such provision by applying provisions of the 2003 Act dealing with absconding patients (sections 301 to 303 of the 2003 Act), with or without modification, to such patients. This enables regulations to make clear the powers of persons escorting patients under authority conferred under legislation in force in other territories, so that there is clear authority under the 2003 Act for those persons to continue to escort the patient whilst in Scotland.

94. Section 24(4) amends section 309A so that regulations made under that section can make provision for and in connection with the keeping in charge of a person who is subject to escorted leave of absence authorised under legislation in force in another member State of the European Union.

95. The effect of all of these changes is that regulations that currently make provision for the cross-border transfer of patients within the UK, under various orders, can now provide for the cross-border transfer of patients within the European Union, provided those patients are subject to equivalent requirements in their home country.

Section 25: Dealing with absconding patients

Amendment of section 303

96. Section 25 makes changes to sections 303, 309 and 310 of the 2003 Act with regard to provisions for absconding patients. Section 303 of the 2003 Act authorises certain persons to exercise powers in relation to any patient subject to an order authorising detention, where that patient has absconded. In particular, section 303(3)(a)(iii) gives a member of staff of any hospital, and where the patient liable to be taken into custody is subject to a compulsory treatment order which specifies a particular hospital, a member of staff of that establishment, the power, amongst other matters to take an absconding patient into custody.
97. Section 25(2) amends section 303(3)(a)(iii) to include a reference to a patient subject to an interim compulsory treatment order as well as a compulsory treatment order.

Amendment of section 309 and 310

98. Section 309 of the 2003 Act enables the Scottish Ministers to make regulations applying sections 301 to 303 of the 2003 Act to patients from England, Wales, Northern Ireland, the Isle of Man or the Channel Islands. Regulations made under section 309 allow persons who have absconded from those jurisdictions and are in Scotland to be taken into custody and returned to their own jurisdiction.

99. Section 25(3) of the Bill amends section 309 by extending the power to make regulations applying provisions in relation to absconds, to persons in Scotland subject to corresponding requirements or measures in a member State of the European Union. The section further provides that regulations made under section 309 applying section 301 to 303 to patients from other jurisdictions or member states may apply specific provisions of Part 16 of the 2003 Act to allow persons held in custody by virtue of these provisions to be provided with medical treatment. The regulations may not however apply any of that Part to persons who are subject to detention in accordance with an emergency detention certificate EDC, or authorise medical treatment of the types mentioned in section 234 and 237 of the 2003 Act. The treatment excluded as a result of being mentioned in those sections is any surgical operation for destroying brain tissue or the functioning of brain tissue, electro-convulsive therapy, and any other types of medical treatment as are specified in regulations made under sections 234 or 237.

100. Section 310 of the 2003 Act currently provides for regulations to provide the circumstances in which certain patients, specified in section 310(3), may be taken into custody, and the steps that can be taken by specified persons upon taking such patients into custody. Section 25(4) of the Bill provides that regulations made under that section may specify persons authorised by the patient’s RMO as persons who can take such patients into custody.

Section 26: Agreement to transfer of prisoners

101. Where a person who is serving a sentence of imprisonment has a mental disorder requiring treatment, section 136 of the 2003 Act allows for that person to be transferred from prison to a specified hospital under a transfer for treatment direction (TTD). Section 26 of the Bill amends section 136 to provide that such a TTD may only be made if a mental health officer has agreed to the making of the direction, unless it is impracticable to obtain such agreement.

Section 27: Compulsory treatment of prisoners

Amendment of schedule 2, part 2

102. Part 2 of schedule 2 to the 2003 Act concerns the organisation and administration of the Tribunal. In particular paragraph 7(4) of schedule 2 provides that the convenor of proceedings before the Tribunal in relation to a patient subject to a compulsion order and a restriction order, a hospital direction (HD) or a transfer for treatment direction (TTD), must be the President of the Tribunal or a member of the Tribunal who serves as a sheriff convenor, unless those proceedings relate solely to the appointment of a named person in respect of the patient, under section 255 and 257 of the 2003 Act.
103. Section 27 amends paragraph 7 to provide, for proceedings relating to an application for a compulsorily treatment order (CTO) in respect of a patient subject to a TTD or an HD, that the convenor does not have to be the President, or a member of the Tribunal who serves as a sheriff convenor. This is in addition to the existing exception for proceedings relating solely to the appointment of named persons.

104. The effect of this amendment is that the default provision in sub-paragraph (3) of paragraph 7 will apply to proceedings relating to an application for a CTO in respect of patients subject to a TTD or an HD, with the result that the convenor of the Tribunal will have to be either the President or a legal member selected from the panel mentioned in paragraph (1)(1)(a) of Schedule 2.

New paragraph 1A, schedule 3

105. Chapter 1 of Part 7 of the 2003 Act is concerned with the application for and making of compulsory treatment orders (CTOs). Schedule 3 to the 2003 Act makes a number of modifications to Chapter 1 of Part 7 insofar as it applies to patients who become subject to a CTO whilst already subject to a HD or TTD.

106. Section 27(3) adds a new paragraph to schedule 3, with the result that when a patient is subject to a HD or a TTD, and an application is made for a CTO, notice of the application requires to be given to the Scottish Ministers, in addition to the existing requirement to give notice to the patient, the patient’s named person and the Commission.

PART TWO – CRIMINAL CASES

Section 28: Making certain orders in remand cases

Amendments to sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P

107. The 1995 Act was amended by Parts 8, 9 and 10 of the 2003 Act with regard to the treatment of mentally disordered offenders. Part 2 of the Bill makes a number of minor amendments to the 1995 Act, mainly concerned with timescales, and procedure.

Amendments to sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P

108. Section 28 of the Bill amends the following sections of the 1995 Act: sections 52B, 52C, 52D, 52F, 52K, 52L, 52M and 52P, in the same way. In each of these sections, reference is made to a person being in custody. The Bill adds the words ‘remanded in’ in front of ‘in custody’, on each occasion it occurs, to clarify that the references to a person being in custody are to persons being held in prison, and do not include persons held in police custody.

Section 28A: Detention under compulsion orders

Amendment of section 57

109. Section 28A of the Bill amends section 57 of the 1995 Act. Section 57(2) of the 1995 Act sets out the disposals available to the court in cases where the accused has been acquitted on grounds of lack of criminal responsibility (section 51A) or where the accused has been found to be unfit for trial (section 53F) and has been found to have committed the acts or omissions constituting the offence following an examination of facts (section 55). Section 57(2) sets out a
number of different orders which the court can make in such cases. This includes at section 57(2)(a) making a compulsion order authorising the detention of the person in hospital and at section 57(2)(b) a restriction order in addition to a compulsion order made under section 57(2)(a).

Section 28A

Section 28A substitutes the words “authorising the detention of the person in a hospital” in section 57(2)(a) of the 1995 Act with the words “(whether or not authorising the detention of the person in a hospital)”. This has the effect of clarifying that either a community-based compulsion order (where the offender is not detained in hospital) or a compulsion order authorising detention in hospital can be made in respect of a person who is unfit for trial or acquitted on grounds of lack of criminal responsibility.

Section 28A also makes a consequential amendment to section 57(2)(b) of the 1995 Act, by substituting paragraph (b) for the words “subject to subsection (4A) below, make a restriction order in respect of the person (that is, in addition to a compulsion order authorising the detention of the person in a hospital)”.

Section 29: Periods for assessment orders

Section 52D of the 1995 Act makes provision for assessment orders. If a person has been charged with an offence, the case has not been concluded, and it appears to the prosecutor that the person has a mental disorder, the prosecutor may apply to the court for an assessment order to allow the appropriate examination and assessment by an approved medical practitioner of a person prior to trial or after conviction but before sentencing. The time periods for assessment orders are amended by section 29 of the Bill.

Amendment to sections 52D, 52F, 52G and 52H

Section 29(2)(a) changes the way in which timescales for removal of a person to hospital under an assessment order (AO) are calculated. At present the AO authorises the removal to and detention of a person in a specific hospital for up to 28 days, beginning with the day that the order is issued and ending 28 days after that event. This approach is different from the general rule applicable to the computation of time periods in the criminal court where time periods are calculated from the day the relevant order begins to the end of the day following the expiry of the relevant period. Section 29(2)(a) amends section 52D of the 1995 Act to align the computation of time periods under the parts of the 1995 Act amended by the 2003 Act, to the computation of time periods generally found in criminal procedure. This approach is replicated in the remainder of section 29 for the purposes of computation of time periods with regard to supplementary provision for AOs, review of AOs, and early termination of AOs in sections 52F, 52G and 52H of the 1995 Act respectively.

In addition, section 29(4) amends the period of extension for consideration of a case. If the court is satisfied on receipt of an assessment report under 52G(1), that further time is necessary to consider the case, it may on one occasion only make an order extending the AO for 14 days, beginning with the day on which the order would otherwise cease to authorise the detention of the person in hospital and expiring at the end of the 14 days following that day. This is an increase of 7 days from the previous power to extend an AO.
Section 30: Periods for treatment orders

Amendment of sections 52M, 52P, 52R

115. Treatment orders can be made by a court and authorise certain measures, including, if required, the removal to hospital and detention of a person there, and the giving of specified treatment. Provision for treatment orders is made in sections 52K to 52U of the 1995 Act. Section 30 amends the timescales for treatment orders in sections 52M, 52P and 52R in the same way, and for the same purpose as the timescales for assessment orders (AOS) are amended by section 29 of the Bill.

Section 31: Periods for short term compulsion

116. Section 53 of the 1995 Act makes provision for interim compulsion orders (ICOs). These orders can be made by the court after conviction if a court is satisfied, on the written or oral evidence of two medical practitioners that the offender has a mental disorder.

Amendment of sections 53, 53A, 53B and 54

117. In the same way that section 29 of the Bill amends the timescales for assessment orders, and section 30 amends the time periods for treatment orders, section 31 amends section 53 and section 53A of the 1995 Act in respect of the timescales for ICOs. This section also amends section 53B and section 54 in respect of the timescales for the review and extension of ICOs in the same way.

Section 32: Periods for compulsion orders

Amendment of sections 57A, 57B and 57D

118. Sections 57A to 57D of the 1995 Act make provision for compulsion orders (CO), which may be made by the courts after conviction if the court is satisfied on the written or oral evidence of two medical practitioners that the offender has a mental disorder.

119. Section 32 of the Bill amends the timescales for COs to bring the computation of these timescales in line with practice in criminal procedure more generally. Section 32 amends sections 57A, 57B and 57D of the 1995 Act in the same way and for the same purposes as was the case with sections 28, 29, 30 and 31 of the Bill.

Section 33: Periods for hospital directions

Amendment of sections 59A and 59C

120. Hospital directions (HDs) are directions which allow a person to receive appropriate medical treatment for mental disorder in hospital, and then, if they become well, to be transferred to prison to complete the prison sentence imposed at the time of making the HD. In accordance with earlier changes made in the Bill, section 33 amends sections 59A(4)(b), 59A(7)(a) and 59C to bring the computation of the relevant timescales in these sections in line with the way timescales are calculated for AOs, treatment orders and compulsion orders under the 1995 Act.
Section 34: Variation of interim compulsion orders

121. When an interim compulsion order (ICO) is made under section 53 of the 1995 Act, the court will specify a hospital to which the offender is to be admitted. Section 53B concerns the review and extension of ICOs. At present whilst the terms of an order can be extended, it is not possible for the court to direct that an offender be moved to a different hospital, notwithstanding the fact that it may have become apparent during the course of the initial period of the ICO that the present hospital was not suitable for the offender in question.

Amendment of section 53B

122. Section 34 of the Bill provides a power for the court to direct that, if it is appropriate to do so, the offender be admitted to a different hospital, specified by direction. If that is done, section 32(2)(c) provides that this is to have the same effect as if the hospital specified in the direction were the hospital specified in the ICO.

Section 35: Transfer of patient to suitable hospital

123. In certain situations, it becomes apparent very quickly that a person who is subject to an assessment order (AO), treatment order (TO), interim compulsion order (ICO) or temporary compulsion order (TCO) and has been admitted to hospital by virtue of that order, would be more appropriately treated in another hospital.

New section 61A

124. Section 35 of the Bill inserts section 61A into the 1995 Act, which gives a person’s responsible medical officer (RMO) the authority to transfer a person subject to an AO, a treatment order, an interim CO, or a temporary compulsion order to a hospital other than that originally specified by the court. Such a transfer can only occur once, and in making the transfer the RMO must be satisfied both that the current hospital is not suitable and that the new hospital is suitable for the purpose for which the order is made. Before carrying out the transfer, the RMO must, as far as practicable, inform the person of the reason for the transfer, notify the managers of the specified hospital and obtain the consent of the managers of the other hospital and the Scottish Ministers. After the transfer, the RMO must notify any solicitor acting for the person, and the court which made the order.

Section 35A: Specification of Unit

New section 61B

125. Section 35A of the Bill inserts section 61B into the 1995 Act. It provides that any reference to a hospital in Part VI of the 1995 Act may be read as a reference to a hospital unit, where a “hospital unit” means any part of a hospital which is treated as a separate unit. The effect is that any order or direction which may already be made under Part VI of the 1995 Act authorising the detention of a person or patient in a specified hospital, may be made authorising detention in a specified hospital unit. This relates to assessment orders, treatment orders, interim compulsion orders, temporary compulsion orders, compulsion orders, compulsion orders and restriction orders, hospital directions and transfer for treatment directions.
126. Section 35A also makes provision as to how section 61A of the 1995 Act (inserted by section 35 of the Bill) is to apply in relation to a transfer from one hospital unit to another within the same hospital. The effect is that persons subject to assessment orders, treatment orders and interim compulsion orders will be able to be transferred to another hospital unit, where the order in question specifies the hospital unit in which the person is to be detained. The conditions for transfer set out in section 61A reflect that the transfer is within a single hospital.

**Section 39: Transfer from specified unit**

*New section 218A*

127. Section 39 inserts section 218A into the 2003 Act. Patients subject to compulsion and restriction orders (COROs), hospital directions or transfer for treatment directions, can be subject to an order or direction specifying a hospital unit rather than a hospital. New section 218A allows hospital managers to transfer a patient who is subject to an order specifying a hospital unit, to another unit within the same hospital, but only if the Scottish Ministers consent to that transfer. Again, hospital unit is defined as meaning any part of the hospital treated as a separate unit.

**Section 40: Consequential repeals**

128. Section 9 of the Crime and Punishment (Scotland) Act 1997, and paragraph 66 of schedule 7 to the Criminal Justice and Licensing (Scotland) Act 2010, relating to power to specify hospital units, are repealed by section 40 of the Bill.

**Section 41: Information on extension of compulsion order**

*New section 153A*

129. Section 151 of the 2003 Act sets out the steps that a responsible medical officer (RMO) must take when he or she has determined that a compulsion order (CO) is to be extended without change. In such cases, an RMO must prepare a record setting out the reasons for the determination and whether the mental health officer (MHO) agrees, disagrees or has not expressed a view, and, in the case of a disagreement, the reasons for that, the type of mental disorder suffered by the patient and whether that has changed from the disorder in the original CO. This record must be submitted to the Tribunal and a copy sent to the patient (unless the RMO considers there would be significant risk to the patient in doing so), the patient’s named person, the MHO and the Commission. The Tribunal must be informed if the RMO is sending a copy or not to the patient and, if not, the reasons for that decision. When the MHO disagrees with the determination, or the type of mental disorder differs from that originally recorded in the CO, the RMO’s decision to extend the CO must be reviewed by the Tribunal.

130. Section 41 of the Bill inserts new section 153A which sets out new duties for the MHO when the Tribunal is required by section 165(2)(a) of the 2003 Act to review the determination. That situation occurs when (i) the determination states that there is a difference between the type of mental disorder that the patient has and that recorded in the CO; and (ii) where the MHO disagrees with the determination, or has failed to comply with the duties imposed by section 151 of the 2003 Act to inform the patient of the determination, their rights in relation to this and the right to independent advocacy, and as far as practicable interview the patient.
131. When section 165(2)(a) applies, the MHO, must prepare and submit a record to the Tribunal with the patient’s name and address and that of the patient’s named person and primary carer, if known, details of what the MHO has done in compliance with section 151 of the 2003 Act, and so far as relevant to the extension of the CO, the details of the personal circumstances of the patient, any advance statement of the patient (if known by the MHO), the views of the MHO on the extension of the CO and any other information the MHO considers relevant in relation to the extension of the CO. A copy of this record must also be sent to the patient and the patient’s named person, RMO and the Commission. The patient need not receive a copy of the record if the MHO considers so doing would carry a significant risk of harm. The Tribunal must be told if the patient is not receiving the report, and the reasons for this decision.

Section 42: Notification of changes to compulsion orders

Amendment of section 157 and 160

132. This section makes consequential minor changes to section 157 and 160 in respect of compulsion orders.

Section 42A: Effect of revocation of restriction order

Amendment of section 198

133. Part 10 of the 2003 Act contains provisions in relation to compulsion orders and restriction orders. There are various provisions which allow for applications or references to be made by patients subject to such orders and their named persons to the Mental Health Tribunal in respect of these orders. In addition, the Scottish Ministers are also required to refer cases to the Tribunal in certain circumstances. Where, following such an application or reference, the Tribunal considers that it is necessary for a compulsion order and restriction order (CORO) patient to remain subject to a compulsion order but considers that the restriction order is no longer necessary, it may make an order under section 193 of the 2003 Act revoking the restriction order.

134. Section 196 of the 2003 Act provides that any order made under section 193 does not take effect until the occurrence of certain events, which can be summarised as: (1) the expiry of the period for appealing against the Tribunal’s order, without any appeal having been lodged; or (2) where an appeal has been lodged, a decision by Scottish Ministers not to seek an order under section 323 suspending the effect of the Tribunal’s order, or the court’s decision not to grant such an order, or (3) where a section 323 order has been made, the recall or expiry of such an order.

135. Section 198 of the 2003 Act provides that from the day on which the Tribunal makes the revocation order under section 193, the patient is to be treated as being subject to a compulsion order to which Part 9 of the 2003 Act applies which had been made on the day on which the Tribunal revoked the restriction order. And accordingly, from the day on which the revocation order is made, the patient is subject to the review requirements of Part 9 of the 2003 Act (relating to compulsion orders).

136. Section 42A substitutes the words “order revoking the restriction order has effect in accordance with section 196 of this Act” for the words “Tribunal revoked the restriction order” in section 198(2) of the 2003 Act. This has the effect that a patient whose restriction order is
revoked should not be treated as being subject to a compulsion order (and its attendant review requirements) until such time as the revocation takes effect.

137. This avoids the possibility that the Registered Medical Officer could be required to carry out a review of the compulsion order despite the patient continuing to be subject to a CORO.

PART THREE – VICTIMS’ RIGHTS

Section 43: Right to information: offender imprisoned

138. Section 16 of the Criminal Justice (Scotland) Act 2003 (the Criminal Justice Act) as amended by the Victims and Witnesses (Scotland) Act 2014, provides that victims of any offence can receive information mainly related to the circumstances in which a prisoner leaves prison. This may be information about: the first time a prisoner is entitled to be considered for temporary release, an escape, transfer to a prison outwith Scotland, release on licence or parole, death of the prisoner or the end of the custodial sentence.

139. The Bill amends the Criminal Justice Act to provide for the disclosure of information about mentally disordered offenders (restricted patients) to their victims or their relatives, in certain circumstances. A mentally disordered offender is the term used to describe a person charged with an offence who, upon conviction or acquittal has either been given a mental health disposal by a court authorising compulsory measures of treatment in hospital without limit of time rather than being sentenced to imprisonment, or a prisoner who has been found to be suffering from a mental disorder whilst in prison and who is thereafter transferred into the mental health system.

Amendment of section 43 of the Criminal Justice (Scotland) Act 2003

140. Section 43 of the Bill amends section 16 of the Criminal Justice Act to add to the information which a victim can receive under the existing scheme in cases where the offender is in hospital receiving treatment for mental disorder by virtue of a hospital direction or a transfer for treatment direction. In such cases, section 43 of the Bill amends section 16 so that victims can receive notification when the offender is unlawfully at large from a hospital, or has been returned to hospital after being unlawfully at large, and when a certificate has been granted, for the first time, allowing unescorted suspension of detention.

141. Section 43 also extends the order making power in section 16(4) of the Criminal Justice Act by giving the power to the Scottish Ministers to modify section 18A of the Criminal Justice Act by adding, amending, or repealing definitions of terms used in section 16(3).

Section 44: Right to information: compulsion order

142. Section 44 makes further amendment to the Criminal Justice Act 2003 by inserting new sections 16A, 16B and 16C, which make provision regarding victims’ rights to receive certain information relating to offenders who are subject to a compulsion order and a restriction order (CORO).
New section 16A of the Criminal Justice Act 2003

143. New section 16A provides that where a person over 16 has been made subject to a CORO in proceedings in respect of an offence perpetrated against a natural person, the Scottish Ministers must give the information described in section 16C to the person entitled to receive that information (as determined by section 16B), provided that the person has requested to be given the information. The information may only be withheld if the Scottish Ministers consider that disclosing the information would be inappropriate due to exceptional circumstances in the case.

New section 16B

144. Section 16B lists those persons who are entitled to ask to be given information under section 16A, namely, the victim of the offence, or if the victim is dead, the spouse, cohabitee, child or parent of the victim, and if the victim died before reaching 16, any other person who cared for the victim before the relevant offence took place.

145. If the victim is under 12, he or she may not ask for information but someone who cares for the victim may ask instead. The section clarifies that a person who asks for information must not be incapable, and must not be a person accused of, or reasonably suspected of being the perpetrator, or been implicated in the perpetration of the offence.

New section 16C

146. Section 16C lists the information that is to be given under section 16A; that is, whether the compulsion order has been modified or revoked, whether the restriction order has been revoked, the date of death of the offender, any transfer of the offender to a place outwith Scotland, the conditional discharge of the offender, the terms of restrictions which have been placed on the things that the offender may do as a condition of their conditional discharge (i.e. exclusion zones or “no contact” conditions), or the recall of the offender to hospital following conditional discharge.

147. If the offender is subject to a compulsion order and restriction order authorising detention in hospital, additional information may be disclosed including (a) whether the offender is unlawfully at large from hospital, (b) if they have been returned to hospital after having been unlawfully at large, (c) that suspension of detention has been granted for the first time and does not impose a supervision requirement and (d) where suspension of detention mention in (c) has been revoked. New definitions of what constitutes being granted suspension of detention for the first time are added by inserted section 18A (mentioned below).

Section 45: right to make representations

New section 17B

148. Section 45 of the Bill inserts new sections 17B to 17D to the Criminal Justice Act.

149. Section 17B provides for the victims of mentally disordered offenders to be given a right to make representations in certain cases. A person who has the right to be given information about the offender must, in a case where the offender is subject to a hospital direction or a transfer for treatment direction and qualifies under the Criminal Justice VNS, be given the
chance to make representations before a decision about suspending the offender’s detention is made for the first time. Where the offender is subject to a compulsion order and restriction order, an opportunity to make representations must be given before a decision is taken about (i) suspending the offender’s detention for the first time (for a definition of this see inserted section 18A); (ii) revoking or varying the compulsion order in any way; (iii) conditionally discharging the offender; or (iv) varying any conditions applying to the conditional discharge of the offender which might affect the victim or family of the victim. Any representations must be about how the decision in question might affect the victim or the victim’s family and the right to make representations only applies if the victim has intimated to the Scottish Ministers a wish to make representations and there is no need to give the victim the opportunity if it is not reasonably practicable to do so.

New section 17C

150. Section 17C provides that if representations concern revoking or varying the compulsion order in any way or varying any conditions which might affect the victim’s family, representation may be made in person or in writing they relate to a decision by the Tribunal under section 193 of the 2003 Act, but otherwise must be made in writing. Section 17C(2) makes provision for the Scottish Ministers to issue guidance as to how representations, whether written or oral, should be made.

New section 17D

151. Section 17D provides that where a decision has been made under section 17B (mentally disordered offender (restricted patient): victim’s right to make representation), if the victim has asked for information about a decision to be given under section 17D then the Scottish Ministers must provide it (even although the Ministers are not required to do so under section 16A) unless there are exceptional circumstances which make it inappropriate to do so.

Section 46: information sharing.

New section 17E

152. Section 46 of the Bill inserts new section 17E to the Criminal Justice Act, which provides that, where the Scottish Ministers are required by section 16 or 16A to give a victim information about an offender, they must give notice to the restricted patient’s responsible medical officer and, if the offender is subject to a compulsion order, the Tribunal.

153. Notice under subsection (1) is to request that the recipient of the notice must give the Scottish Ministers such information as they may require to fulfil their duties to give information to the victim under sections 16, 16A or 17D. The recipient of this notice must comply with the request given. If the Scottish Ministers cease to be required to give anyone information about the offender they must notify all recipients of the notice, which thereafter ceases to apply to persons in receipt of it.

Section 47: associated definitions

New section 18A

154. Section 47 inserts a new interpretation section to the Criminal Justice Act. Section 18A adds references to the 2003 Act, the Tribunal and transfer for treatment direction. It also defines
what is meant by a reference to a certificate under the Mental Health Act which suspends a person’s detention without imposing a supervision requirement, and what it means for such a certificate to be granted for the first time. The latter covers both a person who has been detained and whose detention is suspended for the first time after detention; as well a person who has been recalled to hospital following conditional discharge.

**Section 48: Power to make modifications**

**New section 18B**

155. Section 48 inserts new section 18B to the Criminal Justice Act. Section 18B gives the Scottish Ministers the power to amend sections 16A and 16B of that Act, by substituting a different age for the ages specified in those sections, section 16C by adding descriptions of information, and section 18A by adding, amending or repealing definitions of terms used in 16C.

156. Section 18B further provides that the power to amend by order includes amending section 16A so that information may be given under that section in some or all cases where a person has been made subject to a compulsion order and either, the person has not been made subject to a restriction order or the restriction order to which the person was made subject has been revoked. Section 18B also provides that section 17B may be amended to specify types of decision in respect of which representations may be made.

157. Finally, section 18B(3) gives the Scottish Ministers power to make any necessary, or expedient amendments in consequence of amendments to 16A or 17B, to sections 16C, 17E and 18A, or to the 2003 Act.

**Section 49: Amendments to the 2003 Act**

**Amendment to section 193**

158. Section 49 amends section 193 of the 2003 Act by requiring that where a victim is entitled to make representations before the Tribunal makes a decision, and no opportunity has been given to the victim to make representations, the Tribunal must have regard to any victim’s representations before making a decision about what conditions, if any to impose when directing conditional discharge under that section.

159. Section 49 further amends section 200 of the 2003 Act, by requiring the Scottish Ministers to have regard to any victims’ representations before varying any conditions with regard to a conditional discharge of a patient.

160. Section 49(4) of the Bill amends section 224 of the 2003 Act by requiring a responsible medical officer to consider victims’ representations before deciding what conditions should be included in any certificate suspending detention.

161. Section 329 is amended by section 49(5) of the Bill to include a definition of victim’s representations at the appropriate place in that interpretation section.
PART FOUR – COMMENCEMENT AND SHORT TITLE

Section 50: Commencement

162. Section 50 provides that the provisions of the Bill (except those which come into force at the beginning of the day following the day on which the Bill receives Royal Assent) will come into force on a date or dates determined by order, made by the Scottish Ministers. Such an order may include transitional, transitory or savings provisions as the Scottish Ministers consider necessary or expedient.

Section 51: Short Title

163. Section 51 gives the short title of the Bill.
MENTAL HEALTH (SCOTLAND) BILL

SUPPLEMENTARY DELEGATED POWERS MEMORANDUM

PURPOSE

1. This Memorandum has been prepared by the Scottish Government to assist the Delegated Powers and Law Reform Committee (DPLRC) in its consideration of the Mental Health (Scotland) Bill. This Memorandum describes a new provision in the Bill conferring power to make subordinate legislation which was added at Stage 2. It also describes provisions in the Bill conferring power to make subordinate legislation which were amended at Stage 2. The Memorandum supplements the Delegated Powers Memorandum on the Bill as introduced.

PROVISIONS CONFERRING POWER TO MAKE SUBORDINATE LEGISLATION INSERTED OR AMENDED AT STAGE 2

2. The delegated powers provisions in the Bill which were inserted or amended at Stage 2 are listed below, with a short explanation of what each power allows, why the power has been taken in the Bill and why the selected form of Parliamentary procedure is considered appropriate.

Section 11(4A) – Orders relating to non-state hospitals (Inserting section 271A - Process for Orders: further provision)

Power conferred on: The Scottish Ministers
Power exercisable by: Regulations made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

3. Section 11(4A) was inserted in the Bill at Stage 2. Section 12(3) which contained alternative regulation making powers was removed from the Bill at the same time. Section 11(4A) inserts new section 271A into the Mental Health (Care and Treatment) (Scotland) Act 2003. It provides that the Scottish Ministers may make regulations to (i) further define the expression “qualifying hospital” for the purpose of sections 268 – 271 of the 2003 Act; (ii) specify the test that the Mental Health Tribunal for Scotland will be required to apply for the purpose of determining an appeal against conditions of excessive security (the test for the purposes of sections 268(2), 269(3) and 271(2)(a) of the 2003 Act); (iii) make further specific provision about the test specified in (ii) above, requiring that a requirement for the test to be met is that the Tribunal is satisfied that a patient’s detention in a hospital involves the patient being subject to a level of security that is excessive in the patient’s case; (iv) make provision about when a patient’s detention in a hospital is taken to involve the patient being subject to a level of security that is excessive in the patient’s case; and (v) set out the criteria that a person preparing a supportive report for an appeal must meet, besides being a medical practitioner.
Reason for taking power

4. The regulation making power at subsection (1) reformulates the current power to make regulations at section 268(12) of the 2003 Act and allow Ministers to define this in terms of the hospital or unit of the hospital in which patients are detained. The nature of the secure estate in Scotland means that the levels of security at an individual unit or hospital could change. Framing the power in this way will allow Ministers to ensure that the legislative framework can adapt to changes in the secure estate. A power to make regulations defining “qualifying hospital” was provided by section 268(12) of the 2003 Act. While section 268(12) could have been left in place, because it is necessary to have other new regulation-making powers relating to excessive-security appeals and it is neater to keep all of the enabling powers in one place, new section 271A(1) replicates section 268(12) and the latter will be repealed.

5. The regulation making power at subsection (2) is a reformulation of the power to make regulations currently contained in section 268(14) to set out the test which should be applied by the Tribunal in addition to that already in existence on the face of the 2003 Act. This will allow the test to be specified and then also reformulated through regulations should experience of the Tribunal’s operation of the test indicate a need for it to be refined. The effect of the new power is that the Tribunal will be required to apply the test set out in the regulations made under section 271A(2) to decide whether to uphold a patient’s excessive security appeal (or, in the case of section 271, whether to reverse its earlier decision to uphold a patient’s appeal).

6. The regulation making power at subsection (3) also reformulates the powers at section 268(14) and will allow the Scottish Ministers to clarify the concept of excessive security. This provision elaborates on the test to be set by regulations under subsection (2). In particular, subsection (3) requires that whatever other factors may form part of the test, the regulations must provide that the test can only be met, in any given case, if the Tribunal is satisfied that the patient’s detention in the hospital in question involves the patient being subject to a level of security that is excessive in the patient’s case. That is the test presently specified on the face of the relevant provisions of the 2003 Act. The purpose of the power in this respect is to ensure that the core element of the test remains unaltered, while allowing flexibility for the test to be refined through subsequent regulations (by the addition of extra limbs to the test) should experience of the Tribunal’s operation of the test indicate a need for it to be refined.

7. When exercised, the test set out in regulations made using this power must include as a requirement, for the test to be met, that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is detained involves the patient being subject to a level of security that is excessive in the patient’s case.

8. The regulation making power at subsection (4) of the new section 271A confers a power on the Scottish Ministers to make regulations making further provision about when a patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case. The purpose of the power is to allow regulations to clarify the concept of excessive security, for example by saying relative to what purpose the excessiveness of security is to be judged. New section 271A(4) replicates section 268(14) of the 2003 Act; the existing power will be repealed so that it can be restated more neatly in a single regulation-making section.
9. The regulation making power at subsection (5) is not solely about excessive-security appeals from patients in hospitals other than a state hospital. The Act will give rise to a requirement for a patient making an excessive-security appeal from the state hospital (under section 264 of the 2003 Act) or another hospital (under section 268 of the 2003 Act) to have a report from a medical practitioner supporting the patient’s appeal. New section 271A(5) confers a power on the Scottish Ministers to make provision requiring that a person meet criteria besides being a medical practitioner in order to prepare a report in support of a patient’s excessive-security appeal.

Choice of procedure

10. The regulation making power at section 11(4A) will be subject to affirmative procedure. This is consistent with the existing regulation making powers under section 268 of the 2003 Act and the Scottish Government considers that this gives an appropriate level of parliamentary scrutiny to the exercise of the power.

Section 22A –Conflicts of interest to be avoided

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>The Scottish Ministers</th>
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</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Regulations made by Scottish statutory instrument</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative</td>
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</tbody>
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Provision

11. Section 22A was inserted at Stage 2 of the Bill. It provides that the Scottish Ministers may make regulations specifying circumstances when there is taken, or not taken, to be a conflict of interest in relation to medical examinations at sections 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of the 2003 Act. The existing regulations under Scottish Ministers’ current powers to make regulations about when there is taken, or not taken, to be a conflict of interest in relation to medical examinations at sections 36(1), 44(1), 47(1), or 57(2) of the 2003 Act describe a number of circumstances which are taken to constitute a a conflict of interest. This includes for example, in relation to short term detention in hospital, a situation where the approved medical practitioner is related to the patient or is employed by or contracted to provide services in or to an independent health care service in which the patient will be detained if detention is authorised. Section 22A will also allow Scottish Ministers to specify when the general requirement as to conflict of interest set out in subsection (1) will not apply. Section 22A provides that there must not be a conflict of interest in relation to a medical examination carried out for the purpose of any of the listed sections. The section also repeals the existing equivalent regulation making powers at sections 36, 44, 47 and 58 of the 2003 Act.

Reason for taking power

12. Scottish Ministers currently have powers to make regulations about when there is taken, or not taken, to be a conflict of interest in relation to medical examinations at sections 36(1), 44(1), 47(1), or 57(2) of the 2003 Act. Section 22A of the Bill replaces this power and extends it to allow regulations to be made in relation to medical examinations carried out under sections 77(2), 78(2), 139(2), 140(2) or 182(2) of the 2003 Act. It is considered appropriate that the circumstances when there is taken, or not taken, to be a conflict of interest in relation to medical examinations is set out in regulations so as to allow further consultation with stakeholders and
allow flexibility to make changes from time to time in light of experience of the operation of the regulations.

**Choice of procedure**

13. Section 22A replaces and extends the regulation making powers at sections 36, 44, 47 and 58 of the Act, which were subject to negative procedure. The regulations at section 22A will be subject to negative procedure to be consistent with the powers that this replaces in the 2003 Act. The amendment extends an existing power, it does not alter the nature of the power or what it aims to achieve. It was not considered necessary to alter the parliamentary procedure associated with the power.

**Section 25 – Dealing with absconding patients**

**Power conferred on:** The Scottish Ministers  
**Power exercisable by:** Regulations made by Scottish statutory instrument  
**Parliamentary procedure:** Affirmative

**Provision**

14. Section 25(3) of the Bill provided for Ministers to make regulations to specify how treatment under Part 16 of the 2003 Act is applied to patients who have absconded from jurisdictions outwith Scotland. The Bill has been amended at Stage 2 so that the regulations may specify how treatment under Part 16, other than medical treatment specified under sections 234 or 237 of the 2003 Act, is applied to such patients. (Currently Section 234 of the 2003 Act relates to certain surgical procedures which are for the purpose of destroying brain tissue or the functioning of brain tissue as well as other types of medical treatment specified in regulations for the purposes of the section made by the Ministers. Section 237 relates to electro-convulsive therapy and other such types of medical treatment specified in regulations for the purposes of the section).

**Reason for taking power**

15. It is considered appropriate for regulations to set out how treatment under Part 16, other than medical treatment specified under sections 234 or 237 of the 2003 Act, is applied to absconding patients to allow further consultation with stakeholders and allow flexibility to make changes from time to time in light of experience of the operation of the regulations.

**Choice of procedure**

16. Section 25(3) amends the regulation making power in section 309 which already attracts affirmative resolution procedure by virtue of section 326(4)(c). Affirmative procedure is considered appropriate as regulations made under this power will determine the nature of compulsory medical treatment given to patients who have been taken into custody under these provisions. Affirmative procedure is also considered appropriate as this is an extension to an existing regulatory power which attracts affirmative resolution procedures.
Other relevant amendments

17. The amendments described above are amendments which insert or substantially alter provisions conferring powers to make subordinate legislation. In addition, the DPLRC will wish to note that minor changes were made in relation to one other section included in the Bill’s delegated powers memorandum.

18. Section 45(2) of the Bill inserts new section 17C into the Criminal Justice (Scotland) Act 2003 and provides Scottish Ministers with a power to issue guidance setting out how representations in relation to certain aspects of the Victim Notification Scheme should be framed. At Stage 2, an amendment was made to one of the circumstances in which representations may be made (the occasion of a first grant of suspension of detention which does not impose a supervision requirement). This amendment did not however alter the power to issue guidance.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Delegated Powers Provisions</td>
<td>2</td>
</tr>
</tbody>
</table>
Delegated Powers and Law Reform Committee

The remit of the Delegated Powers and Law Reform Committee is to consider and report on—

a. any—
   i. subordinate legislation laid before the Parliament or requiring the consent of the Parliament under section 9 of the Public Bodies Act 2011;
   ii. [deleted]
   iii. pension or grants motion as described in Rule 8.11A.1; and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

b. proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

c. general questions relating to powers to make subordinate legislation;

d. whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation;

e. any failure to lay an instrument in accordance with section 28(2), 30(2) or 31 of the 2010 Act; and

f. proposed changes to the procedure to which subordinate legislation laid before the Parliament is subject.

g. any Scottish Law Commission Bill as defined in Rule 9.17A.1; and

h. any draft proposal for a Scottish Law Commission Bill as defined in that Rule.

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Scottish Labour

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Stewart Stevenson
Scottish National Party
Introduction

1. At its meeting on 16 June 2015, the Delegated Powers and Law Reform Committee considered the delegated powers provisions in the Mental Health (Scotland) Bill as amended at Stage 2 (“the Bill”)\(^i\). The Committee submits this report to the Parliament under Rule 9.7.9 of Standing Orders.

2. The Bill was introduced by the then Cabinet Secretary for Health and Wellbeing on 19 June 2014. The Bill makes provision in relation to mental health. It makes a large number of technical amendments to the Criminal Justice (Scotland) Act 1995, the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”); and the Criminal Justice (Scotland) Act 2003.

3. The Scottish Government has provided the Parliament with a supplementary memorandum on the delegated powers provisions in the Bill, in advance of Stage 3 of the Bill (“the SDPM”)\(^ii\).

4. The Committee reported on certain matters in relation to the delegated powers provisions in the Bill at Stage 1 in its 61\(^{st}\) report of 2014.

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\(^i\) Mental Health (Scotland) Bill as amended at Stage 2 available here: [http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/b53as4-stage2-amend.pdf](http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/b53as4-stage2-amend.pdf)

\(^ii\) Mental Health (Scotland) Bill as amended at Stage 2 Supplementary Delegated Powers Memorandum available here: [http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/Supplementary_Delegated_Powers_Memorandum.pdf](http://www.scottish.parliament.uk/S4_Bills/Mental%20Health%20(Scotland)%20Bill/Supplementary_Delegated_Powers_Memorandum.pdf)
Delegated Powers Provisions

5. The Committee considered each of the new, removed or substantially amended delegated powers provisions in the Bill after Stage 2.

6. After Stage 2, the Committee reports that it does not need to draw the attention of the Parliament to the substantially amended or new delegated powers provisions listed below, and that it is content with the Parliamentary procedure to which they are subject:

- Section 11(4A) – inserting section 271A into the 2003 Act – Orders relating to non-state hospitals
- Section 22A – inserting section 291A into the 2003 Act – Conflicts of interest to be avoided
- Section 25(3) – Dealing with absconding patients

7. The Committee approves these powers without further comment.
Mental Health (Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 51 Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 2A

Dr Richard Simpson

24  After section 2A, insert—

<Use of psychotropic substances

Use of psychotropic substances

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 242 (treatment not mentioned in section 234(2), 237(3) or 240(3)), there is inserted—

“242A  Scottish Ministers’ power to make provision in relation to psychotropic substances

(1) Regulations must prescribe conditions that must be satisfied before treatment by psychotropic substances may be given to a patient—

(a) who has a learning disability; and

(b) where the giving of medical treatment to the patient is authorised by virtue of this Act or the 1995 Act.

(2) For the purposes of this section, a psychotropic substance is a substance which is listed in any of Schedules 1 to IV of the Psychotropic Substances Convention.”>

Section 3

Jamie Hepburn

2  In section 3, page 3, line 34, at end insert—

<( ) after paragraph (c) there is inserted—

“(ca) if known to the managers and not falling within paragraph (a) or (b) above—

(i) any guardian of the patient; and

(ii) any welfare attorney of the patient;”>
Section 9

Jamie Hepburn

3  In section 9, page 7, line 12, leave out <(or a higher total by virtue of subsection (10) below)>

Jamie Hepburn

4  In section 9, page 7, leave out lines 14 to 16 and insert <within any period of 12 months (whenever counted from).”>

Jamie Hepburn

5  In section 9, page 7, line 25, leave out from beginning to end of line 5 on page 8

Jamie Hepburn

6  In section 9, page 8, line 7, at end insert—
   <( ) after subsection (2) there is inserted—
   “(2A) A day is to count as a whole day towards the 90 days mentioned in subsection (2) above if any part of that day falls within the period mentioned in paragraph (a) or (b) of that subsection.”>

Jamie Hepburn

7  In section 9, page 8, line 13, leave out <(or a higher total by virtue of subsection (11) below)>

Jamie Hepburn

8  In section 9, page 8, leave out lines 14 to 16 and insert <within any period of 12 months (whenever counted from).”>

Jamie Hepburn

9  In section 9, page 8, leave out lines 25 to 37

Jamie Hepburn

10 In section 9, page 8, line 38, leave out subsection (4)

Section 11

Dr Richard Simpson

25 In section 11, page 12, line 17, leave out from <and> to end of line 18

After section 11

Jamie Hepburn

11  After section 11, insert—
Section 11: exercise of powers before commencement

(1) Regulations may be made under section 271A of the Mental Health (Care and Treatment) (Scotland) Act 2003 (which is to be inserted by section 11(4A)) before section 11(4A) comes into force.

(2) In relation to regulations made (or to be made) by virtue of subsection (1), section 11(6) is to be regarded as being in force.

(3) Regulations made by virtue of subsection (1) may not come into force before the day on which section 11(4A) comes into force.

After section 11A

Dr Richard Simpson

After section 11A, insert—

Review of levels of security

(1) The Mental Welfare Commission for Scotland (“the Commission”) must carry out a review to establish the levels of security to which patients are subject where the detention in hospital of such patients is authorised by virtue of—
   (a) the Mental Health (Care and Treatment) (Scotland) Act 2003, or
   (b) the Criminal Procedure (Scotland) Act 1995.

(2) On completing the review under subsection (1), the Commission must, as soon as practicable, provide a report of the review to the Scottish Ministers which—
   (a) sets out the conclusions which it has reached,
   (b) explains why it has reached those conclusions, and
   (c) makes any recommendations as to regulations that may require to be made under section 271A(1)(b) of the Mental Health (Care and Treatment) (Scotland) Act 2003.

(3) The review under subsection (1) must be completed within 3 years of this section coming into force.

(4) The Scottish Ministers must within 1 year of receiving a report under subsection (2)—
   (a) make regulations under section 271A(1)(b) of the Mental Health (Care and Treatment) (Scotland) Act 2003 in accordance with any recommendation made by the Commission, or
   (b) where Ministers do not plan to make such regulations, publish a response to the report of the Commission setting out their reasons for not so doing.

Section 18A

Jamie Hepburn

In section 18A, page 14, line 35, at end insert—

In the definition in subsection (1) of section 329 (interpretation) of “named person”, after the words “the person” there is inserted “(if any)”.

3
Section 20A

Jamie Hepburn
13 In section 20A, page 16, line 29, leave out <or (11A)(b)>

Jamie Hepburn
14 In section 20A, page 16, line 29, after <(4),> insert <153(2)(c),>

Jamie Hepburn
15 In section 20A, page 16, line 30, leave out <218A(4),>

Jamie Hepburn
16 In section 20A, page 16, line 30, leave out <or (12A)(b)>

Jamie Hepburn
17 In section 20A, page 16, line 30, after <(12A)(b)> insert <, 225(3)>

Jamie Hepburn
18 In section 20A, page 16, line 37, after <87(2)(c)> insert <or 153(2)(c)>

Before section 21

Dr Richard Simpson
27 Before section 21, insert—

Effect of advance statements

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 276 (effect of advance statements), after subsection (8) there is inserted—

“(9) Regulations may make provision for the circumstances where—

(a) the Tribunal;

(b) a person giving medical treatment authorised by virtue of this Act or the 1995 Act;

(c) a designated medical practitioner making a decision under section 236(2)(c), 239(1)(c) or 241(1)(c) of this Act,

must comply with the wishes specified by a patient who has made and not withdrawn an advance statement.

(10) The circumstances mentioned in subsection (9) may include reference to specified medical treatment.”.

(3) In section 326 (orders, regulations and rules), in subsection (4)(c), after the words “268(11) to (14),” there is inserted “276(9),”.

896
Section 21

Jamie Hepburn
19 In section 21, page 17, line 38, leave out from beginning to <The> in line 1 on page 18 and insert—

   <(1) Where the Commission receives information by virtue of section 276A(2) of this Act, the>

Jamie Hepburn
20 In section 21, page 18, leave out lines 3 to 5

Bob Doris
28 In section 21, page 18, line 15, at end insert—

   <276D Publicising support for making advance statements>

   (1) A Health Board is to publicise any support that it offers for—

      (a) making or withdrawing an advance statement,

      (b) sending a copy of an advance statement, or a copy of a document

      withdrawing an advance statement, to a Health Board.

   (2) A Health Board must give the Commission such information as the Commission may from time to time seek on what the Health Board is doing in order to comply with subsection (1) above.”.>

After section 21

Jamie Hepburn
29 After section 21, insert—

   <Information about advocacy services>

   (1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

   (2) After section 259 there is inserted—

   “259A Information-gathering

   (1) Each of the bodies mentioned in subsection (2) below must give the Commission such information as the Commission may from time to time seek on how the body—

      (a) has, during a period of at least 2 years specified by the Commission, been exercising the functions conferred on the body by section 259 of this Act, and

      (b) intends, during a period of at least 2 years specified by the Commission, to exercise the functions conferred on the body by section 259 of this Act.

   (2) The bodies are—

      (a) a local authority,
(b) a Health Board,
(c) the State Hospitals Board for Scotland.”.>

Dr Richard Simpson

After section 21, insert—

<Access to advocacy services>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 259 (advocacy), after subsection (11) there is inserted—

“(12) Regulations may make provision for the circumstances in which providers of independent advocacy services under this Act, subject to subsection (13), must be notified of matters relating to a patient.

(13) Regulations under subsection (12) may make provision for providers of independent advocacy services to be notified of matters relating to a patient only where—

(a) there is a requirement under this Act to notify specified persons; and

(b) with the exception of the responsible medical officer (if the patient has a responsible medical officer), none of the specified persons may be notified of matters.”.>

Dr Richard Simpson

After section 21, insert—

<Access to advocacy services: further provision>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 259 (advocacy), after subsection (11) there is inserted—

“(14) Regulations may make provision for the circumstances in which providers of independent advocacy services under this Act, subject to subsection (15), must be afforded an opportunity to make—

(a) representations;

(b) applications,

on behalf of a patient.

(15) Regulations under subsection (14) may make provision for providers of independent advocacy services to be afforded an opportunity to make representations or applications on behalf of a patient only where—

(a) there is a requirement under this Act to afford specified persons an opportunity to make such representations or applications;

(b) the patient is incapable; and

(c) with the exception of the responsible medical officer (if the patient has a responsible medical officer), none of the specified persons are able to make such representations or applications on behalf of the patient.

(16) In this section “incapable” has the same meaning as in section 250(7) of this Act.”.>
Section 22A

Jamie Hepburn

21 In section 22A, page 19, line 36, after <(2)> insert <together with the word “and” immediately following it>.

After section 23

Nanette Milne

33 After section 23, insert—

<Meaning of “responsible medical officer”>

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 230 (appointment of responsible medical officer), after subsection (3) there is inserted—

“(3A) The Scottish Ministers may by regulations provide that persons other than an approved medical practitioner may be appointed or approved as a responsible medical officer under subsection (3).

(3B) Persons to be appointed or approved by virtue of regulations made under subsection (3A) may include registered psychologists.

(3C) Regulations under subsection (3A) may make such consequential provision as is necessary to give effect to provision under subsection (3A), including modifying the term “responsible medical officer”.

(3D) Before making regulations under subsection (3A), the Scottish Ministers must consult—

(a) bodies representing any persons mentioned in subsection (3A);

(b) any other person the Scottish Ministers consider appropriate.

(3) In section 326 (orders, regulations and rules), in subsection (4)(c), after the words “66(2),” there is inserted “230(3A)”.

Section 24

Nanette Milne

34 In section 24, page 21, line 3, at end insert—

<( ) for paragraph (f) of subsection (2) there is substituted—

“(f) enable an appeal against any such decision to be made by—

(i) such a patient,

(ii) the named person of such a patient,

(iii) if such a patient has no named person—

any guardian of such a patient,

any welfare attorney of such a patient,
the primary carer (if any) of such a patient,
the nearest relative of such a patient;”.

After section 27

Jackie Baillie
Supported by: Dr Richard Simpson

1 After section 27, insert—

<Review of the meaning of “mental disorder”

Review of the meaning of “mental disorder”

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 328 there is inserted—

“328A Review of meaning of “mental disorder”

(1) The Scottish Ministers must carry out a review of the definition of mental disorder no later than 3 years after the Mental Health (Scotland) Act 2015 receives Royal Assent.
(2) The purpose of the review under subsection (1) is to consider whether “learning disability” should continue to be within the meaning of “mental disorder”.
(3) In carrying out the review under subsection (1) the Scottish Ministers must consult such persons as they consider appropriate.
(4) The Scottish Ministers must—
(a) publish a report—
   (i) setting out the findings of the review under subsection (1),
   (ii) making a recommendation as to whether “learning disability” should continue to be within the meaning of “mental disorder”,
(b) lay a copy of that report before the Parliament.
(5) The Scottish Ministers must make provision by regulations for the removal of “learning disability” from the meaning of “mental disorder” where a report under subsection (4) recommends that “learning disability” should not continue to be within the meaning of “mental disorder”.”.

35 After section 27, insert—

<The Commission: statistical information

The Commission: statistical information

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 19 (statistical information)—
(a) the words “, in accordance with directions given to it by the Scottish Ministers,” are repealed,
(b) after the words “other information” there is inserted “of such kind as may be prescribed in regulations”,
(c) the existing text becomes subsection (1),
(d) after that subsection, there is inserted—
“(2) Before making regulations under subsection (1), the Scottish Ministers shall consult such persons as they consider appropriate.”.
(3) In subsection (4)(c) of section 326 (orders, regulations and rules) after the words “regulations under section” there is inserted “19(1),”.

Dr Richard Simpson

36 After section 27, insert—

<Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

(1) The Scottish Ministers must carry out a review of the arrangements for investigating the deaths of patients who, at the time of death, were—
(a) detained in hospital by virtue of—
   (i) the Mental Health (Care and Treatment) (Scotland) Act 2003;
   (ii) the Criminal Procedure (Scotland) Act 1995; or
(b) admitted voluntarily to hospital for the purpose of receiving treatment for a mental disorder.
(2) The review must be carried out within 3 years of this section coming into force.
(3) In carrying out the review under subsection (1), the Scottish Ministers must consult—
(a) where practicable, the nearest relatives of patients within the meaning of subsection (1);
(b) such other persons as they consider appropriate.
(4) The Scottish Ministers must—
(a) publish a report setting out the findings of the review under subsection (1);
(b) lay a copy of that report before the Parliament;
(c) notify those persons consulted under subsection (3) of the publication of the report.”.

Nanette Milne

37 After section 27, insert—

<Miscellaneous amendments

Extension of “relevant party” to include curators ad litem

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal)—
   (a) after paragraph (b) of subsection (5) there is inserted—
   “(ba) that person’s curator ad litem;”,
   (b) after paragraph (b) of subsection (6) there is inserted—
   “(ba) that person’s curator ad litem;”,
   (c) after paragraph (b) of subsection (8) there is inserted—
   “(ba) that person’s curator ad litem;”,
   (d) after paragraph (b) of subsection (9) there is inserted—
   “(ba) that person’s curator ad litem;”.

(3) In section 322 (appeal to the Court of Session against certain decisions of the Tribunal)—
   (a) after paragraph (b) of subsection (3) there is inserted—
   “(ba) that person’s curator ad litem;”,
   (b) after paragraph (b) of subsection (4) there is inserted—
   “(ba) that person’s curator ad litem;”.

After section 42A

Dr Richard Simpson

38* After section 42A, insert—

**Miscellaneous amendments**

**Recorded matter**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 167 (powers of Tribunal on application under section 149, 158, 161, 163 or 164) in subsections (2) to (5), after the word “measures” in each place where it occurs there is inserted “or recorded matter”.

(3) In section 168 (interim extension, etc. of order: application under section 149 or 158) in subsection (2)(b)(ii), after the word “measures” there is inserted “or any recorded matter”.

(4) In section 171 (powers of tribunal on reference under section 162) in subsection (1)(a), after the word “measures” there is inserted “or any recorded matter”.

(5) In section 175 (meaning of “modify”), after paragraph (c) there is inserted—
   “(d) specifying a recorded matter in an order”.

(6) In section 193 (powers of tribunal on reference under section 185(1), 187(2) or 189(2) or application under section 191 or 192(2)) in subsection (6)(b), after the word “measures” there is inserted “or any recorded matter”.

(7) In section 196 (general effect of orders under section 193) in subsection (1)(d), after the word “measures” there is inserted “or any recorded matter”.

(8) In section 199 (meaning of “modify”)—
   (a) in paragraph (b) the word “or” is repealed,
(b) in paragraph (c) after the words “any measure” there is inserted “; or”
(c) after paragraph (c) there is inserted—
“(d) specifying a recorded matter in an order”.

**Jamie Hepburn**

22 After section 42A, insert—

<Clarification of meaning of compulsion order>

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) For the definition in subsection (1) of section 307 (interpretation) of “compulsion order” there is substituted—

““compulsion order” means an order under section 57(2)(a) or 57A(2) of this Act;”.

(3) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(4) In subsection (6)(d) of section 1 (principles for discharging certain functions), for the words “section 57A(2)” there is substituted “section 57(2)(a) or 57A(2)”.
(5) For the definition in subsection (1) of section 329 (interpretation) of “compulsion order” there is substituted—

““compulsion order” means an order under section 57(2)(a) or 57A(2) of the 1995 Act;”.

**Dr Richard Simpson**

40* After section 42A, insert—

<Provision for referral and review of certain cases>

**Referral by Tribunal to High Court**

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 195 there is inserted—

“Reference to High Court by Tribunal

195A Tribunal’s powers to make reference to High Court

(1) This section applies where—

(a) a person—

(i) was convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or

(ii) was remitted to the High Court by the sheriff under any enactment for sentence for such an offence;

(b) the person is subject to a compulsion order and a restriction order; and

(c) a determination or order is made under this Act changing the category of the patient’s mental disorder.
(2) If the conditions in subsection (3) apply, the Tribunal may refer the matter to the High Court.

(3) Those conditions are that—
   (a) the Tribunal is satisfied that the category of the patient’s mental disorder has changed from that specified at the time at which the court made the compulsion and restriction order, as the case may be;
   (b) it appears to the Tribunal that, given the change in category, it is appropriate for the patient to be remitted to the High Court for sentence for the offence for which the person was convicted; and
   (c) the Tribunal considers that it is in the interests of justice and consistent with the principles of this Act that such a reference should be made.

(4) In determining whether a reference is in the interests of justice, the Tribunal must have regard to the need for finality and certainty in the determination of criminal proceedings.

(5) In considering whether or not to make a reference, the Tribunal may at any time refer to the High Court for the Court’s opinion on any point on which it desires the Court’s assistance; and on a reference under this subsection the High Court must consider the point referred and provide the Tribunal with its opinion on the point.

(6) A reference under subsection (2) may be made by the Tribunal under this Act—
   (a) on the Tribunal’s own initiative;
   (b) on application to the Tribunal by;
      (i) the patient;
      (ii) the responsible medical officer;
      (iii) the Commission;
      (iv) any other person mentioned in subsection (8).

(7) Before making a reference to the High Court under this section the Tribunal must—
   (a) afford the persons mentioned in subsection (8) below the opportunity—
      (i) of making representations (whether orally or in writing); and
      (ii) of leading, or producing, evidence; and
   (b) whether or not such representations are made, hold a hearing.

(8) Those persons are—
   (a) the patient;
   (b) the patient’s named person;
   (c) the patient’s primary carer;
   (d) any guardian of the patient;
   (e) any welfare attorney of the patient;
   (f) any curator ad litem appointed by the Tribunal in respect of the patient;
(g) the Scottish Ministers;
(i) the mental health officer;
(j) any other person appearing to the Tribunal to have an interest.”

(3) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(4) After section 61 there is inserted—

“Reference by the Tribunal to the High Court

61A Reference by the Tribunal to the High Court

(1) Where the Tribunal makes a reference to the High Court under section 195A of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Tribunal must—

(a) give to the Court a statement of its reasons for making the reference; and

(b) send a copy of the statement to every person who appears to them to be likely to be a party to any proceedings arising from the reference.

(2) The High Court must hear and determine the case, subject to any directions the High Court may make, as if it were an appeal under Part VIII or, as the case may be, Part X of this Act.

61B Further provision on reference

(1) The High Court may reject the reference if the Court considers that it is not in the interests of justice that any proceedings arising from the reference should proceed.

(2) In determining whether or not it is in the interests of justice that any proceedings should proceed, the High Court must have regard to the need for finality and certainty in the determination of criminal proceedings.

(3) On rejecting a reference under this section, the High Court may make such order as it consider necessary or appropriate.

61C Supplementary provision

(1) The Scottish Ministers may by regulations make such incidental, consequential, transitional or supplementary provisions as may appear to them to be necessary or expedient for the purpose of bring section 61A and 61B into operation.

(2) Regulations under subsection (1) are subject to the affirmative procedure.”.

Dr Richard Simpson

39* After section 42A, insert—

Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 63 (appeal by prosecutor in case involving insanity), there is inserted—

“Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons
63A Duty on Health Boards and Mental Welfare Commission to review certain criminal behaviour by mentally disordered persons

(1) Subsection (2) applies where a person—
   (a) is charged with a relevant offence, and
   (b) has been in receipt of care and treatment from a Health Board under the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) at any time within a period of six months prior to being charged with the relevant offence.

(2) As soon as practicable after the person is charged with a relevant offence, the procurator fiscal must, where it appears to the procurator fiscal that the person meets the condition specified in subsection (1)(b), notify—
   (a) the Health Board which provided care and treatment to the mentally disordered person under the terms of subsection (1)(b),
   (b) the Mental Welfare Commission,
that the mentally disordered person has been charged with a relevant offence.

(3) A Health Board which has been notified under subsection (2) must—
   (a) undertake an inquiry into care and treatment provided to the mentally disordered person by the Health Board,
   (b) subject to subsection (4), prepare and publish a report setting out the findings of the inquiry, and
   (c) as soon as practicable after the publication of a report under paragraph (b), prepare an action plan responding to the findings of the report.

(4) Reports under subsection (3)(b)—
   (a) must be published in such a way as not to reveal—
       (i) the identity of any natural person against whom a relevant offence has been perpetrated,
       (ii) the identity of the person charged with the relevant offence,
   (b) must be published in such manner as may be prescribed by the Scottish Ministers in regulations,
   (c) but, must not be published, unless subsection (5) applies, where either the person charged with the relevant offence or the person against whom the offence was perpetrated objects to its publication.

(5) The Scottish Ministers may by regulations make provision for the circumstances in which it may be in the public interest to publish a report under subsection (3) regardless of whether an objection to the publication of the report has been made under subsection (4)(c).

(6) As soon as practicable after the publication of a report and preparation of an action plan under subsection (3), the Health Board must provide the report and action plan to—
   (a) the Mental Welfare Commission,
   (b) any natural person against whom the relevant offence has been perpetrated, provided that the Health Board has ascertained that the person to be given the information wishes to receive it.
(7) The Mental Welfare Commission must, subject to subsection (8), and in accordance with directions given to it by the Scottish Ministers, from time to time, and not less than once in every parliamentary session, lay before the Parliament a report summarising the findings of the reports received since the laying of the last such report.

(8) Reports under subsection (7)—
   (a) must be published in such a way as not to reveal—
      (i) the identity of any natural person against whom a relevant offence has been perpetrated,
      (ii) the identity of a person charged with a relevant offence,
   (b) must be published in such manner as may be prescribed by the Scottish Ministers in regulations,
   (c) but, must not be published, unless subsection (9) applies, insofar as the report relates to a person charged with a relevant offence or the person against whom a relevant offence was perpetrated, where that person charged with a relevant offence or that person against whom an offence was perpetrated objects to its publication insofar as it relates to them.

(9) The Scottish Ministers may by regulations make provision for the circumstances in which it may be in the public interest to publish a report under subsection (8) regardless of whether an objection to the publication of the report has been made under subsection (8)(c).

(10) Subsections (11) and (12) apply where—
   (a) the Parliament is dissolved before the period of 12 months has elapsed since the commencement of the session of Parliament, and
   (b) as at the date of dissolution a report under subsection (7) has not been published.

(11) The session in which the Parliament is so dissolved is not to be regarded as a session in which a report under subsection (7) is to be published.

(12) A report under subsection (7) must be published in the session of the Parliament which—
   (a) next follows the session in which the Parliament is so dissolved, and
   (b) is not itself a session in which the Parliament is so dissolved.

(13) Health Boards must, in exercising any function under this section, have regard to any guidance issued by the Scottish Ministers.

(14) The Scottish Ministers must publish any guidance they issue for the purposes of this section.

(15) The Scottish Ministers may revise and revoke such guidance.

(16) For the purposes of this section, “relevant offence” means the committing of the offence of—
   (a) murder,
   (b) culpable homicide,
   (c) such other offence as the Scottish Ministers may by regulations prescribe.
(17) The Scottish Ministers may by regulations amend this section, so as to—

(a) incorporate within the meaning of this section persons charged with a relevant offence who have been in receipt of care and treatment under the 2003 Act from a body other than a Health Board,

(b) to require that body to be notified of the charging of that person and to be subject to the requirements of subsections (3) to (6) and (13).

(18) Regulations under this section are subject to the affirmative procedure.

Section 44

Jamie Hepburn

41 In section 44, page 32, line 18, at end insert—

<(b) are not to give a person information about the terms of a condition in accordance with section 16C(2)(fa) unless the condition is relevant to that person as described in section 18A(3).>

Jamie Hepburn

42 In section 44, page 32, line 21, leave out from <the order> to end of line 22 and insert—

<(a) the order has been revoked, and

(b) the decision to revoke it is final.>

Jamie Hepburn

43 In section 44, page 33, line 24, at end insert—

<(  ) where the order mentioned in paragraph (a) or the order mentioned in paragraph (b) of subsection (2) has been revoked, that the decision to revoke it—

(i) is being appealed against, or

(ii) cannot competently be appealed against and is therefore final.>

Jamie Hepburn

44 In section 44, page 33, in line 31 leave out from <restrictions> to <conditions> in line 32 and insert <conditions imposed on O>

Jamie Hepburn

45 In section 44, page 34, line 4, at end insert—

<(4) The following information is to be given in a case where the order mentioned in paragraph (a) or the order mentioned in paragraph (b) of subsection (2) has been revoked and that decision is appealed against—

(a) that the Court of Session has decided to allow, or not allow, the appeal against the decision to revoke the order in question,

(b) that the Court of Session’s decision—

(i) has been appealed against to the Supreme Court, or

(ii) is being appealed against by the person affected.

(5) If the Court of Session has decided that the appeal against the decision to revoke the order in question should not proceed, they shall give reasons.>

908
(ii) has not been appealed against to the Supreme Court before the expiry of the time allowed to appeal to the Supreme Court, and therefore if the Court of Session has not allowed the appeal the decision to revoke the order in question is final,

(c) that the Supreme Court has decided to allow, or not allow, the appeal against the Court of Session’s decision,

(d) if the Supreme Court’s decision means that the decision to revoke the order in question has not been set aside, that the latter decision is final,

(e) if the Court of Session’s decision or the Supreme Court’s decision means that O is once more subject to the order in question, that fact.”.>

Section 45

Jamie Hepburn

46 In section 45, page 34, line 35, leave out from <varying> to end of line 36 and insert <imposing, altering or removing a condition which is (or would be) relevant to V as described in section 18A(3).>.

Jamie Hepburn

47 In section 45, page 35, line 18, at end insert—

<(3) Subsection (4) applies where—

(a) in accordance with subsection (2), the Scottish Ministers have informed V that the Tribunal has decided to make an order revoking a compulsion order or restriction order, and

(b) by virtue of section 196 of the Mental Health Act, the Tribunal’s order does not have effect because the Court of Session has made an order under section 323(1) of that Act.

(4) The Scottish Ministers must—

(a) inform V that the Court of Session has made an order under section 323(1) of the Mental Health Act, and

(b) give V the information that they would have had to give V by virtue of section 16C(4) had the Court not made that order.”.>

Section 47

Jamie Hepburn

48 In section 47, page 36, line 29, at end insert—

<(3) For the purposes of sections 16A(3)(b) and 17B(5)(c), a condition is relevant to a person (“V”) if—

(a) the condition is a restriction on the person referred to in the section in question as O contacting an individual or being in a place, and

(b) V has made a valid request to the Scottish Ministers to be informed about any condition which restricts O from—
(i) contacting that individual, or (as the case may be)
(ii) being in that place or any wider area within which the place in question falls.

(4) The Scottish Ministers may treat a request as invalid for the purposes of subsection (3) if or so far as—

(a) it is a request to be informed about any condition which restricts O from being in a place, and

(b) the place referred to in the request—

(i) is not one which V or any member of V’s family is regularly at or in, or

(ii) covers an unreasonably large area having regard to the places where V and members of V’s family regularly go."

Section 50

Jamie Hepburn

23 In section 50, page 38, line 7, leave out <comes> and insert <and section (Section 11: exercise of powers before commencement) come>
Mental Health (Scotland) Bill

Groupings of Amendments for Stage 3

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated during Stage 3 consideration, set out in the order in which they will be debated. THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.

Groupings of amendments

Note: The time limits indicated are those set out in the timetabling motion to be considered by the Parliament before the Stage 3 proceedings begin. If that motion is agreed to, debate on the groups above each line must be concluded by the time indicated, although the amendments in those groups may still be moved formally and disposed of later in the proceedings.

Group 1: Use of psychotropic substances
24

Group 2: Safeguarding of patient’s interests
2, 12, 14, 15, 17, 18, 21, 34, 37

Group 3: Suspension of detention
3, 4, 5, 6, 7, 8, 9, 10, 13, 16

Debate to end no later than 45 minutes after proceedings begin

Group 4: Excessive security
25, 11, 26, 23

Group 5: Advance statement
27, 19, 20, 28

Group 6: Advocacy services
29, 30, 31

Debate to end no later than 1 hour 30 minutes after proceedings begin
Group 7: Meaning of “responsible medical officer”
33

Group 8: Meaning of “mental disorder”
1

Group 9: Commission: statistical information
35

Group 10: Deaths in detention
36

Debate to end no later than 2 hours 15 minutes after proceedings begin

Group 11: Recorded matter
38

Group 12: Definition of compulsion orders
22

Group 13: Referral to the High Court
40

Group 14: Review of criminal behaviour
39

Group 15: Victim notification scheme
41, 42, 43, 44, 45, 46, 47, 48

Debate to end no later than 3 hours after proceedings begin
EXTRACT FROM THE MINUTES OF PROCEEDINGS

Vol 5, No. 20 Session 4

Meeting of the Parliament

Wednesday 24 June 2015

Note: (DT) signifies a decision taken at Decision Time.

Business Motion: Joe FitzPatrick, on behalf of the Parliamentary Bureau, moved S4M-13605—That the Parliament agrees that, during stage 3 of the Mental Health (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limit indicated, that time limit being calculated from when the stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended (other than a suspension following the first division in the stage being called) or otherwise not in progress:

Groups 1 to 3: 45 minutes  
Groups 4 to 6: 1 hour 30 minutes  
Groups 7 to 10: 2 hours 15 minutes  
Groups 11 to 15: 3 hours.

The motion was agreed to.

Mental Health (Scotland) Bill - Stage 3: The Bill was considered at Stage 3.

The following amendments were agreed to (without division): 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 28, 29, 21, 34, 35, 36, 22, 41, 42, 43, 44, 45, 46, 47, 48 and 23.

The following amendments were disagreed to (by division)—

24 (For 48, Against 63, Abstentions 0)  
25 (For 52, Against 61, Abstentions 0)  
26 (For 52, Against 62, Abstentions 0)  
27 (For 52, Against 59, Abstentions 0)  
30 (For 52, Against 60, Abstentions 0)  
33 (For 52, Against 59, Abstentions 0)  
1 (For 52, Against 59, Abstentions 0)  
37 (For 45, Against 62, Abstentions 0)  
38 (For 49, Against 58, Abstentions 0)  
40 (For 49, Against 59, Abstentions 0)  
39 (For 50, Against 59, Abstentions 0).

Amendment 31 was not moved.
Mental Health (Scotland) Bill - Stage 3: The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn) moved S4M-13599—That the Parliament agrees that the Mental Health (Scotland) Bill be passed.

After debate, the motion was agreed to (DT).
Mental Health (Scotland) Bill: Stage 3

15:10

The Deputy Presiding Officer (Elaine Smith): The next item of business is stage 3 proceedings on the Mental Health (Scotland) Bill. Members should have the bill as amended at stage 2, the marshalled list of amendments and the groupings of amendments. The division bell will sound and proceedings will be suspended for five minutes for the first division of the afternoon. The voting period thereafter will be 30 seconds. Following that, I will allow a period of one minute for the first division after each debate.

After section 2A

The Deputy Presiding Officer: Group 1 is on use of psychotropic substances. Amendment 24, in the name of Dr Richard Simpson, is the only amendment in the group.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Amendment 24 follows stage 2 amendment 109, which was lodged by Adam Ingram in response to concerns that were raised with him, me and Nanette Milne. When that amendment was lodged, the National Institute for Health and Care Excellence had just published guidance reinforcing Adam Ingram’s remarks and evidence that was given to the committee by Autism Rights.

The guidance says that patients who have a learning disability, including autism spectrum disorder alone, should not, in the absence of additional serious mental illness, be given psychoactive substances as a first-line treatment. When such substances are given, they should be used only with caution and should be discontinued after six weeks if there is no improvement. I have no doubt that my professional colleagues will pay heed to that guidance.

I should have said at the outset of the debate—I will say this only once—that I am a fellow of the Royal College of Psychiatrists, so I have an interest in the subject.

Too often, there is no recording of medicines used in the treatment of associated conditions such as epilepsy, and so polypharmacy occurs. We know from evidence that has been given to the committee that numerous admissions to hospitals are associated with iatrogenic causes—that is, they are caused by the administration of inappropriate medicine. Part 5 of the Adults with Incapacity (Scotland) Act 2000 gives the added protection to a patient with impaired capacity that their carer or guardian must be consulted and treatment agreed with them, but that is not the case under the Mental Health (Care and Treatment) (Scotland) Act 2003.

At stage 2, I expressed specific concerns about patients with dementia, who we know are not having their diagnosis recorded on admission to an acute hospital in 50 per cent of cases, according to recent Scottish research relating to Scottish hospitals that was published in the British Journal of Psychiatry. I stress that those are patients who already have a diagnosis of dementia. Too often, such patients are treated with psychoactive substances, which can render them more confused and more likely to suffer falls. Although the situation in care homes has definitely improved since Mary Scanlon, I think, raised the issue in the first session of Parliament, it remains a worry.

I appreciate that the principles embodied in the Mental Health (Care and Treatment) (Scotland) Act 2003 should adequately protect patients, but the reality is that they do not. In his reply at stage 2, the minister quoted the Patient Rights (Scotland) Act 2011. That act, too, is helpful, but it is not sufficient. The minister also pointed to the valuable work that is done by the Care Inspectorate and the Mental Welfare Commission for Scotland. The work of both organisations is having an effect in care home and mental health settings, but that is not the case in acute hospitals.

Healthcare Improvement Scotland is carrying out inspections of elderly care, yet in the 950 case records that it has examined since its inspections started, only 50 per cent of patients were assessed for cognitive impairment. I believe that the time has come to regulate matters rather than rely on guidance. Of course regulations cannot interfere with clinical judgment, but we should insist on proper recording. For example, no psychoactive substance should be used unless the patient’s cognitive status has been recorded. We should ensure that the NICE guidelines are followed strictly; otherwise, we will continue to have this debate in future parliamentary sessions. Amendment 24 would tighten up this area of practice, which for too long has continued to affect too many adversely.

I move amendment 24.

15:15

Jim Hume (South Scotland) (LD): One of the most important factors for any legislation to take into account is how it affects the most vulnerable and those in most need of protection in our society—a duty that this Parliament must continue to take extremely seriously.

I support Dr Simpson’s amendment 24 on psychotropic substances. It would provide a layer of protection for those who are vulnerable to being
wrongly steered towards the provision of psychotropic substances without their full consent or acquiescence.

Although I fully understand the scientific justification for treatment by psychotropic substances, we must be fully ready to control any potential gaps in legislation that risk extending their use beyond what is necessary. The safeguard of regulations on prescribing conditions that have to be satisfied for the groups of people included in Dr Simpson’s amendment is a positive step and a fulfilment of the Parliament’s duty to protect the vulnerable while extending their rights in relation to medical treatments.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I thank Dr Simpson for speaking to his amendment. Amendments were lodged on this issue at stage 2 that would have applied specific measures around the giving of psychoactive medication.

Amendment 24 does not seek to apply specific measures; rather, it seeks to require ministers to make regulations setting out conditions that must be satisfied before treatment by psychotropic substances may be given.

I had a useful discussion with Adam Ingram, who raised the issue at stage 2, and with Dr Simpson and Dr Milne after stage 2, and I thank them for taking the time to speak to me and for their work on the issue.

Dr Simpson raised the use of psychotropic substances for those with dementia, which is relevant to the point that Jim Hume rightly made that we should always do what we can to protect the most vulnerable.

I understand that there are particular concerns around the prescribing of psychotropic drugs in care homes. Safeguards and actions are already in place in that regard, including the publication of revised polypharmacy guidance by the Scottish Government in March 2015, which reinforces the principles on the review of, and reduction in, the use of antipsychotics for people with dementia.

The guidance identifies three groups that practitioners should prioritise for review: people in care homes, those with vascular dementia, and those with dementia who have a history of cardiovascular disease, cerebrovascular disease or other vascular risk factors.

We have taken more action this year to further reduce the inappropriate prescribing of antipsychotics for dementia, focusing on three areas: initiation, review and legality. Our proposal has been approved by the national dementia group and is now being aligned with the aforementioned new polypharmacy guidance.

Moreover, as I set out at stage 2, I believe that the Mental Health (Care and Treatment) (Scotland) Act 2003 already provides strong safeguards. That includes requiring medical practitioners to have regard both to the principles set out in section 1 of the act, including those relating to patient participation and minimum restriction, and to any advance statement that a patient makes. Richard Simpson himself said that he has no reason to doubt that professionals are working to those standards.

In relation to medication-specific safeguards, the commission must be informed in writing after use of emergency detention certificates, and there is a requirement for second-opinion medication consent for those on long-term orders.

However, I understand the strongly held concerns that have been raised by some individuals and organisations on the issue and I believe that it would be appropriate for it to be covered in the review that I have said we will undertake on the inclusion of learning disability and autism under the 2003 act.

I do not, however, believe that it would be appropriate to pre-empt the outcome of that review by taking such a regulation-making power now, given that it would require Scottish ministers to make regulations prescribing matters that have yet to be reviewed. Amendment 24 says that regulations must be made, but it would not be appropriate or sensible to do so before we know the outcome of the review.

I am also concerned by the definition of “psychotropic substances”. The reference to the convention on psychotropic substances will capture the substances that are listed in the schedules at the point in time when the provision is commenced, but it does not reflect any subsequent changes to those schedules. The effect would be that newly regulated substances could not be captured by the safeguards in the regulations, while substances that were no longer listed would continue to be captured.

On the basis of those significant problems with amendment 24, and given the work that is, or will be, under way, I ask Dr Simpson not to press the amendment; should he choose to press it, I strongly urge members to vote against it.

Dr Simpson: It is certainly true that amendment 109 was a much more specific amendment: it required action, and detailed that action. That is, I think, what Adam Ingram—the member who moved that amendment—felt was appropriate, and I supported him on that.

However, following discussion with the minister, which was a welcome opportunity to review the issue, it was decided that we should not pursue that approach but instead give the minister, as a
back-up for the excellent work that he is already doing, power to bring in regulations at a point when he felt that that was necessary.

This Government has a history of not bringing forward regulations when it has not felt that they were necessary. For example, we are still waiting for regulations on the responsibility levy in the Alcohol etc (Scotland) Act 2010. The Government does not have to bring in the regulations; it can bring them in if it feels that that is appropriate.

**Jamie Hepburn:** Given that such regulations would apply very specifically to the rights of individuals, does the member accept that if we put on the face of the bill a regulation-making power that we do not use, we could be leaving ourselves open to legal challenge?

**Dr Simpson:** Exactly. That is correct—that is absolutely correct. However, what concerns me is that we have debated the issue for more than 14 years: Mary Scanlon and others raised it in the first session of Parliament, and it continues to be a concern.

Indeed, in the acute hospitals, the situation is getting worse. There are more cases now of people being given psychoactive drugs inappropriately by doctors who are not psychiatrically experienced. That is an abuse of those medicines, and the Government should take the power now, and should commence the provision only when it is needed. My amendment will give the Government the power to bring forward regulations when it believes that to be necessary, which I hope will be before legal action is taken against the Government—I would regret that.

I press amendment 24.

**The Deputy Presiding Officer:** The question is, that amendment 24 be agreed to. Are we agreed?

**Members:** No.

**The Deputy Presiding Officer:** There will be a division. I suspend the meeting for five minutes.

15:22

**Meeting suspended.**

15:27

**On resuming—**

**The Deputy Presiding Officer:** We move to the division on amendment 24.

**For**

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Mallik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
Mcculloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Miline, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

**Against**

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
The Deputy Presiding Officer: The result of the division is: For 48, Against 63, Abstentions 0.

Amendment 24 disagreed to.

Section 3—Emergency detention in hospital

The Deputy Presiding Officer: Group 2 is on safeguarding of patient’s interests. Amendment 2, in the name of the minister, is grouped with amendments 12, 14, 15, 17, 18, 21, 34 and 37. I ask the minister to speak to and to move amendment 2, and to speak to all the amendments in the group. I also ask members in the chamber to be quiet while the minister does so.

Jamie Hepburn: The Government amendments in group 2 will provide further protection for patients who do not have a named person. Amendment 2 complements amendments that were agreed at stage 2 that will allow certain listed persons to act where a patient does not have capacity and does not have a named person. It will ensure that, if a patient is detained in hospital on a 72-hour emergency detention certificate, any guardian or welfare attorney who is known to the hospital managers will be informed quickly.

Amendments 14, 15, 17 and 18 are minor amendments that will ensure consistency in the ability of guardians and welfare attorneys to obtain notification of actions and decisions under the act, where there is no named person. In particular, they will ensure that the relevant guardian or welfare attorney can be notified about a determination that will extend a compulsion order, or about the revocation of a certificate that suspends detention for patients on certain orders.

Amendment 12 is a technical drafting amendment to the definition of “named person” in the 2003 act. It is a consequence of changes to remove default named person provisions from that act, as set out in section 18 of the bill, and it will ensure that the definition reflects the new position that a person may not have a named person. Amendment 21 is a minor technical amendment that will remove a superfluous word—“and”—from section 47(2) of the 2003 act, and is a consequence of amendments that were agreed at stage 2 on preventing conflicts of interest at medical examinations.

I thank Nanette Milne for lodging amendment 34, which I am happy to support. I also thank Voices of Experience for highlighting at our meeting last month the consequences of that lack of a right to appeal. As I noted at stage 2, I agreed with Dr Milne’s policy on the matter, and I intended to ensure that the appeal right was covered by revised cross-border transfer regulations. I agree, however, that it is useful to include that measure in primary legislation and to put it beyond doubt that named persons should have the right to appeal a cross-border transfer to the tribunal. I am pleased that the amendment reflects section 20A of the bill and will ensure that the regulations provide a right of appeal where the patient does not have a named person. I therefore encourage members to support amendment 34.

I also thank Nanette Milne for lodging amendment 37 and for taking time to discuss it with me after stage 2. The amendments that I have lodged will ensure that patients who do not have the capacity to lodge an appeal will not be disadvantaged when appealing a tribunal decision. Currently, the named person and guardian or welfare attorney can make such an appeal, but once the bill is enacted that option will also be available to a carer or nearest relative, if there is no named person. If the curator is concerned about the tribunal’s decision, they will be able to advise the named person, or others, of their concerns.

I carefully considered whether there was any reason not to extend the right of appeal to the curator. Given the number of parties that can lodge an appeal, my concern is that such a
measure would be needed only where there was a disagreement between the curator and those who have a right of appeal. It is not hard to envisage a scenario in which a family member or carer and the curator disagree about whether it is in the best interests of a patient to appeal. The curator could make a valid case for appeal, but other parties might feel that that would be disruptive for the patient, or otherwise not in their interests. Currently, the decision to lodge an appeal rests with the named person or the other listed persons, such as the guardian or carer, and I am not fully convinced that we should change that balance to enable the curator to lodge an appeal against their wishes. For that reason, I ask Nanette Milne not to press amendment 37.

I move amendment 2.

**Nanette Milne (North East Scotland) (Con):** Amendment 34 relates to decisions on cross-border transfers of patients under detention in Scotland. At present, the 2003 act requires regulations to provide for a patient to appeal against such a decision, and the amendment would extend that right in statute to a patient’s named person. Where a patient does not have a named person, the amendment would allow an appeal to be made by the person’s guardian, welfare attorney, primary carer or nearest relative. As there is currently no highly secure provision for women and young people in Scotland, transfers of this nature are a common feature of our compulsory-care landscape. It is in keeping with the spirit of the bill that powers to appeal in such cases rest not only with the patient, but with other persons who may act on their behalf.

Amendment 2 will provide additional notice provisions for a detained person, and will add guardians and welfare attorneys to the list of those who are to be notified when a person is subject to emergency detention. Amendments 14, 15, 17 and 18 relate to cases in which a patient has no named person, and amendments 12 and 21 are minor technical amendments.

Amendment 37 would create a right of appeal for curators ad litem to the sheriff principal and the Court of Session regarding particular decisions of the tribunal, as set out in section 320 of the 2003 act. Currently, patients with capacity can instruct a solicitor to appeal on their behalf in those circumstances, but a patient who lacks capacity, and consequently has a curator appointed, cannot. That gap in provision could give rise to concerns under the European convention on human rights and the UN Convention on the Rights of Persons with Disabilities. When the measure was proposed at stage 2, on the suggestion of the Law Society of Scotland, the minister agreed to consider its merits. He has since expressed the view that the gap that was identified by the Law Society has been addressed through section 20A of the bill, which ensures that where there is no named person, the carer or nearest relative can appeal.

The minister has also questioned whether, in situations in which there is a disagreement between the curator and the named person or others who have the right of appeal, the curator should have the ability to overrule the named person or others and to appeal. On that point, the Law Society does not share his view that section 20A would address its concerns.

Within the tribunal system, the curator ad litem is the only person whose sole function is to act purely in the interests of the patient. Although there are many named persons, carers and relatives who absolutely have the patient’s best interests in mind, unfortunately there are also occasions on which their position will be at odds with the patient’s interests.

There are also occasions on which, as well as having no named person, the patient will have no carer or relative to appeal a tribunal decision that is not in his or her best interests. The Law Society is therefore of the view that the right of appeal could be useful in instances both where there is a named person and where there is not, which is why section 20A does not adequately fill the gap.

In response to the minister’s concern about giving the curator the power effectively to overrule the named person or other relevant party, the Law Society stresses, first of all, that that power would not be exercised lightly or, in practice, regularly. It would be exercised only in situations in which either there was no one else to appeal on the patient’s behalf, or the curator believed that the right was or was not being exercised in the patient’s best interests, which is—as I have stressed—the curator’s sole motivation.

**Jamie Hepburn:** I will direct most of my remarks at Nanette Milne’s amendment 37. My earlier comments on the rest of the group speak for themselves.

Amendment 37 would give the right of appeal to curators ad litem not only when no one else can appeal but in all cases. Section 28 of the bill means that not only will the patient, named person, guardian or welfare attorney be able to lodge an appeal but, where there is no named person, the carer or nearest relative will also be able to do so. The Government believes that that does not leave a gap for vulnerable patients. My main concern here is that, currently, the curator can recommend to the named person or others who have a right of appeal that they should lodge an appeal. However, the named person or others with the right of appeal may not think that that is in the patient’s best interests—for example, because they are concerned that it could be disruptive to
the patient. The ultimate decision to appeal would therefore lie with the named person, guardian, welfare attorney, carer or nearest relative.

The Law Society has suggested that the named person may not act in the best interests of the patient. However, it may also be the case that both parties have a different view of what the best interests of the patient are. The current balance lies with the named person and the others whom I have listed, as they have the ultimate decision. I am not convinced that we should change that to allow the curator to overrule the named person, guardian and so on. That would be quite a substantial change to current practice, which is why I do not support amendment 37.

Amendment 2 agreed to.

Section 9—Maximum suspension of particular measures

The Deputy Presiding Officer: Group 3 is on suspension of detention. Amendment 3, in the name of the minister, is grouped with amendments 4 to 10, 13 and 16.

Jamie Hepburn: The bill will make changes to the provisions in relation to suspension of detention to provide a more effective system for calculating the maximum allowable period in any 12-month period, following recommendations in the McManus report. That maximum will now be 200 days. The bill clearly sets out how periods of suspension should be counted towards that total. That will address the confusion under the current legislation when totting up individual periods of suspension.

We had also introduced provisions that were derived from McManus recommendations that would allow that total to be extended by 100 days with the agreement of the Mental Health Tribunal for Scotland. Although concerns were raised about that approach, we wanted to provide some flexibility in the very small number of cases, as identified by the report, in which variation to a community-based order might not yet be appropriate. [Interruption.]

The Deputy Presiding Officer: There is far too much conversation going on in the chamber. Can members please be quiet and give the minister some respect?

Jamie Hepburn: I appreciate that, Presiding Officer.

In relation to the provision that we set out at stage 2, I wanted to introduce the provision only if we could get it exactly right, with a solution that would be effective and workable in practice, but that has proved not to be possible. The Mental Welfare Commission and others did not feel that the additional days were needed in any case, and there was no clear and simple way to achieve our aim of flexibility.

I have reflected further on the concerns that stakeholders raised and on the important points that Richard Simpson raised at stage 2, for which I express my thanks. I propose that the provisions related to increasing the total by a further 100 days be removed—that will be achieved by amendments 3, 5, 7, 9 and 10. Amendments 4 and 8 will ensure that the maximum total of 200 days is in any 12-month period, and will do so in a way that relates appropriately to how section 8 of the bill expresses a period of suspension of detention. Amendments 13 and 16 will make changes to section 20A of the bill as a consequence of the other amendments. Amendment 6 will ensure clarity in relation to counting the total allowed period of 90 days for suspending measures other than detention.

Throughout the bill’s progress I have tried to ensure that service users’ rights and interests are protected and that the system is made more effective for them. I believe that the amendments will help to achieve that in relation to suspension of detention.

I move amendment 3.

Amendment 3 agreed to.

Amendments 4 to 10 moved—[Jamie Hepburn]—and agreed to.

Section 11—Orders relating to non-state hospitals

The Deputy Presiding Officer: Group 4 is on excessive security. Amendment 25, in the name of Dr Richard Simpson, is grouped with amendments 11, 26 and 23.

Dr Simpson: Amendment 25 is a technical amendment to extend the regulation-making power to all units or qualifying hospitals other than the state hospital. Amendment 26 would require a review of all security before further regulations are made. I moved an extensive amendment at stage 2 seeking to recognise that levels of security in mental health units, apart from provision in the state hospital, were no longer at discrete levels but almost on a continuum.

As it stands, the bill and the accompanying regulations—very helpful—provided by the Government at an early stage—refer only to the three units previously designated as medium secure, which are at Stobhill hospital in Glasgow, the Orchard clinic at the Royal Edinburgh hospital and the Murray royal hospital. However, the amendment now to be enacted is in my view only a partial response to the Supreme Court judgment that found that the Scottish Government had failed to make regulations to allow patients in secure
hospitals other than the state hospital to appeal if they consider that they are being held in conditions of excessive security. However, it must be noted that the appellant in that case had been in a low-security unit at Leverndale hospital for a decade.

Amendment 26, which would require a review to be introduced, is supported by the Scottish Association for Mental Health, the Scottish Human Rights Commission, the Law Society of Scotland, the Equality and Human Rights Commission, the Scottish Independent Advocacy Alliance, the centre for mental health and incapacity law, and Inclusion Scotland. I believe that the time has come for patients to have the right to appeal against any level of security, without the detention order being rescinded. However, the purpose of amendments 25 and 26 is to recognise that that will not be straightforward. Rather than seek to introduce a global measure immediately, amendment 26 seeks a review of all levels of security before regulations are introduced covering all levels of security. [Interruption.]

However, to make sure that we are not taken back to court because of a failure to introduce regulations, I have included a time limit provision in amendment 26 to ensure that a review is followed up.

I realise that the Mental Welfare Commission has slight doubts about the narrow nature of amendment 26 and feels that we will need to look at not simply the estates and their levels of security but the overall situation. Of course, that would be possible without further regulation, but I believe that there should be a review of what is now a continuum.

I move amendment 25.

The Deputy Presiding Officer: Can members please ensure that electronic devices are switched off or at least on silent?

15:45

Jamie Hepburn: The amendments in the group relate to appeals against being detained in conditions of excessive security in hospitals other than the state hospital. The Government’s stated policy intention has been set out in draft regulations and, as Richard Simpson alluded to, the draft timetable for the introduction of the right of appeal outwith the state hospital was provided to the Health and Sport Committee on 24 April. That demonstrates our commitment to bringing regulations into force as soon as possible after royal assent.

Amendments 11 and 23 introduce a new provision that will allow the regulation-making powers that are introduced by section 11 to be exercised in advance of the legislation being fully commenced, and ensure that the provision will come into force on the day after the bill receives royal assent. That will ensure that, as soon as possible after the bill is passed, ministers can make the regulations that are necessary for the excessive security appeal system to become operational.

That will fulfil the intention at the time of the passage of the 2003 act to enable patients who are in the state hospital and those in medium-secure units to seek a move to a lower level of security. That was the Millan recommendation. We do not seek to extend the scheme that was provided for in 2003 to persons or purposes that it was never intended to cover. However, Dr Simpson’s amendment 25 seeks to do just that by defining “qualifying hospital” as a hospital that is not a state hospital. It would give a right of appeal to all patients. However, as Dr Simpson said at stage 2, mental health professionals are not yet ready for an appeal right for patients in low-secure units. We are clear that an extension of the right of appeal to all such patients would require to be supported by a more fundamental reworking of the provisions of the 2003 act, which amendment 25 does not propose. Therefore, with respect, I am unable to support the amendment.

Dr Simpson’s amendment 26 takes a different approach. It would require the Mental Welfare Commission to carry out a review to establish the levels of security to which patients who are detained in hospital are subject. However, broadly speaking, levels of security are high, medium and low and it is already clear when patients are in high security, in the state hospital, or in the medium-secure units of the Orchard clinic in Edinburgh, Rowanbank clinic in Glasgow or the medium-secure service at Rohlallin clinic in Perth. Therefore, it is clear when a patient is detained in low-secure conditions. It is not clear what the proposed review by the commission in the terms that are proposed could achieve.

Dr Simpson is correct that the legal appeal was taken forward by a patient in the low-secure estate, but that is incidental. The Supreme Court’s ruling did not relate to that; in fact, the judgment was only on the basis that regulations had not been made. The court did not express a view on who the right of appeal should extend to. It is important to place that on the record.

Amendment 26 would also require ministers to make regulations within a set period of time to implement any recommendations that the commission makes about regulations under new section 271A(1)(a) in the 2003 act. If ministers did not do so, they would be required to report to the commission on why they had not. We understand that the intention behind the amendment is to
allow a right of appeal beyond medium secure to be introduced within a maximum of four years, if that was recommended by the commission. However, we have been clear that, if there was a wish to change the nature of the appeal so that it could sensibly be extended to all patients, that would have to be supported by a more fundamental reworking of the scheme in the 2003 act, which amendment 26 does not provide.

Patients who are in low security are subject to detention in conditions of lesser security than patients in the state hospital and those in medium security. They are more likely to be treated in hospitals that are closer to their communities and they have gradually increasing periods of time outwith the hospital ward, with up to 200 days’ suspension of detention in any 12 months, as they progress to overnight passes and finally discharge. There are no indications that being in a low-secure unit poses a barrier to rehabilitation and release into the community.

Other applications may be made under the 2003 act that would allow such patients to seek to vary or revoke their detention orders. An appeal by patients in low security is likely to be an appeal against detention and there is already a mechanism for contesting compulsory treatment.

For all those reasons, I am unable to support amendment 26.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): At the end of the consideration of the Mental Health (Care and Treatment) (Scotland) Bill in 2003, the current Cabinet Secretary for Health, Wellbeing and Sport, who was leading for the Scottish National Party on health at the time, said:

“For me, the most satisfying aspect of the bill is that it enshrines in statute the right to appeal against excessive security.”—[Official Report, 20 March 2003; c 16807.]

That gives us some context and an idea of the importance of the aspect of the bill that we are discussing.

Mary Scanlon also made her mark in those debates, because it was her amendment that ensured that regulations should be made by May 2006. As a result, because my Government and the current Government did not make such regulations, there was one of those rare occasions on which the matter ended up in the Supreme Court. That is why we have the minister's amendment 11, which contains an unusual power to allow regulations to be made before the act comes into force. That is because there is a requirement from the Supreme Court that regulations be made.

The minister says that it is irrelevant that the person who took the case to the Supreme Court was in low security, but the fact is that his appeal would not have been valid at all if the 2003 act had specifically said that it is only about those in medium security. That was never in the original act.

Richard Simpson’s amendment 26 is very modest. He is not demanding that we should decide that people in low security should have the right of appeal; he is merely saying that the Mental Welfare Commission for Scotland should do a review of levels of security that can inform regulations at a future date.

The minister talks so much about the intentions of the 2003 act, but the reality is that what drove the change then was the principle of "the least restrictive manner and environment compatible with the delivery of safe and effective care”.

That was a fundamental principle of the Mental Health (Care and Treatment) Scotland Act 2003, and it applies as much to somebody in low security as it does to somebody in medium security. There is no reference to medium security in the 2003 provisions. The provisions looked to the future because everyone said then, of course, that the estate had to be developed, so we had different levels of security. The provision talked about a "qualifying patient in the qualifying hospital”.

I note that, when the Mental Welfare Commission had a major event to consult on that, the conclusion was that qualifying hospitals should include low-secure units. As Richard Simpson said, that is the view of SAMH, the Scottish Human Rights Commission, the Law Society of Scotland, the Equality and Human Rights Commission and the Scottish Independent Advocacy Alliance—I could go on.

Amendment 26 is very modest. We are not insisting that low-security patients are given that right; we are saying that there should be an amendment that investigates the issue to make that a possibility in the regulations that will come in due course.

I have a general concern that, for the past 12 years, both Governments have dragged their feet on the issue and a concern that, even in respect of the Government's plans for medium-secure units, proposed section 271A(3)(b) of the 2003 act talks about “further requirements for the test to be met” over and above the excessive level of security, but that has passed by without an amendment.

We have an opportunity to broaden out the right of appeal in accordance with the fundamental Millan principle of "the least restrictive manner and environment compatible with the delivery of safe and effective care".
My final word to the minister is that he should be inspired by what the cabinet secretary said about that proviso in 2003.

Mary Scanlon (Highlands and Islands) (Con): Malcolm Chisholm mentioned a rare occasion. It is indeed a rare occasion when a Conservative MSP gets unanimous support across the Parliament for an amendment. That was in 2003. Uniquely, the amendment ended up in the Supreme Court.

I want to reiterate the point that Malcolm Chisholm made, as it should not be lost. The 2003 act was based on the 10 Millan principles, the eighth of which is the least restrictive alternative principle. It says:

“Service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner”.

That was the principle on which the 2003 act was based. All of us understood that.

In 2003, I spoke to the amendment and used the case of the state hospital at Carstairs, because there were 29 blocked beds at that time. There were no medium-secure units to move people on to. I gave that as an example of excessive security. Shona Robison, Nicola Sturgeon and many other members were members of the Health and Community Care Committee at that time. The understanding was that there could be excessive security in Carstairs or in the local psychiatric hospital. It was excessive security whether it was in Carstairs, a medium-secure unit, a low-secure unit or a psychiatric hospital. That is because the basic Millan least restrictive alternative principle applied.

I am very much in favour of what has been said by Richard Simpson and Malcolm Chisholm, both of whom were on the Health and Community Care Committee at that time, and Richard Simpson’s amendment 26, which we should all support. If we take one thing from the 2003 act and the many emails and issues that have been raised in the cross-party group on mental health and in the past 12 years, it should be that one fundamental principle that we unanimously agreed on, based on the Millan principles in 2003. We should all support Richard Simpson.

Dr Simpson: I have tried not to be overly prescriptive. I will look at two parts of amendment 26. Although it would require the Scottish ministers to make regulations within a year of receiving the report from the Mental Welfare Commission, there is an escape clause. If ministers did not plan to make such regulations, they could publish a response to the report setting out their reasons. It is an incredibly modest approach to something that is supported by nine organisations—I forgot to include the Royal College of Psychiatrists, which also supports the Mental Welfare Commission’s position.

We should really undertake to do this now. Not to do it is frankly an affront to those organisations and does not support the eighth Millan principle. I will be appalled if the Government uses its majority on this occasion to vote down my very modest amendment. I press amendment 25.

The Deputy Presiding Officer: The question is, that amendment 25 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hum, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Mile, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Urquhart, Jean (Highlands and Islands) (Ind)
Wilson, John (Central Scotland) (Ind)
Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eilean an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Cathness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 52, Against 61, Abstentions 0.

Amendment 25 disagreed to.

After section 11
Amendment 11 moved—[Jamie Hepburn]—and agreed to.

After section 11A
Amendment 26 moved—[Dr Richard Simpson].

The Deputy Presiding Officer: The question is, that amendment 26 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and South Ayrshire) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dundee East) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (East Renfrew) (Lab)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGregor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfries and Galloway) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)
Section 18A—Named person not to be automatic

Amendment 12 moved—[Jamie Hepburn]—and agreed to.

Section 20A—Ability to act if no named person

Amendments 13 to 18 moved—[Jamie Hepburn]—and agreed to.

Before section 21

16:00

The Deputy Presiding Officer: Group 5 is on advance statements. Amendment 27, in the name of Dr Richard Simpson, is grouped with amendments 19, 20 and 28.

Dr Simpson: At stage 2, I moved amendment 88, which attempted to ensure that the wishes that patients with full capacity express in advance statements are respected. Although I hope that the minister will support Jackie Baillie’s amendment 1, which is in group 8, amendment 27 makes another attempt to ensure that when the patient makes it absolutely clear that they do not wish to receive treatment in any circumstances whatsoever, the right to refuse treatment is respected. When patients are physically ill—even if they are going to die—they are entitled to refuse treatment, if they have full capacity. I propose that the minister should be able to determine in regulations exactly the circumstances in which the right should be fully respected.

I appreciate that, under the Mental Health (Care and Treatment) (Scotland) Act 2003, there is a requirement and indeed an obligation on the responsible medical officer and the tribunal to make clear why and in what circumstances they have chosen to overrule the patient’s advance statement. However, there are limited circumstances in which the patient has an absolute rather than a partial right. Those circumstances should be defined. For example, if the patient chooses that in no circumstances should they be treated with electroconvulsive therapy or with a specific psychotropic or psychoactive substance, and provided that that was determined only when they had full capacity and was written in an advance statement that was witnessed by someone such as their general practitioner or a psychiatrist in whom they had confidence, that choice should not be overridden.

When a physical illness exists that might be fatal, a patient with capacity is fully entitled to refuse treatment. However, the view of a patient with a mental illness who has previously stated in writing a witnessed statement that they wish to refuse treatment can be overridden. That is yet
another gap in the parity of esteem between patients with mental health issues and patients with physical issues.

Regulations are needed to ensure that, for example, when a named person or anyone such as a next of kin is conscious that the patient, notwithstanding their advance statement, has changed their mind but has not withdrawn the statement, it can still be overridden.

I look forward to the minister speaking on amendments 19 and 20. I very much welcome amendment 28, in the name of Bob Doris, as it is clear that that will move us towards achieving what we all want—greater awareness and, I hope, more use of advance statements.

I move amendment 27.

Jamie Hepburn: I thank Dr Simpson for speaking to amendment 27 and I look forward to hearing what Bob Doris has to say on his amendment 28.

I understand that Dr Simpson’s concerns relate to the capacity of patients and situations when their wishes as set out in advance statements should or must be adhered to. However, I am not clear about what circumstances it is envisaged should be set out in the proposed regulations. The current framework ensures that doctors and tribunals take account of advance statements and requires them to set out any reasons for overriding statements whenever that is the case.

A competently made advance statement is a strong indication of a patient’s wishes about medical treatment, but it should not be considered in isolation. There must be flexibility. The advance statement cannot bind the medical practitioner or member of the care team to do anything that is illegal or unethical, and nor can it bind them to provide a range of or withhold specific services, medicines or treatments.

I am aware that the Mental Welfare Commission has raised concerns that changes to the balanced approach in the current legislation could lead to dilemmas in cases where not giving treatment could result in severe harm. I recognise the positive intentions behind amendment 27, but I am concerned about the unintended consequences. We should heed the commission’s concerns.

Given that we would not intend to use the proposed regulation-making powers, and given the difficulties that can arise if we agree to a regulation-making power but do not use it, I say with respect that I cannot support amendment 27 and I ask Dr Simpson not to press it.

I thank Bob Doris for amendment 28, which I am happy to support. The Government sees advance statements as an important tool in helping service users to participate in decisions about their treatment when they are not well. We want their use to increase.

I am confident that, taken together with the other measures that the bill introduces, amendment 28 would help to increase the numbers of advance statements that are made. I am aware that, sometimes, service users are not sure about how to access support to make an advance statement. Amendment 28 would make sure that they have information about who in their treatment team, or which other medical professional, can help them with making one and what support they can expect.

Malcolm Chisholm: Can the minister do anything through regulations or guidance to promote advance statements and to get the relevant authorities, particularly health boards, to promote them as well?

Jamie Hepburn: I recognise that amendment 28 cannot be the sum total of what we do to promote advance statements, but it is an important step. I will ask the working group that is to update the code of practice to include guidance in the code that sets out best practice for how health boards could work with local authorities and other organisations in their areas to produce and promote information about the support that is available to anyone in their areas to make advance statements. That goes beyond the support that is directly available from the health board and I hope that it will be of further assistance.

I urge members to support Mr Doris’s amendment, which I have not quite bottomed out yet. Importantly, it will allow the Mental Welfare Commission to find out what support is being offered, which will help with the work that it is undertaking to promote the greater use of advance statements. That will help to address the concern that Malcolm Chisholm expressed.

The purpose of amendments 19 and 20, in my name, is simply to tidy the provisions that were amended at stage 2 on registering advance statements. They make minor technical changes that have no policy effect.

Bob Doris (Glasgow) (SNP): At stage 1, several witnesses highlighted the fact that the use of advance statements is rare. That is worrying because we all—or at least, I am sure, most of us—want our future treatment and care to be informed, or directed, by our wishes, if it is appropriate and possible to respect those wishes even after we are no longer in a position to express them. That is the drive behind the validity of advance statements, which we have to promote.

At stage 2, I proposed a detailed amendment to place duties on health boards regularly to publish
and promote information on advance statements, but I could not persuade the Scottish Government at that point. It believed that the amendment was overly prescriptive and that it would not drive the change that was required. However, I promised to go away and work on the matter further, which I have done by lodging a stage 3 amendment.

Amendment 28 would insert new provisions in section 21 of the bill, which relates to advance statements. It would insert a new section 276D in the 2003 act to impose duties on health boards to publicise support for making advance statements, but not in an overly prescriptive way. The amendment would require health boards to publicise the support that they offer for persons to make or withdraw advance statements, as well as any support that they offer for persons who wish to provide them with a copy of a statement, in accordance with proposed new section 276D(1).

Crucially, the amendment would also require health boards to provide the Mental Welfare Commission with information about what they do to comply with subsection (1) when the commission requests that they do so. The commission has a crucial role in garnering that information and driving change, which is why I have placed amendment 28 before the Parliament.

On amendment 27, I have concerns about the absolutely binding nature of advance statements. I said that the use of advance statements is rare. We have to allow for them to be revised and amended because, while people still have capacity, their will and decisions can change over time and we have no idea how attentive authorities are to having existing advance statements regularly revised and updated.

Because of those concerns, I cannot support amendment 27. I would appreciate the Parliament's support for amendment 28.

Dr Simpson: Amendments 19, 20 and 28 are welcome.

The minister said that I have not defined the circumstances that would apply to the absolute right in an advance statement. That was completely deliberate and was done with the intention of allowing the minister to define those circumstances after consulting those who feel that their wishes have previously been flouted by the tribunal. That is a rare occurrence but, nevertheless, I believe that the time has come for patients to be given the right to refuse treatment if they choose to do so.

Bob Doris talked about the fact that people's wishes might change over time. Of course, they have the right to withdraw a statement, which is entirely appropriate. However, even if they did not do so, it would be perfectly possible to say in regulations that, if they indicated to their GP, psychiatrist, named person or next of kin that their advance statement should no longer apply, that could be the case. Carefully drawn regulations would have get-out clauses.

Not to allow people who have full capacity to have an absolute right, if they define clearly their wishes about specific treatments—this is not about treatment in general—is an infringement of individuals' human rights, and the Parliament might well be challenged on that. My amendment would give the minister the power to make regulations if he wished to do so.

The Deputy Presiding Officer: The question is, that amendment 27 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffith, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Stanley, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Baxter, Jon (Glasgow) (Ind)

Division: 54 for, 54 against

The Deputy Presiding Officer: The amendment is not carried.

The question is, that amendment 28 be agreed to. Are we agreed?

Members: Yes.

The Deputy Presiding Officer: There will be a division.

For
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffith, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Stanley, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Baxter, Jon (Glasgow) (Ind)

Division: 54 for, 54 against

The Deputy Presiding Officer: The amendment is not carried.
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

**Against**
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Alian, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coaffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Carrick, Cumnock and Doon Valley) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Saimond, Alex (Aberdeen East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 52, Against 59, Abstentions 0.

Amendment 27 disagreed to.

Section 21—Advance statements to be registered

Amendments 19 and 20 moved—[Jamie Hepburn]—and agreed to.

Amendment 28 moved—[Bob Doris]—and agreed to.

After section 21

The Deputy Presiding Officer: Group 6 is on advocacy services. Amendment 29, in the name of the minister, is grouped with amendments 30 and 31.

Jamie Hepburn: Richard Simpson lodged a number of amendments at stage 2 relating to advocacy services. Following stage 2, I had some useful meetings with Richard Simpson and I thank him again for his work on these issues.

Amendment 29 relates to monitoring of advocacy provision. I committed to working with Dr Simpson on this issue at stage 3. Although Dr Simpson lodged an amendment at stage 3 on this issue, he has withdrawn it and I hope that he can support amendment 29.

Amendment 29 varies from the amendment that Dr Simpson lodged at stage 2 in the following ways. It adds the State Hospitals Board for Scotland to the list of bodies that must report to the Mental Welfare Commission on the exercise of their functions under the act. It removes the provision that set out the requirement on the commission to monitor the provision of services and report to the Scottish ministers.

16:15

The Mental Health (Care and Treatment) (Scotland) Act 2003 contains a general duty on the Mental Welfare Commission to monitor and report on the act's operation, and I do not believe that it is necessary to add a specific provision in that regard. The act allows the Mental Welfare Commission to seek information from local authorities, health boards and the state hospital at times decided by the commission, covering a period of operation of two years or more. I accept that people's experience of accessing advocacy does not always meet their expectations, and it is important that we understand that and ensure that people are able to access services and their rights. I believe that amendment 29 will help to achieve that aim.

Other amendments that Richard Simpson lodged at stage 2 would have made provision for
rights for advocates that would have gone well beyond the role that they have under the 2003 act of assisting patients in accessing their rights. The amendments would have fundamentally changed the nature of that role by giving advocates rights that they could exercise independently of the patient in order to make representations, access information and lead and produce evidence at the tribunal.

On that basis, I resisted those amendments at that time and, although amendments 30 and 31 simply allow for regulations to be made to set out the circumstances in which advocates must be informed or be allowed to make representations, I remain of the view that the role of advocates should not be extended in that way either through primary legislation or in regulations. As I have pointed out in the debates on other groups of amendments, the general position is that I cannot support the Government taking regulation-making powers when we cannot envisage the circumstances in which we would seek as a matter of policy to exercise them. On that basis, I do not support amendments 30 and 31.

I noted at stage 2 that the amendments might have been developed, at least in part, to fill a gap created by removing the default position of having a named person in cases where a person has not appointed a named person and where the person is not able to act on their own behalf. A Government amendment that was passed at stage 2 addressed that situation by setting out a limited list of people who could act in limited circumstances on behalf of a patient without a named person and unable to act on their own behalf. Indeed, some of that was covered in an earlier debate. I therefore ask Richard Simpson not to press his amendments and, should he do so, ask members not to support them.

I move amendment 29.

**Dr Simpson:** I thank the minister for meeting me on this issue and for lodging amendment 29, which I think is a welcome move and with which I fully concur. In research carried out in May 2015, the Scottish Independent Advocacy Alliance showed that only six of the 14 geographical national health service boards have current strategic advocacy plans; given that a significant proportion of those plans will be expiring soon and that only one board has said that it will be updating its plan, allowing the Mental Welfare Commission to take a much more stringent approach to this matter is a very welcome move.

The reason for lodging amendments 30 and 31, which are designed to strengthen advocacy services further, is that up to the point at which the named person default system was withdrawn and it became apparent that a person could end up without a named person or indeed any other person to act in their interest, the role of the advocate was, as the minister has said, quite circumscribed. At that time, that was entirely appropriate. However, under the new circumstances brought about by the Government amendments to the 2003 act as set out in the bill, the advocates should, as amendment 30 sets out, at least be notified by the tribunal. Reference has been made to others who would be notified in these circumstances, but my point is that, if those others do not exist, the advocate should surely be notified. Amendment 30 does not extend advocates’ powers but simply ensures that they are notified of certain things when no one else is around to be notified.

I accept that amendment 31 is a little more contentious in that it extends the role of the advocate—but only when there is no one else around to make applications or representations on behalf of the patient who, on the presumption that they have reduced capacity or seriously impaired decision-making ability, might not be able to make those representations or applications themselves. Moreover, in such circumstances, no one might be available except for the responsible medical officer, but the patient might not agree with that person making notifications or representations on their behalf. As a result, someone else should be in a position to do that, but I accept that amendment 31 might be a step too far. That said, I will be pressing amendment 30.

**Malcolm Chisholm:** This is an important part of the bill, and I very much welcome amendment 29. The lack of any provisions on advocacy in the bill as introduced was a notable omission. In fact, advocacy was one of the main issues that the Equal Opportunities Committee dealt with when it did some work on the McManus review in 2010.

As we know, the 2003 act states:

“Every person with a mental disorder shall have a right of access to independent advocacy”.

In practice, however, advocacy has often been targeted at people who are subject to compulsory proceedings. As Richard Simpson said, the recent review highlighted problems with advocacy in a large number of boards, and I welcome the fact that boards and local authorities will be accountable to the Mental Welfare Commission and that there will be more scrutiny of strategic advocacy plans. I think that all members in the chamber will be pleased about that.

Richard Simpson’s amendments 30 and 31 are interesting. I always follow the advice of the Scottish Independent Advocacy Alliance, which accepts amendment 30 with the qualification that the code of practice has to provide more detail on ensuring that advocates do not have access to information that they do not have the person’s
permission to see. Presumably, as amendment 30 provides for regulations, that point could be covered by them, so I am glad that Richard Simpson will move the amendment.

I am not sure whether Richard Simpson will move amendment 31, so I am not sure that I should say what I am going to say. There is an interesting dimension to amendment 31. Although Jamie Hepburn said that the current bill goes beyond the 2003 act, the bill that became that act originally contained a section 182(4)(b) that stated that those so affected by their mental disorder that they could not express an opinion should have an advocate. The Health and Community Care Committee objected to that provision, presumably for reasons similar to those that Jamie Hepburn has outlined today.

I could go either way on amendment 31—I will see what Richard Simpson advises.

Jamie Hepburn: I thank Richard Simpson and Malcolm Chisholm for setting out their support for amendment 29. I agree that the amendment should improve the situation.

I want to focus on the protections for patients without capacity that are now in the bill. At stage 2, I lodged amendments to remove the default named person provision from the 2003 act—a move that was widely supported—and to introduce protections for patients without capacity. Those amendments included the provision that, where there is no named person, the guardian, welfare attorney, carer or nearest relative could initiate an application or appeal to the tribunal.

Under the existing provisions in the 2003 act, a curator ad litem could be appointed to protect the patient’s legal interests where the patient does not have the capacity to instruct legal representation. The 2003 act and the bill therefore already provide strong protections for patients without capacity.

I turn to the issue of changing the role of the advocate. An independent advocate helps the patient to understand their rights and communicate their wishes and views. The advocate does not act independently of the patient, and I believe that Dr Simpson’s amendments—amendment 31 in particular—seek to give advocates such an independent role. I am not clear that that is desirable, particularly in relation to appeals, and I am not convinced that such a move has been widely consulted on. It was interesting that Malcolm Chisholm made the point that there was a provision in the 2003 bill as introduced that was later removed. I think that it was removed for good reasons that still stand today.

With regard to notifications, there are already certain circumstances in which the code of practice sets out when it would be best practice to involve the advocate—for example, before a hospital transfer. I believe that the working group should consider further best practice in that respect, and I hope that that will take care of some of the concerns raised in amendment 30, which I still oppose.

Amendment 29 agreed to.

Amendment 30 moved—[Dr Richard Simpson].

The Deputy Presiding Officer: The question is, that amendment 30 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Ferguson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Etrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Mile, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

No.
Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Donnan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (Stuart) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 52, Against 60, Abstentions 0.

Amendment 30 disagreed to.

Amendment 31 not moved.

Section 22A—Conflicts of interest to be avoided

Amendment 21 moved—[Jamie Hepburn]—and agreed to.

After section 23

The Deputy Presiding Officer: Group 7 is on the meaning of “responsible medical officer”. Amendment 33, in the name of Nanette Milne, is the only amendment in the group.

Nanette Milne: Amendment 33 seeks to provide the Scottish ministers with the flexibility to permit, by regulations, professionals who are not approved medical practitioners to perform the statutory functions of responsible medical officers under the 2003 act. It follows an appeal by the British Psychological Society for us to allow practitioner psychologists who are involved in compulsory care to perform additional statutory duties.

Currently, both the AMP and the RMO roles are the exclusive preserve of the medical profession despite the primary treatments for many mental health problems being psychological, particularly in the case of patients with learning disabilities, autistic spectrum disorders, eating disorders or personality disorders. As the clinicians who are most responsible for and have the broadest understanding of the patient’s treatment in such cases, psychologists are best placed to be able to oversee their care in that way.

Under the Mental Health Act 2007, the equivalent positions of approved clinician and responsible clinician in England and Wales can be undertaken by psychologists. As a result, we have access to a wealth of guidance, training and learning to inform how the roles could function in Scotland, so we are by no means venturing into the unknown.

When the issue was raised at stage 2, the minister stated that further consultation would have to take place before additional powers of this nature were extended to psychologists. Amendment 33 addresses that concern by allowing any processes that the minister may need to satisfy himself of the viability of the change to take place. He can then decide whether to extend the categories of eligible RMOs without further primary legislation.

The amendment extends only to the RMO position in connection with treatment. It does not change eligibility for the AMP position, the holder of which is responsible for the initial process of assessment. It is worth noting that the process was subject to extensive scrutiny in the UK Parliament during the passage of the bill that became the 2007 act, which applied equivalent measures in England and Wales.
The statutory positions require a great deal of work from the psychiatric profession, with assessments, reports and appearances at hearings. In addition to providing for the most appropriate clinician to oversee the treatment of people who are receiving psychological treatments, the amendment provides additional professional capacity to support patients who are undergoing compulsory care.

I move amendment 33.

Malcolm Chisholm: I support amendment 33. It is a modest proposal that uses the words “may by regulations”, so the minister and the Scottish Government can be assured that on this occasion there is no prospect of them ending in the Supreme Court. They may, if they wish, not introduce regulations.

I think that the amendment is a response to what the minister said at committee, which Nanette Milne alluded to, because he admitted that there was merit in considering the duties that a broader range of health professionals can undertake. The amendment seems to be the perfect way to progress the view that the minister expressed at that time. As Nanette Milne says, it applies only to the responsible medical officer, who deals not with the admissions process but with the supervision of compulsory treatment orders and advice to the Mental Health Tribunal.

I would not usually invoke English mental health legislation because, in general, the Scottish mental health legislation came before it and is better than it, but the fact is that there is a broader definition in England, with a responsible clinician and an approved clinician under the 2007 act, and there have been no problems with that. There has been post-legislative scrutiny of the legislation and no one has suggested any problems, which suggests that there is no fundamental reason why the definition should not be broadened. If we want to look to English practice, there is a body of relevant guidance, training and learning that could help us, and I do not think that we should rule that out just because it is from England.

16:30

There are other reasons for agreeing to the amendment, which Nanette Milne has suggested. One fairly practical reason that she has not mentioned is that we have a workforce supply issue with psychiatrists. Quite a lot of work is involved in the role of the RMO, and I would have thought that a lot of psychiatrists would welcome the amendment. I note that the briefing from the Royal College of Psychiatrists for today’s debate does not tell us to oppose the amendment.

However, as Nanette Milne said—I hope that the Royal College of Psychiatrists would agree—there are some conditions for which it is better that the decisions are made by psychologists. That may be the case for people with learning disabilities—we will hear more about them in a moment—and for those with autistic spectrum disorder, eating disorders, personality disorders and so on. We should remember that the primary treatments for mental health problems are sometimes psychological.

The amendment sets out a modest proposal that does not commit the minister to making a final decision today but provides a practical way of implementing the view that he himself expressed to the committee.

Dr Simpson: I apologise to Nanette Milne for my brief absence from the chamber. I support the amendment.

In his very full remarks, Malcolm Chisholm has said most of what I wanted to say. However, I add that the proposal fits with the 2020 vision of the Government. It is all about upskilling and allowing practitioners to participate more fully. The other day, I was told by a senior member of the Royal College of Psychiatrists that 42 per cent of the psychiatrists who are qualifying in the UK today by passing the foundation exams are emigrating. We are faced with a serious workforce problem in this and many other areas, and I suggest that the minister would want to take the power to make regulations upskilling psychologists so that he would not have to bring the matter back to the Parliament in seeking a further amendment to the legislation.

Jamie Hepburn: I thank Nanette Milne for lodging the amendment and I thank all those members who have engaged with me on the issue.

Psychologists play a key role, particularly in the care and treatment of persons with learning disabilities and autism spectrum disorder. I am therefore happy to commit to stating that the role played by psychologists is something that I would like to see covered in the review that I spoke about in the debate on amendment 24. I look forward to working with the British Psychological Society and other professional bodies as part of that work.

My concern with amendment 33 is that it would have the effect of extending the responsible medical officer role as a whole beyond approved medical practitioners. Nanette Milne stated that the provisions are limited and that the amendment would apply only in relation to the treatment, but that is not the case as the amendment is drafted—I am afraid that it may have been drafted more widely than was her intention. The duties of the responsible medical officer are wide ranging, beyond supervising treatment, and include assessing the need for, and authorising the
The Deputy Presiding Officer (John Scott):
The question is, that amendment 33 be agreed to. Are we agreed?

**Members:** No.

**The Deputy Presiding Officer:** There will be a division.

**For**
- Baille, Jackie (Dumbarton) (Lab)
- Baker, Claire (Mid Scotland and Fife) (Lab)
- Baxter, Jayne (Mid Scotland and Fife) (Lab)
- Beamish, Claudia (South Scotland) (Lab)
- Boyack, Sarah (Lothian) (Lab)
- Brown, Gavin (Lothian) (Con)
- Buchanan, Cameron (Lothian) (Con)
- Carlaw, Jackson (West Scotland) (Con)
- Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
- Davidson, Ruth (Glasgow) (Con)
- Fee, Mary (West Scotland) (Lab)
- Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
- Ferguson, Alex (Galloway and West Dumfries) (Con)
- Findlay, Neil (Lothian) (Lab)
- Finnie, John (Highlands and Islands) (Ind)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Goldie, Annabel (West Scotland) (Con)
- Grant, Rhoda (Highlands and Islands) (Lab)
- Griffin, Mark (Central Scotland) (Lab)
- Harvie, Patrick (Glasgow) (Green)
- Hilton, Cara (Dunfermline) (Lab)
- Hume, Jim (South Scotland) (LD)
- Johnstone, Alex (North East Scotland) (Con)
- Johnstone, Alison (Lothian) (Green)
- Kelly, James (Rutherglen) (Lab)
- Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
- Macdonald, Lewis (North East Scotland) (Lab)
- Malik, Hanzala (Glasgow) (Lab)
- Marra, Jenny (North East Scotland) (Lab)
- Martin, Paul (Glasgow Provan) (Lab)
- McArthur, Liam (Orkney Islands) (LD)
- McCulloch, Margaret (Central Scotland) (Lab)
- McDougall, Margaret (West Scotland) (Lab)
- McGrigor, Jamie (Highlands and Islands) (Con)
- McInnes, Alison (North East Scotland) (LD)
- McMahon, Michael (Uddingston and Bellshill) (Lab)
- McMahon, Siobhan (Central Scotland) (Lab)
- McNeill, Duncan (Greenock and Inverclyde) (Lab)
- McGinty, Anne (Glasgow) (Lab)
- Milne, Nanette (North East Scotland) (Con)
- Mitchell, Margaret (Central Scotland) (Con)
- Murray, Elaine (Dumfriesshire) (Lab)
- Pentland, John (Motherwell and Wishaw) (Lab)
- Rennie, Willie (Mid Scotland and Fife) (LD)
- Scanlon, Mary (Highlands and Islands) (Con)
- Scott, Tavish (Shetland Islands) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
- Smith, Drew (Glasgow) (Lab)
- Smith, Elaine (Coatbridge and Chryston) (Lab)
- Smith, Liz (Mid Scotland and Fife) (Con)
- Stewart, David (Highlands and Islands) (Lab)
- Wilson, John (Central Scotland) (Ind)

**Against**
- Adam, George (Paisley) (SNP)
- Adamson, Clare (Central Scotland) (SNP)
- Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
- Allard, Christian (North East Scotland) (SNP)
- Beatlle, Colin (Midlothian North and Musselburgh) (SNP)
- Biagi, Marco (Edinburgh Central) (SNP)
- Brodie, Chic (South Scotland) (SNP)
- Burgess, Margaret (Cunninghame South) (SNP)
- Campbell, Roderick (North East Fife) (SNP)
- Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
- Constance, Angela (Almond Valley) (SNP)
- Crawford, Bruce (Stirling) (SNP)
- Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
- Dey, Graeme (Angus South) (SNP)
- Don, Nigel (Angus North and Mearns) (SNP)
- Doris, Bob (Glasgow) (SNP)
- Dornan, James (Glasgow Cathcart) (SNP)
- Eadie, Jim (Edinburgh Southern) (SNP)
- Ewing, Annabelle (Mid Scotland and Fife) (SNP)
- Fabiani, Linda (East Kilbride) (SNP)
- FitzPatrick, Joe (Dundee City West) (SNP)
- Gibson, Kenneth (Cunninghame North) (SNP)
- Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
- Grainger, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
- Hepburn, Jamie (Gmbiemnauld and Kilsyth) (SNP)
- Hyslop, Fiona (Linlithgow) (SNP)
- Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
- Keir, Colin (Edinburgh Western) (SNP)
- Kidd, Bill (Glasgow Anniesland) (SNP)
- Lyle, Richard (Central Scotland) (SNP)
- MacAskill, Kenny (Edinburgh Eastern) (SNP)
- MacDonald, Angus (Falkirk East) (SNP)
which takes time. This revised amendment allows learning disabilities to be fully involved in the review, and him—
means that they would be too busy to carry out the discussion. He argued that civil servants would be complete. I listened very carefully to the minister—
set a time limit of one year for the review to be complete. I listened very carefully to the minister and during our subsequent very helpful discussion. He argued that civil servants would be engaged in implementing the bill and that would mean that they would be too busy to carry out the review. He also argued—and I entirely agree with him—that it is important to ensure that those with learning disabilities are fully involved in the review, which takes time. This revised amendment allows for up to three years for the review to be undertaken, which is plenty of time to ensure that it is thorough and inclusive.

I will explain to the chamber the context of this amendment. In 2001, the Millan committee supported the idea of removing learning disability from the definition of mental disorder. In 2009, the McManus review also supported the idea of removing learning disability from the definition of mental disorder as set out in the Mental Health (Care and Treatment) (Scotland) Act 2003. A review was promised.

We have therefore had two separate expert committees both recommending the same thing, and yet here we are 14 years later and still there is no review.

Let me be clear that this is not party political. The previous Labour Scottish Executive did not carry out a review. The current Scottish Government has not carried out a review. The cross-party group on learning disability has discussed this issue at length. There is huge support from members for a review. People with learning disabilities have been patient. Today is about rewarding their patience and doing the right thing.

Amendment 1 does not in any way prejudice the outcome of such a review. I recognise that there are strongly held arguments on both sides. Some passionately believe that learning disability should not be included in a definition of mental disorder. Those include Enable Scotland, Inclusion Scotland, People First (Scotland) and many more besides.

Let me set out some of their rationale. First, they believe that the inclusion of people with learning disabilities in an act that clearly has as its focus the treatment of people with mental ill health conditions has a detrimental impact.

Secondly, people with learning disabilities are not mentally ill. Unlike mental illness, learning disability is a lifelong condition that cannot be cured or alleviated by medication. It is an intellectual impairment rather than a mental disorder.

Thirdly, people with learning disabilities may require care and support and—except where a mental illness is also present—psychiatrists are unlikely to take the lead role in providing care and support for people with a learning disability.

Additionally, there is evidence that people with learning disabilities are subject to compulsory treatment as a result of their learning disability alone. People with learning disabilities account for more than 11 per cent of those in mental health institutions when they represent just 2 per cent of...
the population and their stay is longer than average. Clearly, that is not right.

On the other hand, some will argue equally passionately that the inclusion of learning disability means access to services and will point to the safeguards that are inherent in the 2003 act so that those with a learning disability are not made subject to its provisions.

Clearly there are complex arguments here, and clearly there are different views, but the desire for a review is long-standing. It transcends Governments; it transcends ministers. The amendment does not presuppose the outcome of that review but, 14 years on, it really is time that we conducted it.

I urge members to support the amendment and to listen to the views of those with learning disabilities, their families, and the organisations that support them.

I move amendment 1.

Mark McDonald (Aberdeen Donside) (SNP): I thank Jackie Baillie for her amendment and for her remarks. I looked at the stage 2 discussions, and I noted that the minister gave a commitment at that stage that a review would be undertaken. I am interested to hear from the minister about what progress there has been in relation to that.

I do not disagree with much of what Jackie Baillie has said. Indeed, in the meetings that I have had with organisations such as the National Autistic Society Scotland, there has been discussion about the views that are held regarding the inclusion of learning disability within the category of mental disorders. Jackie Baillie articulates the points on that very well. She also articulates that there are strongly held views on the other side of the equation in relation to retaining learning disability within that category.

My issue with the amendment as framed comes with subsection (5) of the proposed new section, which states that

“The Scottish Ministers must make provision by regulations”.

If we are going to have this review, have recommendations from the review and then enact the recommendations, I have a concern that provision by regulations does not perhaps allow for the fullest parliamentary scrutiny in terms of evidence taking and debate within Parliament, on something that Jackie Baillie has acknowledged has arguments on both sides and elements of contention.

The minister has given a commitment in relation to the review. Jackie Baillie has articulated the points well, but I think that making provision by regulations would not allow for the fullest debate on the matter to continue both during the review and afterwards.

I hope that Jackie Baillie will take my remarks in the spirit in which they are meant—they are not party political in any way and I agree with much of what she has said. I feel, however, that the way that the amendment is drafted does not give me comfort that we could ensure that the fullest debate was had in relation to the issue.

Malcolm Chisholm: Amendment 1 is a very modest one because it is merely calling for a review and does not pre-empt the conclusions of that review. Goodness knows we have been hearing about reviews on this issue for the whole of this century.

Bruce Millan has been referred to and I can quote him. He said:

“There should be an expert review at an early date on the position of learning disability within mental health law”.

Responding to his report in 2001, the Scottish Executive at the time said in “Renewing Mental Health Law”:

“It will be important to get the context for such a review right, and we will discuss this with the Same as You? Implementation Group and the Scottish Consortium for Learning Disabilities before bringing forward proposals.”

I regret the fact that those proposals were not brought forward. As Jackie Baillie said, this is not a party political matter. Both main parties have failed to have a review, but I think that enough years have passed for a review to be done within the next three years.

Other jurisdictions have had plenty of experience of this issue. For example, in 1992 New Zealand changed its mental health law, and from that time people with learning disabilities were excluded unless they also had a mental illness. That clearly is a position that a lot of people would accept, so it can be done.

Amendment 1 calls only for a review, and I am not quite clear how anybody can still object to that after 15 years.

16:45

Jim Hume: I support amendment 1, in the name of Jackie Baillie, which seeks to set clearer and more progressive definitions of who is to be considered as having mental health disabilities. Clearly in the 21st century we should be expected to have the expertise to distinguish different conditions through not just medical but legislative means. That is why the amendment is important: to delineate the more exact and specific medical conditions that constitute someone having a mental health disorder and better protect those who fall under that category—and those who do not.
I agree that the review must take place within the amendment’s three-year condition, or else we risk failing many people and bringing more burden on to the already stretched mental health services. Ministers must commit to review the term “mental disorder”, with professional and expert consultation, if they are serious about their mental health and human rights priorities.

I support Jackie Baillie’s amendment.

Dr Simpson: As I said at stage 2, the inclusion of learning disabilities and autism spectrum disorder in the mental health legislation was raised by a number of witnesses. As Mark McDonald said, there are contrasting views on the issue, but the weight of opinion is in favour of removing learning disability from the meaning of “mental disorder”, unless a mental illness accompanies the learning disability.

The evidence of Steve Robertson of People First (Scotland), which I quoted at stage 2, was particularly apposite. He said:

“We honestly believe that the time has come for a new piece of legislation that is just about people with learning disabilities. We think that it is only right and fair that learning disability is properly defined as an intellectual impairment rather than a mental disorder.” — [Official Report, Health and Sport Committee, 11 November 2014; c 39-40.]

Indeed, the faculty that covers this area is changing its name to include the term “intellectual disability”. Such conditions are disabilities, not mental illnesses. Although classifying them as mental disorders may have appeared to be appropriate in the past, I am not sure that it does now.

Amendment 1 does not seek to determine the outcome of a review; the important thing about it is that it says that there must be a review. The timescale of the review has been extended to three years, to allow for the bill to be implemented. The bill is fairly modest and it should not take that long to get it through.

Mark McDonald is wrong and is slightly misleading us. The amendment says that ministers must publish a report “making a recommendation as to whether ‘learning disability’ should continue to be within the meaning of ‘mental disorder’”.

It does not presume to say what its recommendation should be. It allows for discussion and for the review to be set up.

Mark McDonald: I take Dr Simpson’s point. My point was about not what the review’s conclusions would be, but how the conclusions would be enacted. Enacting them via regulations as opposed to, for example, primary legislation would reduce the opportunity for parliamentary scrutiny and debate. That was the point that I was making in my comments on the amendment, which were not about presupposing the review’s conclusions.

Dr Simpson: Of course, the Government could introduce primary legislation following the review’s conclusions if it believed that that was necessary at that point. Amendment 1 provides a mechanism that might make it simpler to remove learning disability from the meaning of “mental disorder” if there is a degree of unanimity on the issue at the time.

The other point is that, as Malcolm Chisholm said, if the issue had just come up very recently, the Government’s objections might be valid. However, it has been on the cards since the Millan committee sat. The Government has been on a journey. It began by saying no, and then it said that a review would be extremely complex—it is right, of course, because we would need to look at the Mental Health (Patients in the Community) Act 1995, the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Mental Health Act 2007. It is important that we get this right and protect people with learning disabilities.

The Government has committed to a review, and I am sure that it will do so again, so if it wishes to oppose the amendment, I invite it to provide an idea of the timetable under which that review will be established. If it does not do that, we will wonder whether we can take ministers seriously when they speak about moving this issue forward. I support Jackie Baillie’s modest amendment.

Nanette Milne: I also support the amendment. I accept that the minister has committed to a review but, as Dr Simpson said, such a review was first proposed by the Millan committee as far back as 2001, and it was recommended again by McManus in 2009. I understand the frustration that it has not yet happened. Jackie Baillie’s suggestion of a three-year gap between now and the review being carried out is reasonable. I will not say any more, but I very much support the amendment.

Jamie Hepburn: Let me say at the outset that I appreciate the work done by Richard Simpson and Jackie Baillie on this issue at stage 2, as well as the constructive meeting that followed. I recognise that a number of people and organisations have raised the issue of the inclusion of learning disabilities and autism spectrum disorders under the 2003 act. Indeed, I met representatives from People First and heard their perspective on that matter, and I understand the frustration that a review has not been undertaken thus far. For that reason I have committed to carry out a review on the inclusion of learning disability and autism spectrum disorders under that act.
I am listening to the views of those with learning disability. I put that commitment on the record in the Scottish Government’s response to the stage 1 report—that was a rather stronger response than the one given by the Scottish Executive in 2001 which Malcolm Chisholm alluded to. I repeated that commitment in the stage 2 debate, and I do so again now: the Government will undertake that review; there are no objections to that from this Administration.

Richard Simpson’s point about the Government’s seriousness of intent and how quickly we can establish that review is fair, and I intend to start the process as soon as possible. Indeed, we have already begun that, and my officials have started to discuss with partners how the review will happen. I will share information about progress on that with the Health and Sport Committee.

As Mark McDonald said, there is nothing to disagree with in the general thrust of Jackie Baillie’s amendment; the issue is finding the right way forward. I do not believe that it is sensible for the legislation to require a timescale for the completion of the review. The review must be genuinely participative and must not start with a pre-determined outcome or process. It requires a flexible approach that can adjust to the views of those who are involved.

I understand the desire for a clear timescale, not just for beginning the process but for completion, and I am clear that a review will take place and I want it to start as soon as possible. I believe that a timescale of three years from royal assent—as set out in the amendment—is reasonable, but I do not want to place an artificial time limit on that review or to prejudge where it will go. It is important that the review is participative and allows all voices an opportunity to influence the process and be heard. That should determine how long the review takes, but my clear commitment is for it to be completed as quickly as possible.

More substantially, I am concerned about proposed new subsection (5), which sets out what must be done if ministers recommend in the required report that learning disability should not continue to be within the meaning of mental disorder. It states that, in those circumstances, “The Scottish Ministers must make provision by regulations for the removal of ‘learning disability’ from the meaning of ‘mental disorder’.”

Mr McDonald set out the reasonable concern that that would not allow for a change to be made through a bill, which would allow for far more scrutiny of and engagement on such a major change.

Even more crucially, it is not clear to me that the amendment would allow for any new system to ensure support and protection for those with a learning disability, as exists in the 2003 act. There was common recognition at stage 2 of the importance of doing so, and Ms Baillie and Dr Simpson have set that out again.

The approach also seeks to require ministers to legislate, but their powers to do so are subject to parliamentary approval. While ministers could lay draft regulations before Parliament to implement the recommendations of the report, it is outwith their powers to ensure that they are made. That, rightly, is the prerogative of Parliament. The amendment would appear to be an attempt to bind Parliament to legislate in a particular way in future, just because ministers have published a report containing recommendations to that effect. I am not sure that that is what Jackie Baillie intends.

We all agree that this is an important issue and that it is important that the whole range of views are heard—those who make the case that learning disability and autism should not be included under the 2003 act and those who make the case for the benefit of the protections, safeguards and access that the legislation provides. I have committed to a review; that is my serious and determined commitment. I urge Jackie Baillie not to press amendment 1. If she does so, I urge members not to support it.

Jackie Baillie: I say to the minister that my intentions are always honourable.

We had the Millan committee in 2001; nothing happened. We had the McManus review in 2009, under this Government; nothing happened. I am not questioning the minister’s personal commitment to the issue, but to be frank—I say this to Mark McDonald, too—we have had commitments before. We have waited 14 years. Amendment 1 means that a review will happen and can never be put on the back burner.

Jamie Hepburn rose—

Jackie Baillie: Just give me a second. I would also say to the minister that I anticipate that there would be significant debate and engagement around the review. He has promised that it would be an inclusive process, and I believe him.

If the minister has a problem with the suggestion of regulation, there are opportunities open to this Parliament. It can use a super-affirmative procedure, with additional time for consultation and scrutiny. Committees of this Parliament have challenged Government in the past.

Richard Simpson is absolutely right: this Scottish Government could introduce a bill that would amend the power in proposed new subsection (5). The Government could put it in primary legislation if it chose to do so. Please let us not dance on the head of a pin, because this is
a reasonable and modest amendment. It reflects what the minister has previously said to me was his concern. I can see no sensible reason for not supporting it.

What I have heard around the chamber is agreement about the principle of what we are doing and the need for a review. I genuinely do not understand, therefore, why the minister will not have that review and put it in legislation. Amendment 1 recognises the complexity of the issue. It does not presuppose the outcome—it would not be appropriate to do so. People with learning disabilities have been more than patient. This Parliament and this Government should do the right thing and act now. I urge members to support amendment 1, which I will press.

**Jamie Hepburn rose**—

The Deputy Presiding Officer: I will take your intervention.

**Jamie Hepburn:** I was not clear that Ms Baillie was giving way to me, but would she recognise that we have in fact begun that process? We have done it because it is a serious intention.

**Jackie Baillie:** Presiding Officer, it is usually for the member to accept an intervention, but I bow to your judgment.

People have started the process before. Minister after minister has said, “We will do this.” The minister, in reflecting one of his concerns to me, said there was not time for civil servants to do it now because they would need to get on with the enactment of the bill. That has not changed; therefore, while the minister may have started the process, it is the finish of that process that people care about.

As I said before, I intend to press amendment 1 because it is the right thing to do.

The Deputy Presiding Officer: The question is, that amendment 1 be agreed to. Are we all agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

**For**

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)

**Against**

Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

**Against**

Adam, George (Paisley) (SNP)
Adamson, Clara (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Edie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Jo (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeen South and North Kincardine) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeen South) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

17:00

The Deputy Presiding Officer: The result of the division is: For 52, Against 59, Abstentions 0.

Amendment 1 disagreed to.

The Deputy Presiding Officer: Group 9 is on commission: statistical information. Amendment 35, in the name of Dr Richard Simpson, is the only amendment in the group.

Dr Simpson: At stage 2, Adam Ingram moved amendment 109, which specified a significant amount of information that would be required to be collected, collated and analysed by the Mental Welfare Commission. The minister said in response that he felt that the requirements in the amendment were far too onerous. However, amendment 35 seeks simply to require the Scottish ministers to direct in regulation as they see fit, after consultation, the nature of the information that the Mental Welfare Commission should collect and collate, and the circumstances in which it should do so.

I accept that the issue has been partly covered by the principle of the very helpful amendment 29, which indicates that the minister is prepared to allow situations in which the Mental Welfare Commission can command information from health boards, the state hospital and local authorities. However, that is in relation only to advocacy services. There can be no doubt that the current system is dysfunctional and that effective collection and analysis of data on, for example, suicides, assaults, adverse incidents and the use of restraint within the mental health system are required.

The Scottish Information Commissioner has been critical of at least one health board’s recording of significant adverse events within the mental health system. What we propose in amendment 35 is a much broader approach, but it would allow the minister and his successors to determine how much information should be collected and collated, and how that should be done.

I move amendment 35.

Jamie Hepburn: It has been useful to hear why Richard Simpson lodged amendment 25. Members will know that in its briefing for stage 3, the Mental Welfare Commission set out the extensive range of information that it publishes and noted that it would be happy to consider any requests by ministers for it to produce more statistical information. I know that the commission is keen to do more to make the statistical information that it collects useful and that it is already in discussion with the Information Services Division, NHS National Services Scotland and others about that.

Notwithstanding that, I acknowledge that there is a desire for information to be requested of the commission through regulations that have been consulted on, rather than via ministerial direction. On that basis, I am happy to accept amendment 35. However, it is important that any subsequent regulations do not cause undue or disproportionate burdens or bureaucracy. I will work to ensure that that is not the case. As I said, however, I am happy to accept Richard Simpson’s amendment 35.

Amendment 35 agreed to.

The Deputy Presiding Officer: Group 10 is on deaths in detention. Amendment 36, in the name of Dr Richard Simpson, is the only amendment in the group.

Dr Simpson: Amendment 36 covers the question of deaths in detention and would require a review of the arrangements for investigating “deaths in detention or otherwise in hospital for treatment for a mental disorder”.

The Justice Committee is currently considering the inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill, but people who are detained under mental health legislation or who are voluntarily in hospital for treatment for mental disorders might not be covered by that bill. About half the deaths of patients who die while receiving treatment might be due to natural causes, so a
blanket approach that insists on a fatal accident inquiry for every death would not be appropriate.

However, SAMH, along with the Scottish Human Rights Commission and the Mental Welfare Commission, is concerned that the current system might lead to some individuals falling through the gaps, so they are of the view that the arrangements for investigating the deaths of mental health patients need to be addressed.

Currently, the reports of the Mental Welfare Commission are mainly statistical; although they are interesting, that is not sufficient. In the most recent report, of 78 deaths there was no information for five. Once again, we are not getting from health boards the information that is absolutely necessary to understanding even the statistical progress on the issues. Of the deaths, 38 were deemed to be natural, but we have no idea whether they were premature. One of the big issues is that people with mental illness, particularly severe and enduring mental illness, die much younger. Therefore, it is important to understand their deaths, even if they are apparently from natural causes and a physical condition.

There is a need to ensure that, as happens with Healthcare Environment Inspectorate and Healthcare Improvement Scotland reports, there are transparent assurances that boards will in the future take such action as is required to improve prevention of suicide or of other deaths that may— I stress “may”—be preventable. Families want to know that any lessons that can be learned are learned. I do not believe that that happens at present. I hope that the minister will support amendment 36, as he did with amendment 35, which was very welcome.

I move amendment 36.

Jamie Hepburn: I thank Richard Simpson for his continuing work on the issue, and for the constructive meeting that we had following stage 2 to discuss it.

As I said at stage 2, I believe that improvements should be made to the way in which deaths in detention are reviewed, in order to ensure that the process is effective and timely, that it supports learning and that the reviews are of consistent quality. Members will be aware of the briefing from the Mental Welfare Commission on the issue. The commission noted that it agrees that the arrangements for investigating deaths need streamlining, so it set out a proposed approach, which includes notification of all deaths of patients who are subject to compulsion to the procurator fiscal and the Mental Welfare Commission; a review by the commission of all such deaths to determine whether more detailed investigation is required; in appropriate cases, a more formal review, building on Healthcare Improvement Scotland guidance on adverse events investigation; and a protocol between the commission and the Crown Office to ensure joint working in the context of the Lord Advocate’s responsibilities for investigation of deaths.

My officials have already started to explore with the Mental Welfare Commission how we can bring together a working group to develop a streamlined and effective approach to reviewing deaths in detention. It is important that the approach be focused on ensuring that services can learn from reviews that are carried out, and can improve so that they are more effective and safer. The approach should also ensure that relatives or carers can participate fully in the process.

I believe that the work that is under way is an effective way of dealing with the issue and I do not consider that there is a need for ministers to be compelled to undertake reviews, given that we have given an undertaking to do so. However, I do not consider that amendment 36 will have adverse consequences, so I am happy to support it.

Amendment 36 agreed to.

Amendment 37 moved—[Nanette Milne].

The Deputy Presiding Officer: The question is, that amendment 37 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Ferguuson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGregor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
After section 42A

The Deputy Presiding Officer: Group 11 is on recorded matter. Amendment 38, in the name of Dr Richard Simpson, is the only amendment in the group.

Dr Simpson: Amendment 38 was proposed by the Law Society of Scotland, with which I have had discussions. The amendment would add a new section to part 1 of the bill and ensure that recorded matters under section 64 of the Mental Health (Care and Treatment) (Scotland) Act 2003 are included in the orders that the tribunal may make when confirming the determination or varying a compulsion order in respect of a patient, interim extensions of orders under sections 149 or 158 of that act, and orders that are made under section 193 of that act. It would also amend the meaning of “modify” in relation to both relevant compulsion orders and compulsion and restriction orders under that act to include instances where recorded matters are specified.

The Law Society of Scotland has indicated the reason for the amendment. The 2003 act sets out the definition of “recorded matter”. The tribunal can specify a recorded matter when making a compulsory treatment order and when reviewing a compulsory treatment order. In essence, a recorded matter is regarded as an essential element of the patient’s care and treatment. If a recorded matter is not provided, the registered medical officer must refer the matter to the tribunal under section 96. That reflects the Millan principle of reciprocity.

Recorded matters are a means of ensuring that patients get the essential elements of the care and treatment that they require, and can be used to secure care and treatment that might not otherwise be provided, which is a significant benefit to some patients. However, recorded matters can currently be specified only in compulsory treatment cases; they cannot be specified in cases in which the patient is under a compulsion order or a compulsion order and a restriction order. The Law Society of Scotland’s view is that such patients would benefit from the inclusion of recorded matter provisions.
Compulsory treatment orders are civil orders, whereas compulsion orders and compulsion and restriction orders are criminal justice orders.

All patients should have the right to obtain the essential treatment that they require, regardless of their route into the mental health care and treatment scheme.

I move amendment 38.

**Jamie Hepburn**: I thank Richard Simpson for lodging amendment 38.

As I noted at stage 2, I am confident that the existing provisions work well for patients who are subject to compulsion orders or to compulsion orders with restriction orders. Although I am not opposed in principle to introducing recorded matters to such orders, I am not convinced that that should be done in a way that is different from how the system works for compulsory treatment orders. Amendment 38 would lead to a different mechanism for compulsion orders or compulsion orders with restriction orders. I am concerned that there could be confusion from operating two similar but different systems, and that it would add unnecessary complexity.

Amendment 38 would also omit an equivalent provision to section 96 of the 2003 act to provide for allowing the responsible medical officer to make a reference to the tribunal where a recorded matter is not being complied with. That requires the responsible medical officer to consult relevant parties, such as the mental health officer, to find out why a recorded matter is not being provided and to bring that to the attention of the tribunal. That means that the responsible medical officer will submit the original and most up-to-date care plans to the tribunal, and it allows the tribunal to take the views of the patient and others, and to make a decision whether to vary the recorded matters or other compulsory matters in the order, including on an interim basis. Amendment 38 therefore omits to extend an important part of the existing recorded matters provisions for compulsory treatment orders to the other orders, which ensures that any recorded matter that is not being provided is brought promptly to the attention of the tribunal and allows the tribunal to revise the order accordingly if needed.

On that basis, I urge Dr Simpson not to press amendment 38.

**Dr Simpson**: It is important that the approach is extended to people who are under compulsion orders and compulsion and restriction orders, and amendment 38 would do that. I heard what the minister said—he disagrees with that—but the Law Society of Scotland, which has its own experts in that regard, has looked at the matter very carefully. Therefore, I wish to press the amendment.

**The Deputy Presiding Officer (Elaine Smith)**: The question is, that amendment 38 be agreed to. Are we agreed?

**Members**: No.

**The Deputy Presiding Officer**: There will be a division.

**For**
- Baille, Jackie (Dumbarton) (Lab)
- Baker, Claire (Mid Scotland and Fife) (Lab)
- Baxter, Jayne (Mid Scotland and Fife) (Lab)
- Beamish, Claudia (South Scotland) (Lab)
- Boyack, Sarah (Lothian) (Lab)
- Brown, Gavin (Lothian) (Con)
- Carlaw, Jackson (West Scotland) (Con)
- Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
- Davidson, Ruth (Glasgow) (Con)
- Fee, Mary (West Scotland) (Lab)
- Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
- Fergusson, Alex (Galloway and West Dumfries) (Con)
- Findlay, Neil (Lothian) (Lab)
- Finnie, John (Highlands and Islands) (Ind)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Goldie, Annabel (West Scotland) (Con)
- Grant, Rhoda (Highlands and Islands) (Lab)
- Griffin, Mark (Central Scotland) (Lab)
- Harvie, Patrick (Glasgow) (Green)
- Hilton, Cara (Dunfermline) (Lab)
- Hume, Jim (South Scotland) (LD)
- Johnstone, Alex (North East Scotland) (Con)
- Johnstone, Alison (Lothian) (Green)
- Kelly, James (Rutherglen) (Lab)
- Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
- Macdonald, Lewis (North East Scotland) (Lab)
- Malik, Hanzala (Glasgow) (Lab)
- Marra, Jenny (North East Scotland) (Lab)
- Martin, Paul (Glasgow Provan) (Lab)
- McArthur, Liam (Orkney Islands) (LD)
- McCulloch, Margaret (Central Scotland) (Lab)
- McDougall, Margaret (West Scotland) (Lab)
- McGrigor, Jamie (Highlands and Islands) (Con)
- McInnes, Alison (North East Scotland) (LD)
- McMahon, Michael (Uddingston and Bellshill) (Lab)
- McNeil, Duncan (Greenock and Inverclyde) (Lab)
- McTaggart, Anne (Glasgow) (Lab)
- Milne, Nanette (North East Scotland) (Con)
- Mitchell, Margaret (Central Scotland) (Con)
- Murray, Elaine (Dumfriesshire) (Lab)
- Pentland, John (Motherwell and Wishaw) (Lab)
- Rennie, Willie (Mid Scotland and Fife) (LD)
- Scanlon, Mary (Highlands and Islands) (Con)
- Scott, John (Ayr) (Con)
- Scott, Tavish (Shetland Islands) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
- Smith, Drew (Glasgow) (Lab)
- Smith, Liz (Mid Scotland and Fife) (Con)
- Stewart, David (Highlands and Islands) (Lab)

**Against**
- Adam, George (Paisley) (SNP)
- Adamson, Clare (Central Scotland) (SNP)
- Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
- Allard, Christian (North East Scotland) (SNP)
- Beattie, Colin (Midlothian North and Musselburgh) (SNP)
- Biagi, Marco (Edinburgh Central) (SNP)
- Brodie, Chic (South Scotland) (SNP)
- Burgess, Margaret (Cunninghame South) (SNP)
- Campbell, Roderick (North East Fife) (SNP)
- Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
- Constance, Angela (Almond Valley) (SNP)
following a trial or an examination of facts in respect of a person with a mental disorder, under the Criminal Procedure (Scotland) Act 1995 are a disposal that is open to the criminal courts of provisions relating to compulsion orders, which the group.

The name of the minister, is the only amendment in the group.

Amendment 22, in the definition of compulsion orders. Amendment 22 provides for such clarification, under either section 57(2)(a) or 57A(2) of the 1995 act and the 2003 act, specifically to an order made achieving that would be to refer, in both the 1995 act and the 2003 act. The best way of recasting the definitions and provide a clear, accessible and consistent definition across the 1995 act. Although the definitions deliver a similar result, they are expressed in different terms.

It is worth recapping that a compulsion order can be made in three situations: when the person has been convicted of the offence; when the person has been acquitted of the offence on the ground of lack of criminal responsibility by reason of mental disorder; or when the person is unfit for trial and has been found at an examination of facts to have committed the acts constituting the offence.

As well as containing provisions on what a compulsion order is and what measures it can authorise, section 57A of the 1995 act makes provision allowing the court to make a compulsion order following a conviction. Section 57(2)(a) of the 1995 act makes provision allowing the court to make a compulsion order following an acquittal or an examination of facts, and subsection (4) of that section applies subsections (2) to (16) of section 57A for the purposes of an order.

It is understood in practice that orders that are made under either section 57(2)(a) or 57A(2) are covered by the current definitions. However, the user of the legislation is required to read section 57(2)(a) through the prism of the application of much of section 57A to section 57(2)(a), by virtue of section 57(4), in order to arrive at that understanding.

I hope that it is clear why we believe that it would aid users of the legislation if we were to recast the definitions and provide a clear, accessible and consistent definition across the 1995 act and the 2003 act. The best way of achieving that would be to refer, in both the 1995 act and the 2003 act, specifically to an order made under either section 57(2)(a) or 57A(2) of the 1995 act. Amendment 22 provides for such clarification, and makes a consequential change to section 1(6) of the 2003 act.

I move amendment 22.

Amendment 22 agreed to.

The Deputy Presiding Officer: Group 13 is on referrals to the High Court. Amendment 40, in the name of Dr Richard Simpson, is the only amendment in the group.

Dr Simpson: The first piece of legislation that was passed by our Parliament in 1999, and with which I was personally involved, sought to tackle connection with an offence punishable by imprisonment.

Section 329 of the 2003 act defines “compulsion order” as

“an order made under section 57A(2) of the 1995 Act”

Section 307 of the 1995 act defines it as an order having the meaning given in section 57A of the 1995 act. Although the definitions deliver a similar result, they are expressed in different terms.

The Deputy Presiding Officer: The result of the division is: For 49, Against 58, Abstentions 0.

Amendment 38 disagreed to.

17:15

The Deputy Presiding Officer: Group 12 is on definition of compulsion orders. Amendment 22, in the name of the minister, is the only amendment in the group.

Jamie Hepburn: The 2003 act contains a range of provisions relating to compulsion orders, which are a disposal that is open to the criminal courts under the Criminal Procedure (Scotland) Act 1995 in respect of a person with a mental disorder, following a trial or an examination of facts in
the situation arising from an appeal made by Noel Ruddle under the European convention on human rights against his detention in the state hospital following serious offences.

The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 introduced the serious harm test, under which patients who were convicted on indictment or complaint and subject to special restrictions by the court could be subject to indefinite hospital detention if a mental disorder was present and they were considered to pose a risk of serious harm to the public, irrespective of the appropriateness of the order or the treatability of the subject.

The provisions in the 1999 act were subsequently extended in the Mental Health (Care and Treatment) (Scotland) Act 2003 to apply to all restricted patients in Scotland, who numbered about 250. Because of those provisions, a small number of patients have become stuck in the forensic mental health system. They have been reclassified, in terms of diagnosis, as having no diagnosis, as being personality disordered or as having a learning disability.

The minister had two arguments against a similar amendment—amendment 113—that I lodged at stage 2. His first argument was that the 2003 act covered personality disorder—of course, that is correct—and that in some way the forensic psychiatrists who backed my amendment were seeking to change that. However, that view is quite wrong. They are not seeking to change the incorporation of personality disorder into the 2003 act. That would indeed be a fundamental change, but that is not the intention of amendment 40, nor will it, as drafted, deliver such a change.

The minister’s second argument was that an amendment to the Criminal Procedure (Scotland) Act 1995 to extend the time period for an interim compulsion order from six months to 12 months ensures that a full and rigorous assessment of the offender’s mental disorder is undertaken before the final disposal is made. I concur.

However, the minister went on to say:

“It is very unlikely that an offender would be misdiagnosed in those circumstances, making it much less likely”—

not unlikely—

“now that a patient would receive a hospital disposal from the court that would create the scenario that Dr Simpson describes.”—[Official Report, Health and Sport Committee, 26 May 2015; c 28.]

Again, the minister is correct—the numbers will be small. Most psychoses, if severe and enduring, will be evident within a year. However, for every patient who at the time of the offence had an acute psychosis due to, for example, drug or alcohol misuse that did not resolve until the year had expired, and the disposal was then found to be inappropriate because the diagnosis might be one of personality disorder or learning disability only, the nature of which would be better managed in a prison, without the amendment, we would continue to confine patients unnecessarily—and, in the context of austerity, very expensively—in a mental hospital rather than a prison.

Can that happen? Yes it can. The appeal mechanism is cumbersome, and scarce resource was employed in the case of Alexander Reid. In his case, the court of criminal appeal recognised that the change of diagnostic category could be considered as new evidence, and it allowed a fresh disposal. That allowed him to transfer to prison, which is what he wanted. However, the process for raising his appeal took several years.

There is an alternative approach to the problem that is raised by cases such as that of Noel Ruddle. There should be a mechanism by which the appropriateness of the sentence can be reconsidered for the—admittedly—very small number of patients whose diagnostic category has changed and whose detention in a psychiatric hospital is consequently inappropriate.

Not to act would mean continued substantial excess cost, which I am told amounts to £200,000 a year per patient, as well as inappropriate detention, against which patients would seek redress in the same manner as Mr Reid successfully did.

The whole approach in Scotland to personality disordered offenders was considered by a working group on services for people with personality disorder, chaired by Professor Thomson, which reported as long ago as 2005. The report recommended that the Scottish Government consider whether a mechanism should be created to refer such cases to the Scottish Criminal Cases Review Commission for consideration.

That view was rearticulated in 2011, when the forensic network gave evidence to the commission on women offenders, chaired by the Rt Hon Dame Elish Angiolini. Amendment 40 revises my stage 2 amendment 113 to make the group to whom that mechanism would apply more clear—that is, it would apply only to those with a compulsion order and a restriction order.

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That view was rearticulated in 2011, when the forensic network gave evidence to the commission on women offenders, chaired by the Rt Hon Dame Elish Angiolini. Amendment 40 revises my stage 2 amendment 113 to make the group to whom that mechanism would apply more clear—that is, it would apply only to those with a compulsion order and a restriction order.
Simpson now proposes that the provisions should apply only to patients subject to both a compulsion order and a restriction order, whereas the stage 2 version would also have applied to patients subject to only a compulsion order.

I resisted that proposal at stage 2, and remain of the view, notwithstanding the narrowing of the provision to apply to a smaller patient subset, that this is a major issue and, given the implications for the criminal justice system, not one that we can sensibly consider without thorough consultation, particularly in light of the potential additional risks to the public.

Let me run through the reasons for my view in more detail. The amendment proposes new powers for the tribunal and the courts that would revisit the original sentencing and disposal decision. It also opens up what can be complex competing clinical opinions about diagnosis.

I understand that the approach is designed to address concerns among some psychiatrists that patients who are diagnosed—or, indeed, misdiagnosed—as having a mental illness or learning disability and who are made the subject of a compulsion order and a restriction order on that basis may later be diagnosed as having a personality disorder only. Had the court had full medical evidence based on that diagnosis, the result may have been a prison sentence rather than a mental health disposal. However, once the patient is in the hospital system, they cannot be released because they continue to satisfy the test for a compulsion order and a restriction order, due to the risk of serious harm that they pose.

The proposal would result in a significant shift in how mentally disordered persons are dealt with by the criminal justice system and, indeed, by the health service after conviction. The position in the 2003 act is that many patients who meet the conditions for a mental health disposal and require to be detained may most appropriately be detained in hospital rather than in prison.

As Dr Simpson mentioned, an amendment to the Criminal Procedure (Scotland) Act 1995 extended the time period for an interim compulsion order from six months to 12 months to ensure that a full and rigorous assessment of an offender’s mental disorder is undertaken before the final disposal is made. In those circumstances, it is very unlikely that an offender would be misdiagnosed, so it is now much less likely that a patient would receive a hospital disposal from the court that would create the scenario that Dr Simpson seeks to address.

All patients who are subject to compulsion orders and restriction orders have the right to apply to the tribunal and to ask for the orders to be reviewed periodically. In addition, there is already a means for patients to have their cases considered on appeal. The same appeal route is used for offenders who receive a prison sentence but argue that they should have received a hospital disposal.

As I said at stage 2, the amendment is well intentioned. However, it concerns a major issue and has significant implications for the criminal justice system. We should not consider it without thorough consultation.

I urge Dr Simpson not to press his amendment; if he does, I strongly urge members not to vote for it.

Dr Simpson: The amendment says: “The Tribunal may refer the matter to the High Court.”

There is no compulsion on the tribunal to do so, but that means that it would consider the matter. That is an appropriate locus for an appeal against the previous diagnosis to be argued out, with experts appearing before the tribunal.

The minister says on the one hand that amendment 40 would be a major change to criminal procedure and, on the other hand, that it is very unlikely that the scenario would arise because of the change to the 1995 act. Those two points seem to be quite illogical—in fact, they are completely opposed to each other—so I fail to see why he opposes my proposed measure, which would simplify matters and could reduce costs in relation to the small number of patients concerned. I am told that it might apply to no more than half a dozen patients. Even if that is the case, £1.2 million is still being spent inappropriately on detaining people in the state hospital when they would be better managed in the prison system.

The faculty of forensic psychiatry and the Scottish Prison Service have had extensive discussions since the 2005 report. Both sides believe that offenders with personality disorder, absent another severe and enduring mental illness, should be managed in the prison system. The patients concerned believe that as well, but they have no easy mechanism to follow that up at the moment. The amendment would provide that mechanism. It has been carefully thought out and, therefore, should be agreed to, saving us money and improving the situation for that limited number of patients.

I press amendment 40.

The Deputy Presiding Officer: The question is, that amendment 40 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.
The Deputy Presiding Officer: The result of the division is: For 49, Against 59, Abstentions 0. Amendment 40 disagreed to.

17:30

The Deputy Presiding Officer: Group 14 is on review of criminal behaviour. Amendment 39, in the name of Richard Simpson, is the only amendment in the group.

Dr Simpson: Out of the 137 homicides committed by those with mental illness in the past 10 years in Scotland, only two appear to have been the subject of published reports by the Mental Welfare Commission, and few seem to have been the subject of adverse incident reviews by health boards. In England, over the same period, there were 576 homicides, 321 of which were the subject of reviews. Those English reviews suggest that 25 to 35 per cent of homicides could have been prevented if different actions had been taken.
It is important that we recognise and put on record the fact that cases of murder, culpable homicide or, indeed, violence by persons who are suffering from a mental illness are rare. However, the intention of amendment 39 is to amend the Criminal Procedure (Scotland) Act 1995 in order to provide in primary legislation clarity, consistency and accountability with regard to reviewing, reporting and taking appropriate action, where lessons can be learned, with regard to an offence as specified in proposed new section 63A(16) of the 1995 act that involves a person with a mental illness who is known to mental health services. The provision would apply to “murder ... culpable homicide” and “such other offence as the Scottish Ministers may by regulations prescribe.”

The amendment has three purposes: to ensure that we learn lessons so that in future, those with mental health problems can, as far as possible, be protected and prevented from committing such offences; to assure the families of the victims, and the victims, if they survive, that all that can be done to prevent a recurrence will be done; and to ensure that the public can have confidence in the NHS.

At present, we have a dysfunctional system of reporting and review. It involves decisions by multiple organisations—if, that is, they choose to act. Elements of the process include the procurator fiscal, the UK confidential inquiry reports into homicide and suicide, health boards and the Mental Welfare Commission. The commission can act if it believes that there is a deficiency of care, but how can it know that if the case has not been reported to it? Other organisations that might or might not have a role include Health Improvement Scotland and, indeed, the Health and Safety Executive. The minister can also order a review.

The issue was brought to my attention because of concerns that were expressed by the Hundred Families organisation, which draws together information and provides mutual support for families who are affected by such offences. My purpose in moving the amendment is to ensure that, under proposed new sections 63A(2)(a) and 63A(2)(b), the procurator fiscal informs the health board and the Mental Welfare Commission if a person with a mental health problem is charged.

At stage 2, the minister expressed concerns in relation to individuals who might be found not guilty or found to be incapable of pleading. However, the experience of Hundred Families is that, in almost every case, there is no attempt to hide, and the offence is almost always admitted. As members will see, my amendment, which I have adjusted to take account of the minister’s concerns, says that the perpetrator has the opportunity to give permission and, if that permission is not given, the minister should proceed only if they feel that it is in the public interest to do so.

The proposal is not about guilt or innocence—that is a matter for the justice system—but about learning lessons and preventing future incidents. If a person with a severe mental illness is involved in an incident and is known to mental health services, usually from contact within the past six months, the health board would be obliged to make inquiries under proposed new sections 63A(3)(a), 63A(3)(b) and 63A(3)(c); it would also be obliged to prepare and publish a report and an action plan.

The minister also expressed a concern that the confidentiality of the patient would be infringed. I have addressed that by ensuring that, unless the person consents or publication is in the public interest, which is the alternative course of action, the patient’s name should be redacted. The same restriction applies to mental welfare reports, which I believe should be placed before Parliament in a collation of health board reports. Those affected by these rare offences have a right to know that all that can be done will be done to prevent a recurrence.

I am aware of two further concerns about my proposal, the first of which relates to the length of time mental health services should have been involved to require them to conduct an inquiry. Instead of having a fixed time limit—or indeed no time limit—I have in the amendment, if it is agreed to, allowed the minister to determine the matter in regulations. Secondly, there is a concern that a review by the board would cut across the justice process. I believe that that is nonsense, because this is not about whether the offence was committed or what legal action was appropriate but about a review of the care and treatment of the person charged.

Finally, although I very much welcome the ongoing discussions between the Mental Welfare Commission, Health Improvement Scotland and the health boards, will the outcome of their discussions be enshrined in primary legislation or regulations? It will not. For more than a decade, we have had a permissive system that has not been good, and enough time has passed for the law to be made clear.

I move amendment 39.

**Jamie Hepburn:** I thank Richard Simpson for his continuing work on the issue. Indeed, I know that he has been working closely with victims organisations in particular.
Although amendment 39 is similar to one that Dr Simpson lodged at stage 2, I note that he has sought to address in it some of the problems in the previous amendment. Notably, he has addressed concerns relating to confidentiality and has restricted the scope of the provisions to people who have been treated in the six months before being charged with an offence.

However, I still have fundamental concerns about a review being triggered upon a person being charged with an offence prior to any conviction. I am concerned that that would cut across the prosecution system, the independence of which is guaranteed by the Scotland Act 1998, and the requirement for a fair trial. I cannot accept investigations that run parallel to what the fiscal and the police are doing, especially if they involve the publication of findings that could interfere with that process. I do not believe that that is a nonsense—it is a serious concern.

I agree that a more streamlined process is needed to ensure that lessons are learned and shared across the system and to provide comfort and reassurance to families in these tragic cases. Members will be aware of the briefing covering the issue that the Mental Welfare Commission has produced for this stage of our consideration of the bill.

Under section 11 of the 2003 act, the commission already has a power to investigate cases of deficiency of care and, under that power, has from time to time investigated homicides by patients. The commission has proposed that, working with Healthcare Improvement Scotland, it should build on existing systems to ensure that all cases are reviewed appropriately. In doing so, it would consult key stakeholders such as the faculty of forensic psychiatry of the Royal College of Psychiatrists and, of course, Hundred Families. The commission has noted that it will be able to share an outline proposal with interested parties in the summer.

In light of the work that is already under way and my significant concerns about amendment 39, I urge Dr Simpson not to press it.

Dr Simpson: On the point about the triggering of a review on a person being charged cutting across the justice process, it is perfectly possible for the review to be undertaken and the report to be put together but for the report itself not to be published until the fiscal or the court determines the outcome. If the process is undertaken privately, it will not lead to the process being interfered with or to court cases proceeding in the way that concerns have been raised about. On that basis, I reject the minister’s concerns about the matter.

I welcome the fact that the minister is proceeding with discussions with the various interested bodies to sort out a system that everyone, including the Mental Welfare Commission, accepts is dysfunctional, but I simply do not believe that we have regulators in Scotland with sufficient teeth to ensure that all cases are properly investigated. There is no great evidence to suggest that that has occurred under the current permissive system. Without regulation—which, of course, the minister will determine, subject to the Parliament’s approval—I am not confident that, even with the best will in the world and new protocols being determined, we will not be sitting here in five or six years’ time, debating exactly the same topic in exactly the same way.

I press amendment 39.

The Deputy Presiding Officer: The question is, that amendment 39 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Ferguson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGirgrim, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gi (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)

White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 50, Against 59, Abstentions 0.

Amendment 39 disagreed to.

Section 44—Right to information: compulsion order

The Deputy Presiding Officer: Group 15 is on a victim notification scheme. Amendment 41, in the name of the minister, is grouped with amendments 42 to 48.

Jamie Hepburn: The amendments are all to part 3 of the bill, which introduces a statutory notification and representation scheme for victims of offenders who are mentally disordered and as a result subject to certain orders. The intention is to develop a scheme that resembles as closely as possible the scheme that is available to victims under the Criminal Justice (Scotland) Act 2003.

Amendments 42, 43, 45 and 47 make provision for providing information to victims when a tribunal has made a decision to revoke a patient’s restriction order but the decision is successfully appealed and overturned.

Victims can choose to join the victim notification scheme. A victim can also opt into the victim representation scheme to make representations to the Mental Health Tribunal. To opt into the representation scheme, the victim must also opt into the notification scheme. If a victim has opted into the notification scheme but not the representation scheme, he or she will receive a notification only when the restricted patient’s position changes and that change is covered by the scheme.

Matters are, however, complicated by the possibility of an appeal against the tribunal’s revocation of a compulsion order or restriction order. They are further complicated by the fact that, under section 323 of the Mental Health (Care and Treatment) (Scotland) Act 2003, the court can make an order to render the tribunal’s decision to revoke the order ineffectual until an appeal against it has been finally determined. The amendments provide for a range of scenarios in those circumstances.

When a victim has chosen not to join the representation scheme, and the tribunal’s decision is appealed and the court makes an order under section 323 to suspend the decision of the tribunal pending determination of the appeal, the victim will be notified only if and when the order is revoked. That will happen once the appeal process is complete and the outcome is that the order is revoked. That is on the basis that there has not been a material change to the patient’s position.
and that the compulsion order or restriction order remains in place until the order is revoked at the end of the appeal process.

When a victim has chosen not to join the representation scheme, and the tribunal's decision is appealed but the court does not make a section 323 order to suspend the decision pending the determination of the appeal, the victim will be notified and kept informed of the appeal's progress. That is on the basis that there has been a material change to the patient's position—that is, that the restriction order or compulsion order has been revoked.

When a victim has chosen to join the representation scheme, the bill provides that the victim will be told of the outcome of the tribunal's decision. If that decision is appealed, the victim will get information that the decision has been appealed and information on the progress and outcome of that appeal, whether or not the court makes a section 323 order.

The bill provides for ministers to give a victim an opportunity to make representations about varying conditions that are imposed on a patient in a way that may affect the victim or members of the victim's family. Amendments 41, 44, 46 and 48 are intended to ensure that the provisions are workable in practice.

At stage 2, I lodged an amendment on the sort of information that may be provided to a victim about a patient, which covered conditions that restrict the things that the patient may do after his or her conditional discharge. I indicated that, in practice, that will commonly involve restrictions on where the patient can go and persons with whom the patient may have contact.

Having considered further how that would work in practice, I recognise that there could be circumstances in which the officials operating the scheme might not know which conditions could affect the victim or a member of the victim's family. If ministers failed to seek the victim's representations in those circumstances, they would unwittingly be in breach of their statutory duty. The amendments take account of that but still ensure the rights of victims to make representations on specific conditions.

I move amendment 41.

Amendment 41 agreed to.

Amendments 42 to 45 moved—[Jamie Hepburn]—and agreed to.

Section 47—Associated definitions
Amendment 48 moved—[Jamie Hepburn]—and agreed to.

Section 50—Commencement
Amendment 23 moved—[Jamie Hepburn]—and agreed to.

The Deputy Presiding Officer: That ends consideration of amendments.
The Mental Health (Scotland) Bill

The Deputy Presiding Officer (Elaine Smith): The next item of business is a debate on motion S4M-13599, in the name of Jamie Hepburn, on the Mental Health (Scotland) Bill. I ask members who are leaving the chamber to do so quickly and quietly.

17:45

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): The Mental Health (Scotland) Bill’s overarching objective is to help people with a mental disorder to access effective treatment quickly and easily. It does so by improving the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedure (Scotland) Act 1995, which provide fundamental protections and safeguards to people with a mental disorder. The bill also introduces a victim notification scheme for victims of mentally disordered offenders in a way that respects the rights of both victims and vulnerable offenders.

I am grateful for the detailed and thorough scrutiny that the Health and Sport Committee gave the bill at stages 1 and 2, which has helped to ensure that we get it right and continue to maximise the protections and safeguards. The bill has been significantly improved during its parliamentary passage as a result, and I thank the committee members, as well as members who are not on the committee but have engaged with the process, for the work that they have done.

I will take a few moments to set out key aspects of the bill. The 2003 act brought in important protections including advance statements, which help to involve patients in decision making about their treatment by allowing service users to state how they would like to be treated if they become unwell. The bill strengthens the position of advance statements, gives service users greater confidence that their wishes will be taken into account in their treatment and ensures that the Mental Welfare Commission for Scotland has a better picture of the use of advance statements.

I am pleased that the Parliament supported Bob Doris’s amendment 28, which will help service users to access support in taking up the opportunity to make a statement. We want advance statements to be used far more widely, and that was a common theme in the committee’s scrutiny of the bill. Taking those provisions together, the bill should increase the use of advance statements and, through that, help more service users to have greater involvement in decisions about their treatment when they are unwell.

Many service users have found the role of the named person, which the 2003 act introduced, to be an important protection, as it gives someone they know a role to act independently to protect their interests. However, I listened to the significant concerns about the fact that service users do not always want a named person, particularly as that person will see confidential information about the patient’s medical treatment.

The bill means that a service user will have a named person only if they want one. That is an important step in promoting service users’ rights. Through stage 2 amendments, we ensured that protections are in place for vulnerable service users who do not have the capacity to decide whether to appeal an order or certificate, while ensuring that that does not impact on their privacy or autonomy.

The bill fulfils the intention behind introducing the excessive security appeal provisions in the 2003 act and the Millan recommendations by extending the right of appeal against being detained in conditions of excessive security to those who are detained in medium-secure units. The intention was to give patients in high-secure units and medium-secure units a right to appeal against detention in conditions of excessive security. We now need to ensure that the scheme that was provided for in 2003 can operate effectively in the present secure estate. Amendments that we debated today will ensure that we do that by extending the right to patients in medium-secure units as quickly as possible. I look forward to discussing that further when the committee and the Parliament consider draft regulations after the recess.

Those are just some of the key changes through the bill that will make the 2003 act work more effectively and enhance the experience of, and protections for, service users.

There has been widespread support for the introduction of the victim notification scheme for victims of mentally disordered offenders. The intention is that the scheme will respect the rights of both victims and vulnerable offenders and will closely resemble the scheme that is already available to victims under the Criminal Justice (Scotland) Act 2003. The scheme will be of huge benefit to victims who were not previously covered by the criminal justice scheme and it will provide them with greater reassurance when offenders begin the process of discharge from treatment.

We have also recognised that mentally disordered offenders may be vulnerable—that perspective was expressed by the committee during its consideration of the bill at its earlier stages—and we have taken that into account. I am grateful to the victims’ rights working group, which included representatives of Victim Support and
Hundred Families, for its assistance in getting the balance right.

The bill amends the Mental Health (Care and Treatment) (Scotland) Act 2003, and I am aware that some members would have liked wider issues to be included. The bill is not a full stop at the end of a process, and I am happy to put on record my commitment to certain further steps. I have heard the concerns that a number of people and organisations have raised about the inclusion of learning disability and autism spectrum disorders under the definition in the 2003 act. I thank Jackie Baillie and Richard Simpson for the discussions that we have had on that. We have also debated the issue extensively at stage 3.

The 2003 act provides people with learning disabilities and autism spectrum disorders with protections, safeguards and—importantly—access to care and treatment, and it is essential that, in anything that we seek to do, we ensure that those protections continue. I have committed to reviewing the inclusion of learning disability and autism under the definition of mental disorder in the 2003 act. It is important that that review is genuinely participative and is commenced with an open mind about the outcome and process. As I set out earlier, we have started to discuss with stakeholders how we can undertake that engagement. I hope that the review further demonstrates our serious intent.

A number of committee members also raised issues about the role that psychologists play under the 2003 act, following consideration of the issue by the British Psychological Society, which I thank for its positive engagement. I also thank Dr Milne for raising the issue again today. It is important that we debate such issues. I have made the point before—I make it again—that I am sympathetic to the proposal in Dr Milne’s amendment 33 but that I was not convinced by the provisions in the amendment. It is important that we have widespread consultation on the matter and, as I said, I am committed to looking at the issue alongside the wider review of learning disabilities and autism spectrum disorders. That is a serious commitment.

Amendments were lodged at stages 2 and 3 on the investigation of the deaths of patients who were in hospital for the treatment of mental illness and on the reporting of homicides by those who are being treated for a mental health condition. Although I did not believe that a legislative approach was appropriate, I was happy to accept amendment 36 at stage 3. Further work is necessary, and my officials have already started to explore with the Mental Welfare Commission how we can bring together a working group to develop a streamlined and effective approach to reviewing deaths in detention.

In relation to the reporting of homicides by those who are being treated for a mental health condition, the Mental Welfare Commission will work with Healthcare Improvement Scotland and the Government to produce proposals that build on current practice, to ensure that all cases are reviewed appropriately. In doing that, they will consult key stakeholders such as the forensic division of the Royal College of Psychiatrists and organisations such as Hundred Families.

I will ensure that the Health and Sport Committee is informed of developments on both those issues, and I will always be happy to consider the committee’s perspective in any work that we undertake.

The bill is part of the wider work that the Government is undertaking to improve mental health services, including funding. I announced in May this year an additional £85 million for mental health over five years, beyond the £15 million over three years that was announced in November 2014 for the mental health innovation fund. That is £100 million in total.

We will work with NHS Scotland and its partners to get the maximum benefit from the investment. We will focus on further improvement to child and adolescent mental health services to bring down waiting times; improved access to services and in particular psychological therapies; and better responses to mental health issues in community and primary care settings, including promoting wellbeing through physical activity and, crucially, improved patient rights. I will be happy to keep Parliament up to date with progress on those matters.

The bill further enhances the ability of people with a mental disorder to access effective treatment quickly and easily, while maintaining and enhancing protections and safeguards.

I move,

That the Parliament agrees that the Mental Health (Scotland) Bill be passed.

17:55

Jenny Marra (North East Scotland) (Lab): I welcome the final stage of the Mental Health (Scotland) Bill. I thank the members who moved amendments this afternoon and who put all that work into considering the detail of the bill—specifically the minister and my colleagues Richard Simpson and Jackie Baillie.

We recognise that the bill is an important step in tackling one of the greatest public health challenges of our time. We can reflect today on the progress that we have made as a country in removing the stigma attributed to mental health problems and addressing the complex and varied
need for support that the many people who are affected have. In acknowledging the rise in awareness of mental health problems and the growing confidence that people now have in coming forward to access help, we also recognise that we still have much to do to ensure that a proper preventative agenda is in place and that we support people to overcome or better manage mental health issues.

The bill brings to an end a long and often technical process, which implements much of the comprehensive and detailed work of Professor Jim McManus and his review team on how we help people to access quick and effective treatment for mental health issues. The amount of work—which builds on Bruce Millan’s review of some years ago—that has gone into the bill and the level of engagement on the detail from outside groups prove what a serious and important issue this is for our Parliament and Scotland.

I think that every member in the chamber shares my experience of dealing with a vast amount of constituency casework on mental health issues, access to mental health services and the effect of mental health issues on our communities and on families—every family in Scotland, I think.

I commend the Government for the early approach that it took to the passage of the bill by listening and responding to concerns that were raised at stage 1. I believe that we have improved the bill, which will be passed today with our support. However, there are areas in which we could have gone further, particularly on the definition of mental disorder and on patients’ rights.

As we know, the Millan review in 2001 recommended that there should be an expert review at an early date of the position of learning disability within mental health law. That was echoed by the McManus review, which said in 2009 that it was time that a review was done. That is supported by a number of groups, including Inclusion Scotland and Enable Scotland. Inclusion Scotland said:

“We believe that evidence presented to the Health and Sport Committee raises serious questions on whether the safeguards in the 2003 Act, particularly on the role of Mental Health Officers and the right to advocacy, are working as intended, and on whether mental health legislation is compatible with ... ECHR.

Inclusion Scotland therefore believes that the time is right for a more comprehensive review of mental health legislation in Scotland to ensure compliance with human rights obligations and to provide specific legislation to meet the needs of people with learning disabilities or Autistic Spectrum Disorders.”

Enable pointed out that “14 years after a review was first recommended in Millan, people with learning disabilities are still waiting for a review to take place.

The case for a review was made very ably today in this chamber by my colleagues Richard Simpson and Jackie Baillie. Jackie Baillie’s amendment 1 would have instigated a major review of mental health services, putting rights first.

Jamie Hepburn: Will the member take an intervention?

Jenny Marra: I would like to make progress first, thank you.

A major review would have explored whether learning disability and autism should be considered mental disorders. It would have scrutinised the human rights implications of a patient’s right to refuse treatment. It would have allowed us to have a proper look at advocacy services and allowed transparent investigations into deaths in mental health units or under community treatment orders.

With both reviews calling for that change, many of the mental health charities and other organisations supporting it, and a well-argued amendment by my colleagues, this was an opportunity to make that change, which is needed. Although we are disappointed that the Government failed to support that approach today, there is enough in the bill in its current form for us to support the Government and welcome the passage of the bill.

Jamie Hepburn: Ms Marra suggests that we have rejected the approach that will see a review of the inclusion of learning disability and autism within the scope of the 2003 act. That is fundamentally not the case. I have committed repeatedly now to that review. We will undertake that review. I presume that the member will welcome that fact.

Jenny Marra: I thank the minister for that assurance but it is my understanding that Jackie Baillie’s amendment was rejected by the Government. Will the minister clarify that?

Jamie Hepburn: The debate was around the specifics of the amendment. We had the detailed debate. I am happy to go over it again in closing. Rejecting the amendment was not about rejecting the principle of having a review—I have committed to the Government undertaking that review; we will have that review. There were just some concerns about the specifics of Ms Baillie’s amendment.

Jenny Marra: When the minister sums up, I hope that he might put a timeframe on that review and make a commitment to that.
We welcome many of the well-thought-out steps that will be implemented as a result of the bill with regard to advance statements and advocacy. However, we cannot leave the chamber today with the sense of a job done. In Scotland, a quarter of people will experience a diagnosable mental health problem at some point in their lives. The varied and complex nature of mental health and the slow and invisible way in which a mental health problem can take hold of people’s lives mean that we have to stay vigilant and continually look forward to improve support for mental health.

Scotland has long been regarded as a world leader in its support for mental health, and the Parliament is rightly proud of that. However, if that is to continue, we must keep building on it and ensure that we are offering person-centred, rights-based support.

18:02

Nanette Milne (North East Scotland) (Con): I add my thanks to the Health and Sport Committee clerks, the bill team, and the many witnesses and stakeholders who have been so helpful throughout the parliamentary process of the bill.

The Mental Health (Care and Treatment) (Scotland) Act 2003 was a very important piece of legislation, which sought to minimise interference in people’s liberty and maximise the involvement of people with mental health issues in their treatment, giving them the right to express their views about their care and treatment, the right to independent advocacy, the right to submit an advance statement about how they wish to be treated when they become ill, and the right to choose a named person to act on their behalf when necessary.

Twelve years on from that act, and following the McManus review in 2009, it became clear that some aspects of the 2003 act were not working as well as intended. The current bill aims to improve and bring additional clarity to the act so that patients indeed benefit from the intended minimum interference and maximum involvement with their treatment.

The principles of this amending bill were generally welcomed at stage 1, but it was recognised that significant amendments would be needed to ensure that the policy intention became effective, and there were serious concerns in certain policy areas. Amendments at stages 2 and 3 have served to allay a number of the concerns that were expressed to the Health and Sport Committee by witnesses and stakeholders, but some remain unresolved.

The minister has made it very clear that he sees the current bill as a light-touch review of the 2003 act and that he does not intend to accept more fundamental changes without further detailed consultation and review.

Among the amendments to be welcomed is the one that removes the initial proposal to extend the period of short-term detention from five to 10 days—an issue of concern that was raised by the Law Society—and the Mental Welfare Commission for Scotland is pleased to see the limit of a suspension of detention kept at 200 days and not extended to 300 days as originally proposed.

The tightening of the bill to ensure that a named person is identified only when the patient wants one, the requirement for health boards to publicise the support that they offer to make or withdraw an advance statement and to respond to requests about such support from the Mental Welfare Commission, the right of appeal for named persons in cases of cross-border transfer, and the steps taken to gather information about the provision of advocacy services so that they may become more readily available to people who wish to use them are all very welcome improvements to the bill as originally proposed.

However, concerns remain, particularly—as we heard a lot this afternoon—around people with learning disability and those on the autistic spectrum, who are currently included within mental health legislation because they have those lifelong conditions, whether or not they are also mentally ill. There are differences of opinion among experts as to whether that is right, but there is strong feeling among those affected that current mental health legislation is inappropriate, and that learning disability should be defined as an intellectual impairment rather than a mental disorder. A strong plea has been made for a wholesale review of mental health and incapacity legislation.

Such a review was proposed by the Millan committee as far back as 2001 and it was again recommended by McManus in 2009, so there is understandable frustration that it has not yet been achieved. The minister’s clear commitment to a comprehensive, participative review of the inclusion of learning disability and autism in mental health legislation is very welcome, and I can understand why he does not want to commit to a timescale that might curb the scale of the review. Nevertheless, there is a degree of urgency about this, and I am sorry that the minister did not accept Jackie Baillie’s stage 3 amendment to ensure that it would be done within three years.

Jamie Hepburn: I understand where Nanette Milne is coming from and I understand the frustrations that exist out there—that is one of the reasons why we have committed to undertake the review. She spoke about urgency and the necessity of getting on with the task, and in that
regard I can say—as I have already pointed out—that officials are in dialogue with some stakeholders on the process. We are beginning the process. I hope that that gives a signal of our intent.

Nanette Milne: I understand and fully accept the intent, but we would really like to know when the process will end, rather than that it has begun.

There are unresolved issues around the use of psychoactive substances. The minister has agreed to consider them during the promised review, which is welcome.

This amending bill, which intends to clarify and improve the implementation of the 2003 act in the interests of the patients who are affected by it, is timely and welcome, but I expect that more changes will be required after further review has taken place. Significant advances have already been made in helping patients with mental health problems, but that is still work in progress, and continuing scrutiny of current legislation must be on-going, with an open mind regarding further changes as and when required.

I have confined my remarks to some of the proposals in part 1 and have chosen not to elaborate on parts 2 and 3, on criminal cases and victims’ rights. I merely add that the legislative changes proposed in parts 2 and 3 are welcome, and we are supportive of them. All in all we are comfortable with the amending bill, which we will support at decision time this evening.

18:08

Bob Doris (Glasgow) (SNP): I welcome the Mental Health (Scotland) Bill as amended at stage 2 and stage 3, which I very much hope and believe will be passed this evening. The bill is specific and focused and will deliver in a number of significant, although in some regards incremental, ways to benefit the people of Scotland.

I am pleased that members agreed to my amendment to place a duty on health boards to publicise any support they offer in the making and withdrawing of advance statements and to require them to provide information to the Mental Welfare Commission in meeting that duty. I very much hope that that will drive change, boosting the awareness, numbers and use of advance statements and ensuring that the wishes of those with mental health disorders regarding their treatment and their lives are respected where they can be.

I am pleased that we have extended rights in other areas, such as the rights of victims of crime to a victim notification scheme. It is fitting and correct that we have done that.

This bill has also been a listening process. As I said, the Scottish Government listened to my case about advance statements at stage 3, and it backed a variety of other amendments, including some at stage 2. One of my amendments was about restricting the amount of invasive treatments that a cross-border absconding patient could receive as emergency treatment should they arrive in Scotland. The Government moved to protect the rights of those vulnerable, if at times challenging, individuals, and it was fit and proper that that was done.

The issue of learning disabilities in the bill has been shaped by the whole Parliament. A Government that listens will accept some—quite a lot, but not necessarily all—amendments that are lodged, which is right. There seems to be an undercurrent that if the Government does not accept all the amendments on learning disabilities it is somehow not listening, but that is simply not the case. I look forward to receiving more information about a review of learning disabilities, and I hope that we will have a rights-based approach to treating people with learning disabilities and those living with autism.

I hope that we can give cognisance to how aspects such as the implementation of self-directed support by local authorities, particularly in Glasgow, has negatively impacted on those with learning disabilities in the city that I represent, and I hope that that can be reflected in how we take the measure forward. We need service provision for those who are living with learning disabilities. Some fine learning disability centres in Glasgow were gateways that enabled vulnerable adults to engage and interact with the wider community, but many of those people have been left without the required support because their right to that facility was withdrawn by the local authority. In considering how we treat and respect those who live with learning disabilities, we must look at the role of local authorities and ensure that they fulfil their obligations regarding the rights of those people—certainly the people who I represent in Glasgow feel that many of their rights have been withdrawn. I look forward to supporting the bill, which will improve the lot of those who live with mental health challenges in Scotland.

18:12

Rhoda Grant (Highlands and Islands) (Lab): This bill is welcome and the changes that it makes to the law will make a positive difference to the lives of individuals. However, it is clear that much more needs to be done. We must give mental health the same focus and consideration as physical health. There is still a huge amount of misunderstanding and stigma surrounding mental
health, and through the laws we make we need to tackle that.

Like other members I was disappointed that amendment 1, in the name of Jackie Baillie, was not accepted. It is clear that mental health legislation covers people who are not mentally ill but who have learning difficulties or other conditions such as autism. Those people need additional support, but their condition is not a mental illness, albeit at times they may be predisposed to mental illness due to their isolation from wider society. We need laws that not only support and protect such people but go further to integrate them into society—perhaps we need laws to change societal attitudes and structures so that people do not face the barriers and attitudes that prevent them from playing their full part.

When I spoke to constituents about the bill, they told me about the lack of services available for people who have personality disorders. Those people do not receive crisis mental health support and are often left for the police to deal with. Sadly, one constituent told me that that was not necessarily such a bad thing, given that the police often showed more compassion than those providing mental health services. Although I acknowledge the compassion that the police exercise when dealing with vulnerable people, that should not be the only help available for those with personality disorders who have become psychotic. There must be a better way of providing them with emergency mental health support through the health service.

There is also a lack of support for carers, especially when the cared-for person comes out of hospital. We all know that that transition is a time of the greatest risk of suicide, yet carers are often ignorant of that risk and how they can best support their loved ones. That is not right. Carers should have the information and support that they need to help recovery, especially during the early stages, when the risk is greatest.

That issue was raised with me recently by carers of people who had suffered brain injury. I reiterate that mental health services deal with illness rather than injury or disability. Carers are left to care for their loved ones, not knowing how the condition will progress, whether it will improve and what, if anything, they can do to enhance recovery. There must be a better way of supporting people in that situation.

We need to reassess what is covered by our mental health services and where the gaps are with regard to disabilities and brain injuries. We need to ensure that services are available to all and are compassionate and caring. I hope that the Government reviews the current legislation and renews it in order to make it fit for its intended purpose and to ensure that emergency provision is available for all.

I welcome the bill but hope that we will deal with the issues of mental health impairments and brain injuries before too long. Carers and patients cannot afford to wait much longer.

18:16

Jim Hume (South Scotland) (LD): I am pleased to see the Mental Health (Scotland) Bill at this final stage. I am hopeful about the positive changes that the bill will make to the Mental Health (Care and Treatment) (Scotland) Act 2003.

As I noted earlier, the bill must aim to protect the vulnerable while extending their rights. Like others, though, I believe that if it had been amended today in certain areas, it would have been so much better.

Throughout the passage of the bill, we have heard concerns that patients are not its focus; that patients’ rights are compromised for the sake of administrative ease; that issues of patient privacy are not taken as seriously as they should be; and that mental health officers and staff are expected to undertake an overwhelming number of tasks despite overstretched resources and a reduced workforce. Like other members, however, I was pleased that there was wide outreach to key stakeholders and organisations. The British Psychological Society, Inclusion Scotland, Autism Rights, the Scottish Association for Mental Health and many others helped to improve key components of the bill. We are very grateful to all of those organisations.

I was pleased that a number of amendments to the bill sought to address some of its shortfalls. There was Dr Simpson’s amendment on psychotropic substances and the minister’s move to safeguard patients’ rights by extending notification of detention to a patient’s guardian or welfare attorney. Jackie Baillie urged ministers to review the meaning of “mental disorder” within a specified period. I was disappointed that that amendment was not passed. By successfully amending the bill, we would have created a stronger bill, which would have addressed a number of those shortfalls. Much hard work still lies ahead, including amending the rights of those with learning disabilities.

Although the bill aimed to help people with a mental disorder to access effective treatment quickly and efficiently, I remain concerned about the state of our mental health system in Scotland. We can legislate, and we can try to protect the vulnerable and ensure that everyone’s rights are protected, but we cannot ignore the condition that the mental health system is in. Services are severely underfunded and staff are overworked, all
against a background of a growing number of people of all ages asking for help and support.

Most important is the fact that mental health is not yet enshrined in law as being of equal importance to physical health. That is a provision that is lacking from the wider legislative framework in Scotland. I am pleased that steps are being taken by Parliament to address mental health but remain worried about how much longer we will have to wait until serious action is taken to remove the disparity.

Jamie Hepburn: I praise the member for his consistency in raising that issue. I will not rehearse again the fact that there is already equality in law. Jim Hume suggests that there was a need to legislate. We had a legislative vehicle—we had the Mental Health (Scotland) Bill—but I am not aware of Mr Hume having introduced an amendment to that effect.

Jim Hume: We looked into that but realised that the structure of the bill was such that we could not introduce an amendment seeking parity of status between mental health and physical health.

We know that mental health problems do not affect just a small and invisible group of people; they affect one in four Scots at some point in their lives. Children and adolescents are being admitted to hospitals in growing numbers due to self-harm and eating disorders, and people are taking more and more days off work because of underlying causes such as depression and anxiety, which are conditions that our society continues to stigmatise.

I am hopeful that we are taking the right steps today to help our fellow citizens get better access to treatment while ensuring that their rights are protected. I hope to see further action taken in law and in practice to create a mental health system in Scotland that sets a standard to be followed and is fit for the future. We shall, of course, support the motion on the bill at decision time today.

18:20

Mark McDonald (Aberdeen Donside) (SNP): The bill is a very important piece of legislation, but it is close to me personally for a number of reasons. I have experience of close family members who have gone through periods of mental ill health, some of whom continue to go through such periods. I therefore have a very strong interest in mental health. Aside from that, I am also interested in learning disability and the autistic spectrum, so I will address that issue first.

There is often a feeling that in politics we invent division where division does not exist. Amendment 1, in the name of Jackie Baillie, was rejected, but the intention behind it and what it sought to do were broadly supported; indeed, they were supported by the Scottish National Party in the Parliament, which is why the minister has committed repeatedly to undertake a review. However, I rejected amendment 1 because I felt that it had technical elements that might have constrained the process at a later stage.

One thing that might be helpful—I am interested to know whether the minister might be open to this at a later stage—is to have an early, wide-ranging stakeholder event that could look at, for example, terms of reference for the review and other matters that require to be considered. That could be an opportunity to demonstrate good faith to those on different sides of the chamber who have expressed doubt about the Scottish Government's commitment to the matter and could be a helpful approach. I wonder whether the minister could address that in his closing remarks.

To respond to Jim Hume's comments, I think that another difficulty that we often face in politics is that we overstate the effect of certain situations on sections of our society and our health service. There is no doubt that mental health services face pressures, but all our health services face pressures. It is the nature of the health service that it will face pressures, because it is a demand-led service and people will seek out support and help from it as they require it.

If we look back to mental health services prior to the SNP Government coming into being, we see that there has been a remarkable improvement in the funding that is allocated to them and in the driving down of waiting times for treatment. I would not disagree for a second that there is more to be done; indeed, the minister has said repeatedly that there is more to be done on waiting times for mental health treatment. However, I think that anyone who looked at the situation that the SNP Government inherited and compared it with where we have got to would be hard pressed to say that no progress had been made. That is not to say that there is not more to be done, though. That is why it is welcome that the minister has on more than one occasion announced funding allocations specifically to drive improvement in mental health services.

Funding is not the only answer in this area, however. Funding for mental health services is important, but it often focuses on dealing with problems as they arise. We cannot prevent all mental health conditions from arising and we know that mental health problems can affect anybody in society at any time, but we can look at where in society there are more occurrences of certain mental health problems and see whether they are linked to societal pressures. In particular, I would welcome an opportunity for us to consider—perhaps not in the Parliament but elsewhere—the great pressures that young people in society now
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I, too, welcome the bill. As ever at stage 3, we have to decide whether the glass is half empty or half full. On one hand, we certainly welcome the fact that several amendments that were lodged at stage 2 and 3 were accepted, but on the other we are disappointed that the Government rejected some good amendments today. I should say to the minister that the glass is quite small compared to that for the original bill in 2003. I note that the minister has had 48 amendments to deal with at stage 3 today whereas, in 2003, there were 756 amendments at stage 3 and 1,367 at stage 2.

Jamie Hepburn: Does Malcolm Chisholm agree that that speaks to my collaborative and open approach at stage 2?

Malcolm Chisholm: I think that we were collaborative in 2003, as well.

Clearly, the bill is an amending bill, so in due course there might well be a need for a wider review, not only of the learning disability issue—I hope that that review will proceed without delay—but, in the longer run, of how the mental health legislation interacts with the Adults with Incapacity (Scotland) Act 2000, given the different and overlapping functions and the different definitions of incapacity.

Obviously, the discussion is set against the backdrop of the principles of the 2003 act, including those on reciprocity and the least restrictive alternative. All the things that we have discussed today relate to what was set up in the 2003 act—for example, the Mental Health Tribunal for Scotland, the named person and advocacy rights. On the progress that has been made, it is good that changes were made at stage 2. The proposal in the bill to extend short-term detention from five days to 10 days was reversed, and the proposal for a default named person was also rejected at committee.

Today, we have made progress on suspension of detention and—through two Richard Simpson amendments—on statistical information and the review of deaths in detention. On advocacy, we have had perhaps one of the most welcome advances today, and all credit to the minister for that. We have also had Bob Doris’s amendment about health boards publicising support for people to make advance statements. However, we in the Labour Party are disappointed that there is not a stronger duty to promote advance statements. We are also disappointed with the limited progress on levels of security, although I will not rerun that debate now.

I am very disappointed that there was no movement on psychologists. At one point—perhaps it was in committee—the minister invoked the fact that it is not appropriate to deal with that issue in an amending bill, but the proposal was for a very discreet change, particularly given that it was to be done through regulations. It was unfortunate that the minister completely rejected that opportunity.

Some recommendations in the McManus review have not been taken up, although we welcome the fact that many of them have been. The 2010 Equal Opportunities Committee report on McManus is worth looking at, as it focuses very much on the equality issues in McManus and the original legislation. Equality was one of the 10 Millan principles, but there are still concerns about equality issues for some groups in relation to the legislation; for example, we know that there is still an issue about young people in adult beds. McManus and the Equal Opportunities Committee also highlighted the duties of local authorities under sections 25 to 31 of the 2003 act to promote the wellbeing and social development of all persons in their area who have or have had mental disorders. That is outwith the scope of the amending bill, but we should not forget those wider aspects of mental health.

My final point is made just to remind us of that. I welcome all the progress that has been made on mental health, but we have all seen the horrifying story on today’s front pages about a postnatal depression tragedy that arose in my area because a service was not available for the woman in question.

We know that there is a lot still to do, but we welcome the progress that has been made on mental health in general and in the bill.

Mary Scanlon (Highlands and Islands) (Con): I, too, commend the members of the Health and Sport Committee for their sterling work on the bill, and give credit for all the progress that is contained in it. I appreciate that it is a step in the right direction, but we would be failing in our duty to mental health if we did not put on record how much more there is to do.

In amendment 1, Jackie Baillie asked for a review. It is reasonable that the minister said that he would conduct a review, but we were promised the Sandra Grant review of mental health services
in 2004. We thought that we were being very reasonable in giving that review 10 years to be completed, but 2014 came and went, and we are still waiting for it. I know that it is supposed to come later this year, but the Government needs a prod in the right direction.

In preparing for the debate, I looked at my closing speech on the Mental Health (Care and Treatment) (Scotland) Bill in March 2003, which was made in the week before dissolution of Parliament. I said that it was with "a sigh of relief" rather than a sense of pride that I contemplated the passing of the bill, given the huge number of amendments that had been lodged. I said at the time—I think that others said it, as well—that the legislation would be effective only if health boards and local authorities gave it the priority that it deserved.

I looked up what the Mental Health (Scotland) Bill's policy memorandum says about local authorities. Paragraph 168 states:

"The Scottish Government does not consider that the measures in the Bill have any disproportionate effect on local government."

The policy memorandum also states:

"Mental health officers are affected by the terms of the Bill."

It seems that the Scottish Government has not been listening to the many calls that have been made. I give credit to Jim Hume and many other members who have highlighted the drastic shortage of mental health officers across Scotland and the increased workload that Parliament has imposed on them. At Highland Council last week, it was stated that mental health officer reports that are legally required within three weeks under the Adults with Incapacity (Scotland) Act 2000 are taking three years. That patient group's being detained should be for two or three hours. tightened up rather than the rules and whether existing cases were not still do not understand where all that came from or what consultation was done on it. It is fine to tighten up the rules, but existing cases were not being reported to the Mental Welfare Commission. I regret that the nurse's power to detain was not left as it was. I do not disagree with the abolition of ring-fenced funding for local authorities, but the Scottish Government should at the very least ensure that local authorities fulfil their statutory obligations in line with the bill that we will pass today and with previous acts of Parliament.

It is worth considering why mental health should be a priority. According to an Audit Scotland report, up to 75 per cent of people who use illegal drugs have a mental health issue. Up to 50 per cent of people with alcohol problems have a mental health issue—that is often called self-medication. Seven in every 10 prisoners are identified as having mental health problems, one in every three visits to a general practitioner is to do with a mental health issue, and about 9 per cent of our population are on anti-depressants.

The bill deals with access to treatment. The first Millan principle is:

"People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs."

If those people have the same entitlements as others, why do only eight health boards meet the child and adolescent mental health services target of 90 per cent being seen within 18 weeks? In NHS Tayside, only 35 per cent of children are seen within 18 weeks, and there is a median wait of 49 weeks. That is not good enough. In March this year, 4,200 children waited to start treatment in a CAMH service, which is not good enough. If that was not bad enough, I was absolutely shocked to read that 17,530 people are on the waiting list for psychological therapies. That figure is up by 1,500 since the minister took office.

The Government needs to look at how positive mental health can influence physical health. We do not need more legislation; we simply need better understanding, more empathy and better working together. It need not cost more money.

18:35

Dr Richard Simpson (Mid Scotland and Fife) (Lab): The bill is modest but, as Mark McDonald and Jenny Marra said, it is important. It is based on the McManus report but, as Malcolm Chisholm reminded us, there was a massive number of amendments to the 2003 bill—the number of amendments today was fairly modest, thank goodness—but even then not all the McManus proposals were included.

I welcome the fact that the Government carefully considered the evidence, the stage 1 report and the stage 2 debates. As a result, I can commend the Government for acknowledging concerns, which has led it to withdraw some of the original proposals, such as the proposed 10-day extension to tribunal hearings, the length of time to appeal against transfer, and the proposed possible extension by 100 days of the community treatment order suspension period.

I also particularly welcome the victim notification scheme and some of other measures in the bill that will undoubtedly help the mental healthcare and treatment of people in Scotland. I regret that the nurse's power to detain was not left as it was. I still do not understand where all that came from or what consultation was done on it. It is fine to tighten up the rules, but existing cases were not being reported to the Mental Welfare Commission in the first place, so that is what needs to be tightened up rather than the rules and whether detention should be for two or three hours.

I also regret that many of my, Jackie Baillie's and Nanette Milne's amendments were rejected.
They were lodged after careful consideration of the evidence that had been presented and after discussions with and support from a number of organisations. Notwithstanding their rejection, I hope that many of them will be part of the wider review that the Government has already instructed civil servants to start thinking about. I welcome the sense of urgency that the minister is lending to the issue. I hope that he will be able to continue to apply that pressure.

Learning disability, or intellectual impairment, and autism spectrum disorder will need to be addressed. Mark McDonald called for a wider stakeholder conference to look at the remit for the review. I hope that the minister will consider that and I hope that it will not be some sort of internal review that leads to a bill, but that there will be a full-blown commission of the same sort as the Millan commission. Millan and McManus recommended that all the acts—the Criminal Procedure (Scotland) Act 1995, the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Protection of Vulnerable Groups (Scotland) Act 2007—be considered. As the minister has said, that will be complex and will require a commission that is of good standing and which can command broad support. If we begin with the sort of conference that Mark McDonald suggested, we might be able to set an appropriate remit.

There are serious concerns about a range of issues. The right to refuse treatment is fundamental, but it is not applied to people who have mental health problems except under specific conditions. It does not apply if they give an advance statement; that was rejected today.

The use of psychoactive medicines is still far too widespread. The fact that antidepressants were being used in increasing amounts was appropriate because GPs were learning to prescribe appropriate doses for longer periods. However, the amounts that are being prescribed have gone on rising and it is becoming a matter for concern, although the particular target on that has been dropped.

There is the vexed question of the difference in application between a seriously impaired decision-making ability under the 2003 act and the definition of incapacity under the 2000 act. That needs to be addressed. Use of physical restraint has been addressed in respect of children, but it needs to be looked at again for adults because it might be being used inappropriately in one or two situations. The number of people who have been adversely affected by the issues that I have mentioned might be small, but one is too many. The guardians of good care and treatment should have more powers.

The Mental Welfare Commission in its many helpful reports draws attention to too many occasions on which it has not been able to get the information that it requires. The acceptance of amendments 25, 35 and 36 will undoubtedly help in that regard, but Scotland must have regulators that have teeth. If we continue to have regulators—the Healthcare Environment Inspectorate and, on occasion, the Mental Welfare Commission—covering only small areas, that will not be enough. We need to look again at HIS, the Care Inspectorate, and the Mental Welfare Commission. We decided not to integrate them during the previous reform, which was the correct decision at the time, but there are now issues that may need to be looked at.

I agree and disagree with Mark McDonald’s comments on mental health. I agree that there has been progress in care plans for patients who have severe and enduring mental illness. However, on child and adolescent mental health, although there was progress on the issue of admissions to adult wards, which was welcomed by the Mental Welfare Commission, the situation has gone backwards since 2009, as Malcolm Chisholm reminded us.

Mary Scanlon listed a number of issues, including the number of MHOs, which has reduced, and local authorities’ ability to deal with mental health. She also listed a number of other areas of concern with which I agree, particularly in relation to prisoners, in respect of whom far more must be done.

Rhoda Grant drew attention to personality disorders, which are still not being managed effectively in Scotland, as well as to intellectual impairment that is associated with brain damage.

I thank all those who gave evidence, and the many organisations that helped me to formulate the amendments and gave support on issues that were raised. I also thank the Parliament’s legislation team, whose drafting and responses to the changes that I sought were always patient and often creative.

The debates have been of value if only to inform the review. We have made progress since 1999, but we must keep moving forward and acknowledge the changes that have been made, in particular in neurodevelopmental science, but also in the culture. We must change things, but Labour will fully support the bill tonight.

18:41

Jamie Hepburn: I thank members for their speeches. I will try and cover as much ground as I can.
Although the bill has a relatively narrow focus, many of its provisions will make a difference for service users. Jenny Marra was right to talk about the constituents who approach us about many mental health-related issues. It is always important to have them in mind as we progress this work.

The bill has, at its heart, the aim of protecting service users’ rights and interests and of ensuring that the system under the Mental Health (Care and Treatment) (Scotland) Act 2003 works as effectively as possible. As I have said before, I am grateful to members and stakeholders for working with the Government to get the provisions exactly right. It has been a collaborative process. We have been able to work with the Health and Sport Committee very effectively to ensure that the bill is as good as it possibly can be.

The bill is only part of the Government’s wider programme to improve mental health services. Rhoda Grant is right to say that more must be done. She and other members can be assured that my focus will always be on that. Nonetheless, it is important that those who need compulsory treatment under the act are able to access treatment quickly and to have their rights and interests protected. The bill will play a key role in doing that.

Jenny Marra raised concerns about the bill’s compatibility with the ECHR. I take seriously the responsibility to have due regard to human rights. It is essential from a human perspective; it is also a legal requirement. The bill is underpinned by various processes of appeal and rights to express a view. I believe that the bill is compatible with the ECHR. I am unaware of any ruling that says the 2003 act and this bill are not compatible with it. I assure her that I will always listen and respond to serious concerns.

Various members have raised the review of the inclusion of learning disability and autism spectrum disorder in the scope of the 2003 act. I recognise the disappointment that the review has not taken place sooner. Let me be clear: I made the commitment to that review in the Government’s response to the committee’s stage 1 report. That commitment was made in advance of amendments at stages 2 and 3. It is a serious commitment.

Work has tentatively begun to engage stakeholders. I hope that that is an indication of our serious intent. Bob Doris asked whether the approach would be rights based. He can be assured that I absolutely commit to that being the process that we will follow.

I say to Mark McDonald—and to Dr Simpson, who latched on to his suggestion—that I am absolutely open to an early stakeholder event to help move the process forward. I will ensure that Scottish Government officials move forward on that basis.

There is no disagreement across the chamber on the need for a review. The Government was not able to accept the amendment on that—amendment 1—that was debated earlier not because of the principle but because of some of the mechanisms. It contained a hard timescale, which is not necessarily helpful to ensuring that we have the fullest review possible.

More substantially, amendment 1 provided for the removal of learning disabilities from the definition of mental health disorder by way of regulations if the review concluded that that had to be done. I am not convinced that that is the best way forward because it would summarily remove all the protections and rights that people with learning disabilities have under the 2003 act without replacing them. I do not think that any of us would want to proceed on that basis. The point that was made about the need for scrutiny of any measures that might be introduced is valid, and I am not convinced that that could readily be done by introducing regulations.

Let me be clear: the review will be participative and we have not yet determined exactly how it will be conducted. We want to involve stakeholders in shaping it. I am committed to beginning it as soon as possible, and I do not want to put an artificial timescale on its conclusion. The timescale that was set out in amendment 1 might be possible. I make my commitment: I want the review to be concluded as soon as possible but it is important that we do not curtail it, especially in light of the fact that I have also committed to the review covering the use of psychotropic substances and the inclusion of psychologists in the scope of the legislation.

Jim Hume and Mary Scanlon referred to the burdens that the Parliament places on mental health officers through its legislation. I recognise the invaluable contribution that mental health officers make to improving the lives of mental health patients, their friends and their families. I said earlier that the Government has announced an additional £85 million of investment over the next five years but, taking the investment that was announced in May and November last year, our additional investment in mental health services is £100 million.

The Scottish Government has also undertaken a scoping exercise to gather evidence on the capacity of the mental health officer workforce. That includes data provided in Mental Welfare Commission reports and the Scottish Social Services Council’s most recent workforce data report on mental health officers in Scotland. We will consider the draft report of that work in due course.
Mary Scanlon: I gave the example that Highland Council, which should, under the Adults with Incapacity (Scotland) Act 2000, provide a report by a mental health officer in three weeks, cannot do that in three years. How will the £150 million—I think that that is what the minister said—impact on the workforce planning? Does that mean that more mental health officers are coming through the system?

Jamie Hepburn: It is important to clarify that it is £100 million, not £150 million, although that is still a substantial sum of money, as I am sure Mary Scanlon agrees. There is a range of ways that the additional money can be used to improve systems, including what Ms Scanlon suggests.

Malcolm Chisholm raised the need for further promotion of advance statements. The Mental Welfare Commission is currently undertaking a project to promote them, and the provisions in amendment 28, which Bob Doris moved, will complement that work. As I said to Mr Chisholm in our debate on amendments, I have also suggested that the working group on the code of practice consider further whether the guidance that it has could help to promote their use. It is essential that advance statements be used more widely, and I am serious about us working to that end.

I have heard general support for the bill from across the chamber. That is very welcome. I have also heard some disappointment that some amendments were not accepted. I understand that. The amendments were all proposed earnestly, but they were not necessarily an effective way forward.

I also recognise that, beyond the bill, there is more to do. The bill is only part of the work. Members can be reassured of my commitment to doing everything that the Scottish Government can do to ensure a better sense of mental wellbeing throughout Scotland.

I commend the bill to the Parliament.
18:51

The Presiding Officer (Tricia Marwick): There are two questions to be put as a result of today’s business.

The first question is, that motion S4M-13599, in the name of Jamie Hepburn, on the Mental Health (Scotland) Bill, be agreed to.

Motion agreed to,

That the Parliament agrees that the Mental Health (Scotland) Bill be passed.
Mental Health (Scotland) Bill

[AS PASSED]

CONTENTS

Section

PART 1

THE 2003 ACT

Procedure for compulsory treatment

1 Measures until application determined
2 Information where order extended
2A Transfer to another hospital

Emergency, short-term and temporary steps

3 Emergency detention in hospital
4 Short-term detention in hospital
5 Meaning of temporary compulsion

Suspension of orders and measures

6 Suspension of orders on emergency detention
7 Suspension of orders on short-term detention
8 Suspension of detention for certain purposes
9 Maximum suspension of particular measures

Specification of hospital units

9A Specification for detention measures
9B Transfer of prisoner to hospital unit
9C Transfer from specified unit

Orders regarding level of security

9D Requirement for medical report
10 Process for enforcement of orders
11 Orders relating to non-state hospitals
11ZA Section 11: exercise of powers before commencement
11A Meaning of hospital in sections 268 to 273 of the 2003 Act

Removal and detention of patients

13 Notifying decisions on removal orders
14 Detention pending medical examination

Periodical referral of cases

16 Periodical referral of cases
Representation by named persons

18A Named person not to be automatic
19 Consent to being named person
20 Appointment of named person
20A Ability to act if no named person

Advance statements, support and services

21 Advance statements to be registered
21A Information about advocacy services
22 Communication at medical examination etc.
22A Conflicts of interest to be avoided
22B Safeguarding the patient’s interest
23 Services and accommodation for mothers

Cross-border transfers and absconding patients

24 Cross-border transfer of patients
25 Dealing with absconding patients

Arrangements for treatment of prisoners

26 Agreement to transfer of prisoners
27 Compulsory treatment of prisoners

The Commission: statistical information

27A The Commission: statistical information

Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

27B Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

PART 2

CRIMINAL CASES

Making and effect of disposals

28 Making certain orders in remand cases
28A Detention under compulsion orders
29 Periods for assessment orders
30 Periods for treatment orders
31 Periods for short-term compulsion
32 Periods for compulsion orders
33 Periods for hospital directions

Variation of certain orders

34 Variation of interim compulsion orders
35 Transfer of patient to suitable hospital

Specification of hospital units

35A Specification of unit
39 Transfer from specified unit
40 Consequential repeals

Miscellaneous amendments

41 Information on extension of compulsion order
PART 3

VICTIMS’ RIGHTS

Information and representations
43 Right to information: offender imprisoned
44 Right to information: compulsion order
45 Right to make representations

Additional provisions
46 Information sharing
47 Associated definitions
48 Power to make modifications
49 Amendments to the 2003 Act

PART 4

COMMENCEMENT AND SHORT TITLE

50 Commencement
51 Short title
Amendments to the Bill since the previous version are indicated by sidelining in the right margin. Wherever possible, provisions that were in the Bill as introduced retain the original numbering.

Mental Health (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

PART 1
THE 2003 ACT

Procedure for compulsory treatment

1 Measures until application determined

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 64 (powers of Tribunal on application under section 63: compulsory treatment order), after subsection (8) there is inserted—

“(8A) If the patient has been detained in hospital by virtue of section 47(4)(a) or 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 6 months referred to in subsection (4)(a)(i) above is to be regarded as reduced by the period during which the patient has been so detained under that section.

(8B) Subsection (8A) above is of no effect if the patient has been detained in hospital in accordance with an interim compulsory treatment order made in connection with the application by virtue of which this section applies.”.

(3) In section 65 (powers of Tribunal on application under section 63: interim compulsory treatment order), after subsection (6) there is inserted—

“(7) If the patient has been detained in hospital by virtue of section 47(4)(a) or 68(2)(a) of this Act in connection with the application by virtue of which this section applies, the 56 days referred to in subsection (3) above is to be regarded as reduced by the period during which the patient has been so detained under that section.”.
Information where order extended

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 87 there is inserted—

“87A Further information where order extended

(1) Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 86 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 101(2)(a) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and

(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—

(i) a copy of the record, and

(ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—

(a) the name and address of the patient,

(b) if known by the mental health officer, the name and address of—

(i) the patient’s named person, and

(ii) the patient’s primary carer,

(c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 85 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),

(d) so far as relevant to the extension of the compulsory treatment order—

(i) the details of the personal circumstances of the patient, and

(ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),

(e) the views of the mental health officer on the extension of the compulsory treatment order, and

(f) any other information that the mental health officer considers relevant in relation to the extension of the compulsory treatment order.

(5) The matters referred to in subsection (2)(c) above are—
(a) whether the mental health officer is sending a copy of the record to the patient, and
(b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.

(6) For the purposes of subsection (2)(c) above, the persons are—
(a) the patient’s named person,
(b) the patient’s responsible medical officer, and
(c) the Commission.”.

2A Transfer to another hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 124 (transfer to other hospital)—
(a) in subsection (1), for the words “by a compulsory treatment order.” there is substituted “by—
   (a) a compulsory treatment order, or
   (b) an interim compulsory treatment order.”,
(b) in subsection (14), for the words “compulsory treatment order” there is substituted “order in question”.

Emergency, short-term and temporary steps

3 Emergency detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 36 (emergency detention in hospital), after paragraph (d) there is inserted—
“(da) section 113(5) of this Act;”.

(3) In section 38 (duties on hospital managers: examination, notification etc.)—
(a) in paragraph (b)(i) of subsection (3), for the words “persons mentioned in subsection (4) below” there is substituted “Commission of the granting of the certificate and”,
(b) after subsection (3) there is inserted—
“(3A) The managers of the hospital may, so far as they consider it appropriate, give notice of the matters notified to them under section 37 of this Act to the persons mentioned in subsection (4) below.”,
(c) in subsection (4)—
   (i) in the text preceding paragraph (a), for the words “subsection (3)(a) and (b)(i)” there is substituted “subsections (3)(a) and (3A)”,
   (ia) after paragraph (c) there is inserted—
   “(ca) if known to the managers and not falling within paragraph (a) or (b) above—
   (i) any guardian of the patient; and
(ii) any welfare attorney of the patient;”;
(ii) paragraph (d) is repealed together with the word “and” immediately preceding it.

(4) In subsection (2) of section 40 (revocation of emergency detention certificate: notification), after the word “inform” there is inserted “the Commission and”.

(5) In subsection (4) of section 42 (certificate under section 41: revocation), after the word “inform” there is inserted “the Commission and”.

4 Short-term detention in hospital

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 44 (short-term detention in hospital), after paragraph (c) there is inserted—

“(ca) section 113(5) of this Act;”.

(3) In section 46 (hospital managers’ duties: notification)—

(a) in subsection (3), the words “, and send a copy of it,” are repealed,

(b) after subsection (3) there is inserted—

“(4) When giving notice under subsection (2) or (3) above, the managers of the hospital are to send a copy of the certificate to each recipient of the notice.”.

5 Meaning of temporary compulsion

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 230 (appointment of patient’s responsible medical officer), in paragraph (c) of the definition of “appropriate act” in subsection (4), the words “under section 54(1)(c) of the 1995 Act” are repealed.

(3) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—

““temporary compulsion order” means an order made under section 54(1)(c) of the 1995 Act;”.

Suspension of orders and measures

6 Suspension of orders on emergency detention

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 43 (effect of subsequent emergency detention certificate on compulsory treatment order)—

(a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,

(b) in subsection (2), for the words “The compulsory treatment order” there is substituted “A relevant order”,

(c) in subsection (3)—

(i) after the word “Act” there is inserted “or (as the case may be) section 57A(8)(b) of the 1995 Act”,

...
(ii) for the words “compulsory treatment order” in each place where they occur there is substituted “relevant order”,

(d) after subsection (3) there is inserted—

“(4) In this section, the references to a relevant order are to—

(a) a compulsion order, or

(b) a compulsory treatment order or an interim compulsory treatment order.”.

(3) In relation to section 43—

(a) its title becomes “Effect of emergency detention certificate on certain earlier orders”,

(b) the italic heading immediately preceding it becomes “Effect of emergency detention certificate on certain orders”.

7 Suspension of orders on short-term detention

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 56 (effect of subsequent short-term detention certificate on compulsory treatment order)—

(a) in paragraph (a) of subsection (1), for the words “compulsory treatment order” there is substituted “relevant order”,

(b) for subsection (2) there is substituted—

“(2) A relevant order shall cease to authorise the measures specified in it for the period during which the patient is subject to—

(a) the short-term detention certificate, or

(b) an extension certificate.”,

(c) after subsection (2) there is inserted—

“(3) In this section, the references to a relevant order are to—

(a) a compulsion order, or

(b) a compulsory treatment order or an interim compulsory treatment order.”.

(3) In relation to section 56—

(a) its title becomes “Effect of short-term detention certificate etc. on certain earlier orders”,

(b) the italic heading immediately preceding it becomes “Effect of short-term detention certificate etc. on certain orders”.

8 Suspension of detention for certain purposes

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 127 (suspension of measure authorising detention)—

(za) in subsection (1), the words “not exceeding 6 months” are repealed,

(zb) after subsection (1) there is inserted—
“(1A) A certificate under subsection (1) above may specify—
   (a) a single period not exceeding 200 days, or
   (b) a series of more than one individual period falling within a particular 6
       month period.”,

(zc) after subsection (3) there is inserted—
“(3A) A certificate under subsection (3) above may specify—
   (a) a single period, or
   (b) a series of more than one individual period.”,

(a) subsection (4) is repealed,

(b) after subsection (4) there is inserted—
“(4A) The purpose for which a certificate under subsection (1) or (3) above is granted
must be recorded in the certificate.”.

(3) In section 221 (assessment order: suspension of measure authorising detention)—
(za) after subsection (2) there is inserted—
“(2A) A certificate under subsection (2) above may specify—
   (a) a single period, or
   (b) a series of more than one individual period.”,

(a) after subsection (3) there is inserted—
“(3A) Subsection (3) above does not require the consent of the Scottish Ministers if
the granting of the certificate is for the purpose of enabling the patient to—
   (a) attend a hearing in criminal proceedings against the patient, or
   (b) meet a medical or dental appointment made for the patient.”,

(b) subsection (4) is repealed,

(c) after subsection (4) there is inserted—
“(4A) The purpose for which a certificate under subsection (2) above is granted must
be recorded in the certificate.”.

(4) In section 224 (patients subject to certain other orders and directions: suspension of
measure authorising detention)—
(a) in subsection (1), after paragraph (b) there is inserted—
   “(ba) a temporary compulsion order;”,

(aa) in subsection (2), the words “not exceeding 3 months” are repealed,

(ab) after subsection (2) there is inserted—
“(2A) A certificate under subsection (2) above may specify—
   (a) a single period not exceeding 90 days, or
   (b) a series of more than one individual period falling within a particular 3
       month period.”,

(b) after subsection (3) there is inserted—
“(3A) In the case of a treatment order, an interim compulsion order or a temporary compulsion order, subsection (3) above does not require the consent of the Scottish Ministers if the granting of the certificate is for the purpose of enabling the patient to—

(a) attend a hearing in criminal proceedings against the patient, or
(b) meet a medical or dental appointment made for the patient.”,

(c) subsection (5) is repealed,
(d) after subsection (5) there is inserted—

“(5A) The purpose for which a certificate under subsection (2) above is granted must be recorded in the certificate.”.

9 Maximum suspension of particular measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 127 (suspension of measure authorising detention)—

(aa) for subsection (2) there is substituted—

“(2) The total period that an order does not, by reason of certification under subsection (1) above, authorise the measure mentioned in section 66(1)(a) of this Act must not exceed 200 days within any period of 12 months (whenever counted from).”,

(ab) after subsection (2) there is inserted—

“(2A) For the purpose of subsection (2) above—

(a) a day does not count towards the total period if the measure is (by reason of such certification) not authorised for a period of 8 hours or less in that day,
(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”.

(2A) In section 128 (suspension of other measures)—

(a) in each of subsections (1) and (2), for the words “3 months” there is substituted “90 days”,

(b) after subsection (2) there is inserted—

“(2A) A day is to count as a whole day towards the 90 days mentioned in subsection (2) above if any part of that day falls within the period mentioned in paragraph (a) or (b) of that subsection.”.

(3) In section 224 (patients subject to certain other orders and directions: suspension of measure authorising detention)—

(aa) for subsection (4) there is substituted—

“(4) The total period that an order or direction does not, by reason of certification under subsection (2) above, authorise the detention of a patient in hospital must not exceed 200 days within any period of 12 months (whenever counted from).”,

(ab) after subsection (4) there is inserted—
“(4A) For the purpose of subsection (4) above—

(a) a day does not count towards the total period if the detention is (by reason of such certification) not authorised for a period of 8 hours or less in that day,

(b) a single period (specified in such certification) of more than 8 hours and less than 24 hours, whether in one day or spanning two days, is to count as a whole day towards the total period.”.

Specification of hospital units

9A Specification for detention measures

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 36 (emergency detention in hospital), after subsection (12) there is inserted—

“(13) A reference in this section to a hospital may be read as a reference to a hospital unit.

(14) For the purpose of subsection (13) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(3) In section 44 (short-term detention in hospital), after subsection (11) there is inserted—

“(12) In this section and sections 46 to 49 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(13) For the purposes of subsection (12) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

(4) After section 71 there is inserted—

“71A Compulsory treatment in hospital unit

(1) In sections 62 to 68 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(2) For the purposes of subsection (1) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

9B Transfer of prisoner to hospital unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after subsection (10) there is inserted—

“(11) A reference in this section to a hospital may be read as a reference to a hospital unit.

(12) For the purpose of subsection (11) above, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

9C Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 124 there is inserted—
“124A Transfer to other hospital unit

(1) Subsection (2) below applies where—
   (a) the detention of a patient in hospital is authorised by—
      (i) a compulsory treatment order, or
      (ii) an interim compulsory treatment order, and
   (b) that order specifies the hospital unit in which the patient is to be detained.

(2) The managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) In relation to a transfer or proposed transfer under subsection (2) above, section 124(4) to (14) of this Act applies subject to the following modifications—
   (a) a reference to section 124(2) is to be read as a reference to subsection (2) above,
   (b) subsection (10)(a) is to be ignored,
   (c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,
   (d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.

(4) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Orders regarding level of security

9D Requirement for medical report

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 264 (detention in conditions of excessive security: state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—
   (a) states that in the practitioner’s opinion the patient does not require to be detained under conditions of special security that can be provided only in a state hospital, and
   (b) sets out the practitioner’s reasons for being of that opinion.”.

(3) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals), after subsection (7) there is inserted—

“(7A) An application may not be made under subsection (2) above unless it is accompanied by a report prepared by a medical practitioner which—
   (a) states that in the practitioner’s opinion the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, and
   (b) sets out the practitioner’s reasons for being of that opinion.”.
10 Process for enforcement of orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Section 266 (order under section 265: further provision) is repealed.

(3) In section 267 (orders under sections 264 to 266: recall)—

(a) in subsection (1), for the words “, 265(3) or 266(3)” there is substituted “or 265(3)”;

(b) in subsection (3), for the words “, 265(4) to (6) or 266(4) to (6)” there is substituted “or 265(4) to (6)”.

(4) The title of section 267 becomes “Order under section 264 or 265: recall”.

(5) Section 270 (order under section 269: further provision) is repealed.

(6) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), for the words “, 269(3) or 270(3)” there is substituted “or 269(3)”;

(b) in subsection (3), for the words “, 269(4) to (6) or 270(4) to (6)” there is substituted “or 269(4) to (6)”.

(7) The title of section 271 becomes “Order under section 268 or 269: recall”.

(8) In section 272 (proceedings for specific performance of statutory duty)—

(a) in subsection (1), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 264(2) of this Act, or
(c) an order under section 268(2) of this Act,”;

(b) in subsection (2), for paragraphs (a) to (d) there is substituted—

“(a) an order under section 265(3) of this Act, or
(c) an order under section 269(3) of this Act.”.

11 Orders relating to non-state hospitals

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 268 (detention in conditions of excessive security: hospitals other than state hospitals)—

(a) in subsection (1), the word “qualifying” in the first place where it occurs is repealed,

(ba) in subsection (2), for the words “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”;

(c) in subsection (5), for the words “to the managers” to the end there is substituted “of the name of the hospital so identified to the managers of the hospital in which the patient is detained”;

(d) in subsection (6), the word “qualifying” in each place where it occurs is repealed,

(e) in subsection (10)—
(i) except in paragraph (e), the word “qualifying” in each place where it occurs is repealed,

(ii) in paragraph (e), for the words “qualifying hospital” there is substituted “hospital in which the patient is detained”,

(f) subsections (11) to (14) are repealed.

(3) In section 269 (order under section 268: further provision)—

(a) in each of subsections (1) and (2), the word “qualifying” is repealed,

(aa) in subsection (3), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient”,

(c) in subsection (6), for the words from “to the managers” to the end there is substituted “of the name of the hospital so identified to the managers of the hospital in which the patient is detained”.

(4) In section 271 (orders under sections 268 to 270: recall)—

(a) in subsection (1), the word “qualifying” is repealed,

(aa) in subsection (2)(a), for the words from “detention” to “patient’s case” there is substituted “the test specified in regulations made under section 271A(2) of this Act is not met in relation to the patient”.

(4A) After section 271 there is inserted—

“Process for orders: further provision

271A Regulation-making powers

(1) A hospital is a “qualifying hospital” for the purposes of sections 268 to 271 of this Act if—

(a) it is not a state hospital, and

(b) it is specified, or is of a description specified, in regulations.

(2) Regulations may specify the test for the purposes of sections 268(2), 269(3) and 271(2)(a) of this Act.

(3) Regulations under subsection (2) above specifying the test—

(a) must include as a requirement for the test to be met in relation to a patient that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient’s case, and

(b) may include further requirements for the test to be met in relation to a patient.

(4) Regulations may make provision about when, for the purposes of—

(a) any regulations made under subsection (2) above, and

(b) sections 268 to 271 of this Act,

a patient’s detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient’s case.
(5) Regulations may modify sections 264 and 268 of this Act so as to provide that a person must meet criteria besides being a medical practitioner in order to prepare a report for the purpose of subsection (7A) in each of those sections.”.

(5) In section 273 (interpretation of Chapter), for the definition of “relevant patient” there is substituted—

“relevant patient” means a patient whose detention in hospital is authorised by—

(a) if the patient is also subject to a restriction order, a compulsion order,

(b) a hospital direction, or

(c) a transfer for treatment direction.”.

(6) In section 326 (orders, regulations and rules), in subsection (4)(c), for the words “268(11) to (14)” there is substituted “271A”.

11ZA Section 11: exercise of powers before commencement

(1) Regulations may be made under section 271A of the Mental Health (Care and Treatment) (Scotland) Act 2003 (which is to be inserted by section 11(4A)) before section 11(4A) comes into force.

(2) In relation to regulations made (or to be made) by virtue of subsection (1), section 11(6) is to be regarded as being in force.

(3) Regulations made by virtue of subsection (1) may not come into force before the day on which section 11(4A) comes into force.

11A Meaning of hospital in sections 268 to 273 of the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 273 (interpretation of Chapter)—

(a) the words up to the end of the definition of “relevant patient” become subsection (1),

(b) after that subsection there is inserted—

“(2) In this Chapter, a reference to a hospital may be read as a reference to a hospital unit.

(3) For the purposes of this Chapter, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

Removal and detention of patients

13 Notifying decisions on removal orders

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 295 there is inserted—
“295A Notification of decision under section 293 or 295

(1) Subsection (2) below applies in relation to a decision of a sheriff or a justice of the peace under section 293 of this Act making, or refusing to make, a removal order.

(2) As soon as practicable after the decision is made, the mental health officer who made the application for the removal order must notify the Commission of the decision.

(3) Subsection (4) below applies in relation to a decision of a sheriff under section 295 of this Act making, or refusing to make, an order recalling or varying a removal order.

(4) As soon as practicable after the decision is made, the mental health officer specified in the removal order must notify the Commission of—

(a) the decision, and

(b) any additional order made under subsection (6) of section 295 of this Act.”.

14 Detention pending medical examination

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 299 (nurse’s power to detain pending medical examination)—

(a) in subsection (2)—

(i) paragraph (b) is repealed together with the word “and” immediately preceding it,

(ii) in the text following paragraph (b), for the words from “, subject” to the end there is substituted “be detained in the hospital for a period not exceeding 3 hours (“holding period”) for the purpose of enabling the carrying out of a medical examination of the patient by a medical practitioner”,

(b) in paragraph (c) of subsection (3), for the words “to carry out a medical examination of the patient” there is substituted “for a medical examination of the patient to be carried out by a medical practitioner”,

(d) subsection (4) is repealed.

Periodical referral of cases

16 Periodical referral of cases

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(1A) In subsection (3)(c) of section 101 (Tribunal’s duty to review determination under section 86), for the words “made to” there is substituted “determined by”.

(2) In section 189 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2), for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) for the words “made to” there is substituted “determined by”,
Mental Health (Scotland) Bill
Part I—The 2003 Act

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(3) In section 213 (reference to Tribunal by Scottish Ministers)—

(a) in subsection (2), for the words “made to” in each place where they occur there is substituted “determined by”,

(b) in subsection (3)—

(i) for the words “made to” there is substituted “determined by”,

(ii) after the words “made under subsection (2) above” there is inserted “that has been determined by it”.

(4) In Schedule 2 (the Mental Health Tribunal for Scotland), paragraph 13A is repealed.

Representation by named persons

18A Named person not to be automatic

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) Sections 251 and 253 are repealed.

(3) In subsection (2) of section 318 (false statements), sub-paragraph (ii) of paragraph (b) is repealed.

(4) In the definition in subsection (1) of section 329 (interpretation) of “named person”, after the words “the person” there is inserted “(if any)”.  

19 Consent to being named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 250 (nomination of named person)—

(a) in subsection (1), for the words “(3) and (6)” there is substituted “(2A), (3) and (6)

(b) after subsection (2) there is inserted—

“(2A) A nomination under subsection (1) above is valid only if—

(a) a docket to the nomination states that the person nominated has consented to the nomination,

(b) the docket is signed by the nominated person, and

(c) the nominated person’s signature is witnessed by a prescribed person.”,

(c) in subsection (6), for the words “may decline” there is substituted “ceases”.  

(4) In section 257 (named person: Tribunal’s powers)—

(a) in subsection (3), after the word “(4)” there is inserted “or (5)

(b) after subsection (4) there is inserted—

“(5) An order under this section appointing a person to be a patient’s named person may be made only if—

(a) a document, signed by the person, states that the person has consented to being the patient’s named person, and
Part I—The 2003 Act

20 Appointment of named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 255 (named person: mental health officer’s duties etc.)—

(a) subsections (3) to (5) are repealed,

(b) in paragraph (b) of subsection (7), sub-paragraph (i) is repealed together with the word “or” immediately following it.

(3) In section 256 (named person: application by patient etc.)—

(a) paragraph (a) of subsection (1) is repealed,

(b) in paragraph (b) of subsection (1), for the words “the applicant” there is substituted “a person mentioned in subsection (2) below (“the applicant”).

(4) In section 257 (named person: Tribunal’s powers)—

(a) subsection (1) is repealed,

(b) in subsection (2), for the words from “declaring” to the end there is substituted “as allowed by subsection (3A)”.

(c) after subsection (3) there is inserted—

“(3A) For the purpose of subsection (2), this subsection allows an order—

(a) in any case, to declare that the acting named person is not the named person,

(b) if the patient has not attained the age of 16 years, to appoint the person specified in the order to be the patient’s named person in place of the acting named person.”.

(5) In section 320 (appeal to sheriff principal against certain decisions of the Tribunal), paragraph (t) of subsection (1) is repealed.

20A Ability to act if no named person

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 257 there is inserted—

“Ability to act if no named person

257A Ability to act if no named person

(1) This section applies if—

(a) a patient does not have a named person,
(b) the patient has attained the age of 16 years, and
(c) the patient is incapable in relation to a decision as to whether to initiate an application or appeal in the patient’s case.

(2) In subsection (1)(c) above, “incapable” has the same meaning as in section 250 of this Act.

(3) Each of the persons listed in subsection (9)(a) to (d) below has authority to initiate an application or appeal that may be made by the patient under section 50(1), 99(1), 100(2), 120(2), 125(2), 126(2), 163(1), 164(2), 192(2), 201(1), 204(1), 214(2), 219(2), 220(2), 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act.

(4) Each of the persons listed in subsection (9)(a) and (b) below has authority to obtain any notice or information that is to be provided under section 54(3), 60(1), 87(2)(c), 124(4) or (6), 127(7), 128(3), 129(3) or (4), 153(2)(c), 200(3), 218(4), (6) or (10)(b), 224(8), 225(3) or 226(3) of this Act.

(5) The reference in subsection (3) above to section 264(2), 268(2), 320(2), 321(1) or 322(2) of this Act does not apply in relation to a guardian or a welfare attorney of the patient (as that person is already entitled to make an application or appeal under that section).

(6) In the application of subsection (4) above—

(a) the reference to section 87(2)(c) or 153(2)(c) relates only to notice of the determination mentioned in that section (and not also to a copy of the record mentioned in that section),
(b) the reference to section 128(3) or 129(4) relates to a responsible medical officer’s reasons only if that officer is satisfied that it is appropriate to give notice of them to a guardian or a welfare attorney of the patient (having regard to the need to ensure the patient’s wellbeing and confidentiality).

(7) Neither of the persons listed in subsection (9)(c) or (d) below has authority to act in relation to a patient by virtue of this section if the patient has made a written declaration precluding the person (or all persons) from so acting.

(8) Subsections (2) to (5) and (7) of section 250 of this Act apply to a declaration mentioned in subsection (7) above as they apply to a nomination to which subsection (1) of that section relates (with that section to be read accordingly).

(9) The listed persons are—

(a) any guardian of the patient,
(b) any welfare attorney of the patient,
(c) the patient’s primary carer (if any),
(d) the patient’s nearest relative.”.

Advance statements, support and services

(21) Advance statements to be registered

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 276 there is inserted—
Part 1—The 2003 Act

“276A  Advance statements to be put with medical records

(1)  Subsection (2) below applies where a Health Board receives a copy of an advance statement, or a copy of a document withdrawing an advance statement, from—

(a)  the person who made the statement, or

(b)  any individual acting with the person’s authority in relation to the statement.

(2)  The Health Board must—

(a)  place a copy of the statement or document with the person’s medical records, and

(b)  inform the Commission—

(i)  that a copy of the statement or document is held with the person’s medical records, and

(ii)  of the premises at which the medical records are kept (and the personal and administrative details essential for identifying the records as the person’s).

276B  Advance statements to be registered by the Commission

(1)  Where the Commission receives information by virtue of section 276A(2) of this Act, the Commission must enter the information in a register of advance statements maintained by it (and mark the date on which the entry is made).

(2)  The Commission must allow an entry in the register to be inspected at a reasonable time—

(a)  by the person whose medical records are referred to in the entry,

(b)  with respect to treatment of the person for mental disorder, by any individual acting on the person’s behalf,

(c)  for the purpose of making decisions or taking steps with respect to the treatment of the person for a mental disorder, by—

(i)  a mental health officer dealing with the person’s case,

(ii)  the person’s responsible medical officer,

(iii)  the Health Board responsible for the person’s treatment.

276D  Publicising support for making advance statements

(1)  A Health Board is to publicise any support that it offers for—

(a)  making or withdrawing an advance statement,

(b)  sending a copy of an advance statement, or a copy of a document withdrawing an advance statement, to a Health Board.

(2)  A Health Board must give the Commission such information as the Commission may from time to time seek on what the Health Board is doing in order to comply with subsection (1) above.”.
21A Information about advocacy services

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 259 there is inserted—

“259A Information-gathering

(1) Each of the bodies mentioned in subsection (2) below must give the Commission such information as the Commission may from time to time seek on how the body—

(a) has, during a period of at least 2 years specified by the Commission, been exercising the functions conferred on the body by section 259 of this Act, and

(b) intends, during a period of at least 2 years specified by the Commission, to exercise the functions conferred on the body by section 259 of this Act.

(2) The bodies are—

(a) a local authority,

(b) a Health Board,

(c) the State Hospitals Board for Scotland.”.

22 Communication at medical examination etc.

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 261 there is inserted—

“261A Help with communication at medical examination etc.

(1) Subsection (2) below applies where—

(a) a medical examination or interview referred to in subsection (4)(a) or (b) below is to be carried out, and

(b) the subject of it—

(i) has difficulty in communicating, or

(ii) generally communicates in a language other than English.

(2) The appropriate person must take all reasonable steps to secure that, for the purpose of enabling the subject of the medical examination or interview to communicate during it—

(a) arrangements appropriate to the subject’s needs are made, or

(b) the subject is provided with assistance, or material, appropriate to those needs.

(3) As soon as practicable after taking any steps under subsection (2) above, the appropriate person must make a written record of the steps.

(4) This subsection refers to—

(a) a medical examination by virtue of section 36(1)(a), 44(1)(a), 57(2) or 136(2) of this Act,

(b) an interview by virtue of—
(i) section 45(1)(a) or 61(2)(a) of this Act, or
(ii) section 59B(2)(a) or 57C(2)(a) of the 1995 Act.

(5) In subsections (2) and (3) above, “the appropriate person” means—

(a) in relation to a medical examination by virtue of section 136(2) of this Act, the Scottish Ministers,

(b) in relation to a medical examination by virtue of any of the other sections of this Act mentioned in subsection (4)(a) above—
   (i) if it is to be carried out at a hospital, the managers of the hospital,
   (ii) if it is to be carried out elsewhere, the medical practitioner carrying it out,

(c) in relation to an interview referred to in subsection (4)(b) above—
   (i) if it is to be carried out at a hospital, the managers of the hospital,
   (ii) if it is to be carried out elsewhere, the mental health officer carrying it out.”.

22A Conflicts of interest to be avoided

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 291 there is inserted—

“Conflicts of interest to be avoided

291A Conflicts of interest to be avoided

(1) There must not be a conflict of interest in relation to a medical examination to be carried out for the purpose of section 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of this Act.

(2) Regulations may—

(a) specify circumstances in which, in the application of subsection (1) above—
   (i) there is to be taken to be a conflict of interest,
   (ii) there is not to be taken to be a conflict of interest,

(b) specify circumstances in which subsection (1) above does not apply.”.

(3) These provisions are repealed—

(a) in section 36 (emergency detention in hospital)—
   (i) paragraph (a) of subsection (3),
   (ii) subsection (9),

(b) in section 44 (short-term detention in hospital)—
   (i) paragraph (a) of subsection (3),

(c) in section 47 (extension of detention pending application for compulsory treatment order)—
22B Safeguarding the patient’s interest

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 245 (certificates under sections 235, 236, 239 and 241), in subsection (3)—

(a) the word “and” immediately preceding sub-paragraph (ii) of paragraph (a) is repealed,

(b) after sub-paragraph (ii) of paragraph (a) there is inserted—

“(iii) any guardian of the patient; and
(iv) any welfare attorney of the patient;”.

23 Services and accommodation for mothers

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 24 (provision of services and accommodation for certain mothers with post-natal depression)—

(a) in paragraph (d) of subsection (1), for the words “for post-natal depression,” there is substituted “for—

(i) post-natal depression; or
(ii) a mental disorder (other than post-natal depression),”;

(b) after subsection (1) there is inserted—

“(1A) But a Health Board is required to provide services and accommodation under subsection (1) above only if it is satisfied that doing so would be beneficial to the wellbeing of the child.”.

(3) The title of section 24 becomes “Services and accommodation for mothers”.

Cross-border transfers and absconding patients

24 Cross-border transfer of patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 289 (cross-border transfer: patients subject to requirement other than detention), in paragraph (b) of subsection (1)—

(a) the words from “a person” to the end become sub-paragraph (i),

(b) after that sub-paragraph (as so numbered) there is inserted—

“(ii) a person subject to corresponding requirements in a member State of the European Union (apart from the United Kingdom) and removed from that State.”.

(3) In section 290 (cross-border transfer: patients subject to detention requirement or otherwise in hospital)—
(a) in paragraph (c) of subsection (1)—
   (i) the words from “a person” to the end become sub-paragraph (i),
   (ii) after that sub-paragraph (as so numbered) there is inserted—
      “(iii) a person subject to corresponding measures in a member State of the
      European Union (apart from the United Kingdom) and removed from
      that State.”,
(b) for paragraph (f) of subsection (2) there is substituted—
      “(f) enable an appeal against any such decision to be made by—
          (i) such a patient,
          (ii) the named person of such a patient,
          (iii) if such a patient has no named person—
              any guardian of such a patient,
              any welfare attorney of such a patient,
              the primary carer (if any) of such a patient,
              the nearest relative of such a patient;”.
(4) In section 309A (cross-border visits: leave of absence), in subsection (1)—
   (a) the words from “a person” to the end become paragraph (a),
   (b) after that paragraph (as so numbered) there is inserted—
      “(b) a person who is subject to a corresponding suspension of detention in a
      member State of the European Union (apart from the United
      Kingdom).”.

25 Dealing with absconding patients

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) In paragraph (a)(iii) of subsection (3) of section 303 (taking into custody and return of
absconding patients), after the words “compulsory treatment order” there is inserted “or
an interim compulsory treatment order”.
(3) In section 309 (patients from other jurisdictions)—
   (a) in subsection (1)—
       (i) the words from “persons” to the end become paragraph (a),
       (ii) after that paragraph (as so numbered) there is inserted—
           “(b) persons in Scotland who are subject to corresponding requirements or
           corresponding measures in a member State of the European Union (apart
           from the United Kingdom).”,
   (b) in subsection (2), for the words “Those regulations” there is substituted
       “Regulations under subsection (1) above”,
   (c) after subsection (2) there is inserted—
       “(2ZA) Regulations may make provision applying specific provisions in Part 16 of this
       Act to persons to whom sections 301 to 303 of this Act apply by virtue of
       subsection (1) above.”.
(2ZB) Regulations under subsection (2ZA) above may make such modifications of that Part in that application as the Scottish Ministers think fit.

(2ZC) But regulations under subsection (2ZA) above may not—

(a) apply any of that Part to persons who are subject to requirements or measures corresponding only to detention in hospital in accordance with an emergency detention certificate, or

(b) authorise medical treatment of the types mentioned in section 234(2) or 237(3) of this Act.”.

(4) In section 310 (regulations as to absconding by other patients), after subsection (3) there is inserted—

“(3A) In making provision as described in paragraphs (a) and (b) of subsection (1) above, regulations under that subsection may specify persons who are authorised by patients’ responsible medical officers.”.

Arrangements for treatment of prisoners

26 Agreement to transfer of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 136 (transfer of prisoners for treatment for mental disorder), after paragraph (a) of subsection (3) there is inserted—

“(aa) that—

(i) a mental health officer has agreed to the making of the direction, or

(ii) it has been impracticable to obtain the agreement of a mental health officer;”.

27 Compulsory treatment of prisoners

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In schedule 2 (the Mental Health Tribunal for Scotland), in paragraph 7—

(a) in sub-paragraph (4), for the words “(other than proceedings relating solely to an application under section 255 or 256 of this Act)” there is substituted “(other than excepted proceedings)”,

(b) after sub-paragraph (4) there is inserted—

“(4A) For the purpose of sub-paragraph (4) above, the following are excepted proceedings—

(a) proceedings relating solely to an application under section 255 or 256 of this Act, or

(b) proceedings relating to an application for a compulsory treatment order in respect of a patient subject to—

(i) a hospital direction, or

(ii) a transfer for treatment direction.”.
(3) In schedule 3 (application of Chapter 1 of Part 7 to certain patients), after paragraph 1 there is inserted—

“1A In the case of a patient subject to a hospital direction or a transfer for treatment direction, section 60(1) of this Act shall have effect as if, after paragraph (b), there were inserted—

“(ba) to the Scottish Ministers;”.”.

The Commission: statistical information

27A The Commission: statistical information

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 19 (statistical information)—

(a) the words “, in accordance with directions given to it by the Scottish Ministers,” are repealed,

(b) after the words “other information” there is inserted “of such kind as may be prescribed in regulations”,

(c) the existing text becomes subsection (1),

(d) after that subsection, there is inserted—

“(2) Before making regulations under subsection (1), the Scottish Ministers shall consult such persons as they consider appropriate.”.

(3) In subsection (4)(c) of section 326 (orders, regulations and rules) after the words “regulations under section” there is inserted “19(1),”.

Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

27B Review of deaths in detention or otherwise in hospital for treatment for a mental disorder

(1) The Scottish Ministers must carry out a review of the arrangements for investigating the deaths of patients who, at the time of death, were—

(a) detained in hospital by virtue of—

(i) the Mental Health (Care and Treatment) (Scotland) Act 2003;

(ii) the Criminal Procedure (Scotland) Act 1995; or

(b) admitted voluntarily to hospital for the purpose of receiving treatment for a mental disorder.

(2) The review must be carried out within 3 years of this section coming into force.

(3) In carrying out the review under subsection (1), the Scottish Ministers must consult—

(a) where practicable, the nearest relatives of patients within the meaning of subsection (1);

(b) such other persons as they consider appropriate.

(4) The Scottish Ministers must—

(a) publish a report setting out the findings of the review under subsection (1);

(b) lay a copy of that report before the Parliament;
(c) notify those persons consulted under subsection (3) of the publication of the report.”.

PART 2
CRIMINAL CASES
Making and effect of disposals

28 Making certain orders in remand cases
(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In each place where they occur as follows, before the words “in custody” there is inserted “remanded”—
(a) in section 52B (prosecutor’s power to apply for assessment order), in subsection (3)(c),
(b) in section 52C (Scottish Ministers’ power to apply for assessment order), in subsection (1)(c),
(c) in section 52D (assessment order), in subsection (10)(d),
(d) in section 52F (assessment order: supplementary), in subsection (1)(a),
(e) in section 52K (prosecutor’s power to apply for treatment order), in subsection (3)(c),
(f) in section 52L (Scottish Ministers’ power to apply for treatment order), in subsection (1)(c),
(g) in section 52M (treatment order), in subsection (9)(d)(i) and (ii),
(h) in section 52P (treatment order: supplementary), in subsection (2)(a) and (b)(ii).

28A Detention under compulsion orders
(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 57 (disposal of case where accused found not criminally responsible or unfit for trial), in subsection (2)—
(a) in paragraph (a), for the words “authorising the detention of the person in a hospital” there is substituted “(whether or not authorising the detention of the person in a hospital)”,
(b) for paragraph (b) there is substituted—
“(b) subject to subsection (4A) below, make a restriction order in respect of the person (that is, in addition to a compulsion order authorising the detention of the person in a hospital);”

29 Periods for assessment orders
(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.
(2) In section 52D (assessment order)—
(a) in subsection (6)—
(i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”,
(ii) in each of paragraphs (b) and (c), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (6A) below”,

(b) after subsection (6) there is inserted—

“(6A) For the purpose of subsection (6)(b) and (c) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring at the end of the 28 days following that day.”.

(3) In section 52F (assessment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 52G (review of assessment order)—

(a) in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”,

(b) in subsection (4), for words from “7 days” to the end there is substituted “the relevant period given by subsection (4A) below”,

(c) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above, the relevant period is the period—

(a) beginning with the day on which the order would otherwise cease to authorise the detention of the person in hospital,

(b) expiring at the end of the 14 days following that day.”.

(5) In section 52H (early termination of assessment order)—

(a) in subsection (1)—

(i) in paragraph (a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,

(ii) in paragraph (b), for the words “period of 28 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,

(b) after subsection (1) there is inserted—

“(1A) For the purpose of subsection (1)(a) and (b) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring—

(i) as regards subsection (1)(a) above, at the end of the 7 days following the day mentioned in paragraph (a) of this subsection,

(ii) as regards subsection (1)(b) above, at the end of the 28 days following the day mentioned in paragraph (a) of this subsection.”.
30  **Periods for treatment orders**

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 52M (treatment order)—
   
   (a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”;
   
   (b) in subsection (6)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 52P (treatment order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 52R (termination of treatment order)—
   
   (a) in subsection (1)(a), for the words “period of 7 days beginning with the day on which the order is made” there is substituted “relevant period given by subsection (1A) below”,
   
   (b) after subsection (1) there is inserted—
      
      “(1A) For the purpose of subsection (1)(a) above, the relevant period is the period—
   
   (a) beginning with the day on which the order is made,
   
   (b) expiring at the end of the 7 days following that day.”.

31  **Periods for short-term compulsion**

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 53 (interim compulsion order)—
   
   (a) in subsection (3)(c), for the words “expiry of the period of” there is substituted “end of the day following the”;
   
   (b) in subsection (8)—
      
      (i) in paragraph (a), for the words “expiry of the period of” there is substituted “end of the day following the”;
      
      (ii) in paragraph (b), for the words “12 weeks beginning with the day on which the order is made” there is substituted “the relevant period given by subsection (8A) below”;
      
      (iii) in paragraph (c), for the words “period of 12 weeks beginning with the day on which the order is made” there is substituted “relevant period given by subsection (8A) below”;
   
   (c) after subsection (8) there is inserted—
      
      “(8A) For the purpose of subsection (8)(b) and (c) above, the relevant period is the period—
   
      (a) beginning with the day on which the order is made,
      
      (b) expiring at the end of the 12 weeks following that day.”.

(3) In section 53A (interim compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 53B (review and extension of interim compulsion order)—
(a) in subsection (4), for the words from “(not exceeding” to “not made)” there is substituted “not exceeding the relevant period given by subsection (4A) below”,

(b) after subsection (4) there is inserted—

“(4A) For the purpose of subsection (4) above, the relevant period is the period—

(a) beginning with the day on which the order would cease to have effect if it were not extended,

(b) expiring at the end of the 12 weeks following that day.”,

(c) in subsection (5), for the words “12 months beginning with the day on which the order was first made.” there is substituted “the period—

(a) beginning with the day on which the order was first made,

(b) expiring at the end of the 12 months following that day.”.

(5) In section 54 (unfitness for trial: further provision), in subsection (2B)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

### 32 Periods for compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 57A (compulsion order)—

(a) in subsection (2), for the words “period of 6 months beginning with the day on which the order is made” there is substituted “relevant period given by subsection (2A) below”,

(b) after subsection (2) there is inserted—

“(2A) For the purpose of subsection (2) above, the relevant period is the period—

(a) beginning with the day on which the order is made,

(b) expiring at the end of the 6 months following that day.”,

(c) in subsection (5)(b), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 57B (compulsion order authorising detention in hospital or requiring residence at place: ancillary provision), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

(4) In section 57D (compulsion order: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.

### 33 Periods for hospital directions

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 59A (hospital directions)—

(a) in subsection (4)(b), for the words “expiry of the period of” there is substituted “end of the day following the”,

(b) in subsection (7)(a), for the words “expiry of the period of” there is substituted “end of the day following the”.

(3) In section 59C (hospital direction: supplementary), in subsection (1), for the words “expiry of the period of” there is substituted “end of the day following the”.


Variation of certain orders

34 Variation of interim compulsion orders

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) In section 53B (review and extension of interim compulsion order)—

(a) in subsection (4)—

(i) the words from “if satisfied” to the end become paragraph (a),

(ii) after that paragraph (as so numbered) there is inserted “, and

(b) if it seems appropriate to do so, direct that the offender be admitted to

the hospital specified in the direction.”,

(b) in subsection (6), after the word “order” there is inserted “or make a direction

specifying a hospital”,

(c) after subsection (7) there is inserted—

“(7A) Where a direction is made under subsection (4) above, the interim compulsion

order has effect as if the hospital specified in the direction were the hospital

specified in the order.”.

35 Transfer of patient to suitable hospital

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) The italic heading immediately preceding section 61 becomes “Miscellaneous

provision”.

(3) After section 61 there is inserted—

“61A Transfer of person to suitable hospital

(1) Subsection (2) below applies in relation to a person who is subject to—

(a) an assessment order,

(b) a treatment order,

(c) an interim compulsion order, or

(d) a temporary compulsion order (see section 54(1)(c) of this Act).

(2) The person’s responsible medical officer may transfer the person from the

specified hospital to another hospital.

(3) The responsible medical officer may transfer the person only if satisfied that,

for the purpose for which the order in question is made—

(a) the specified hospital is not suitable, and

(b) the other hospital is suitable.

(4) In considering the suitability of each hospital, the responsible medical officer is

to have particular regard to the specific requirements and needs in the person’s

case.

(5) As far before the transfer as practicable, the responsible medical officer must—

(a) inform the person of the reason for the transfer,

(b) notify the managers of the specified hospital, and
(c) obtain the consent of—
   (i) the managers of the other hospital, and
   (ii) the Scottish Ministers.

(6) As soon after the transfer as practicable, the responsible medical officer must notify—
   (a) any solicitor known by the officer to be acting for the person, and
   (b) the court which made the order in question.

(7) A person may be transferred under subsection (2) above only once with respect to the order in question.

(8) Where a person is transferred under subsection (2) above, the order in question has effect as if the other hospital were the specified hospital.

(9) In this section—
   “managers” has the meaning given by section 329(1) of the Mental Health (Treatment and Care) Scotland Act 2003,
   “responsible medical officer” has the meaning given by section 329(4) of that Act,
   “specified hospital” means hospital to which the person is admitted by virtue of the order in question.”.

**Specification of hospital units**

35A **Specification of unit**

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) After section 61 there is inserted—

“61B **Specification of hospital unit**

(1) A reference in this Part to a hospital may be read as a reference to a hospital unit.

(2) In the operation of section 61A of this Act in relation to a transfer from one hospital unit to another within the same hospital—
   (a) subsection (2) of that section applies by virtue of subsection (1) of that section where the order in question specifies the hospital unit in which the person is to be detained,
   (b) in subsection (5) of that section—
      (i) paragraph (b) is to be ignored,
      (ii) in paragraph (c)(i), the reference to the managers of the other hospital is to be read as a reference to the managers of the hospital in which the person is detained.

(3) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.
39 Transfer from specified unit

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) After section 218 there is inserted—

"218A Transfer of patient from specified hospital unit"

(1) Subsection (2) below applies where—

(a) a patient is subject to—

(i) a compulsion order and a restriction order,

(ii) a hospital direction, or

(iii) a transfer for treatment direction, and

(b) that order or (as the case may be) direction specifies the hospital unit in which the patient is to be detained.

(2) If the condition in subsection (3) below is satisfied, the managers of the hospital in which the patient is detained may transfer the patient to another hospital unit within the same hospital.

(3) The condition is that the Scottish Ministers consent to the transfer.

(4) In relation to a transfer or proposed transfer under subsection (2) above, section 218(4) to (14) of this Act applies subject to the following modifications—

(a) a reference to section 218(2) is to be read as a reference to subsection (2) above,

(b) in subsection (10)(a), a reference to section 218(3) is to be read as a reference to subsection (3) above,

(c) in subsection (12), a reference to the hospital from which the patient is transferred is to be read as a reference to the hospital in which the patient is detained,

(d) in subsections (13)(b) and (14), a reference to the hospital to which the patient is transferred is to be read as a reference to the hospital unit to which the patient is transferred.

(5) For the purposes of this section, “hospital unit” means any part of a hospital which is treated as a separate unit.”.

40 Consequential repeals

The following enactments are repealed—

(a) section 9 of the Crime and Punishment (Scotland) Act 1997,

(b) paragraph 66 of schedule 7 to the Criminal Justice and Licensing (Scotland) Act 2010.

Miscellaneous amendments

41 Information on extension of compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.
(2) After section 153 there is inserted—

**“153A Further information on extension of compulsion order**

(1) Subsections (2) and (3) below apply where—

(a) a mental health officer receives notice of a determination under section 152 of this Act from a patient’s responsible medical officer, and

(b) the Tribunal is required by virtue of section 165(2)(a) of this Act to review the determination.

(2) The mental health officer must—

(a) prepare a record stating the information mentioned in subsection (4) below,

(b) submit the record to the Tribunal, and

(c) at the same time as submitting the record to the Tribunal, send to the persons mentioned in subsection (6) below—

(i) a copy of the record, and

(ii) a statement of the matters mentioned in subsection (5) below.

(3) At the same time as submitting the record to the Tribunal, the mental health officer must send a copy of the record to the patient except where the officer considers that doing so carries a risk of significant harm to the patient or others.

(4) The information to be stated in the record is—

(a) the name and address of the patient,

(b) if known by the mental health officer, the name and address of—

(i) the patient’s named person, and

(ii) the patient’s primary carer,

(c) the things done by the mental health officer in compliance with the requirements in subsection (2) of section 151 of this Act (and, if by virtue of subsection (3) of that section the first-listed one has not been complied with, the reason why compliance with it was impracticable),

(d) so far as relevant to the extension of the compulsion order—

(i) the details of the personal circumstances of the patient, and

(ii) if known by the mental health officer, the details of any advance statement made by the patient (and not withdrawn by the patient),

(e) the views of the mental health officer on the extension of the compulsion order, and

(f) any other information that the mental health officer considers relevant in relation to the extension of the compulsion order.

(5) The matters referred to in subsection (2)(c) above are—

(a) whether the mental health officer is sending a copy of the record to the patient, and

(b) if the mental health officer is not sending a copy of the record to the patient, the reason for not doing so.
(6) For the purposes of subsection (2)(c) above, the persons are—

(a) the patient’s named person,

(b) the patient’s responsible medical officer, and

(c) the Commission.”.

5 Notification of changes to compulsion order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 157 (application for extension and variation of compulsion order: notification), paragraph (f) is repealed together with the word “and” immediately preceding it.

(3) In section 160 (application for variation of compulsion order: notification), for the word “(f)” there is substituted “(e)”.

42A Effect of revocation of restriction order

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In subsection (2) of section 198 (effect of revocation of restriction order), for the words “Tribunal revoked the restriction order” there is substituted “order revoking the restriction order has effect in accordance with section 196 of this Act”.

42B Clarification of meaning of compulsion order

(1) The Criminal Procedure (Scotland) Act 1995 is amended as follows.

(2) For the definition in subsection (1) of section 307 (interpretation) of “compulsion order” there is substituted—

““compulsion order” means an order under section 57(2)(a) or 57A(2) of this Act;”.

(3) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(4) In subsection (6)(d) of section 1 (principles for discharging certain functions), for the words “section 57A(2)” there is substituted “section 57(2)(a) or 57A(2)”.

(5) For the definition in subsection (1) of section 329 (interpretation) of “compulsion order” there is substituted—

““compulsion order” means an order under section 57(2)(a) or 57A(2) of the 1995 Act;”.

30 Part 3 Victims’ rights

Information and representations

43 Right to information: offender imprisoned

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) In section 16 (victim’s right to receive information concerning release etc. of prisoner), in subsection (3)—
Mental Health (Scotland) Bill
Part 3—Victims’ rights

(a) in paragraph (e)—
   (i) for the words “or young” there is substituted “, young”,
   (ii) after the word “institution” there is inserted “or hospital”,

(b) the word “and” immediately preceding paragraph (f) is repealed,

(c) in paragraph (f)—
   (i) for the words “or young” there is substituted “, young”,
   (ii) after the word “institution” there is inserted “or hospital”,

(d) after paragraph (f) there is inserted—

“(g) where the convicted person is liable to be detained in a hospital under a hospital direction or transfer for treatment direction—
   (i) that a certificate has been granted, for the first time, under the Mental Health Act which suspends the person’s detention and does not impose a supervision requirement,
   (ii) that the certificate mentioned in sub-paragraph (i) has been revoked.”.

(3) In section 16, in subsection (4)—

(a) the word “or” immediately preceding paragraph (b) is repealed, and
(b) at the end of paragraph (b) there is inserted “; or
(c) modify section 18A, by adding, amending or repealing definitions of terms used in the descriptions of information in subsection (3) of this section.”.

44 Right to information: compulsion order

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 16 there is inserted—

“16A Victim’s right to receive information concerning offender subject to compulsion order

(1) Subsection (2) applies where—

(a) an offence has been perpetrated against a natural person,
(b) another person (“O”) has been made subject to a compulsion order and a restriction order in proceedings in respect of that offence,
(c) a person has asked to be given information about O under this section and that person is, or was at the time of asking, a person entitled to ask to be given the information (see section 16B), and
(d) O has attained the age of 16 years.

(2) The Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).

(3) But the Scottish Ministers—
(a) need not give a person information under this section if they consider there to be exceptional circumstances which make it inappropriate to do so,

(b) are not to give a person information about the terms of a condition in accordance with section 16C(2)(fa) unless the condition is relevant to that person as described in section 18A(3).

(4) If the compulsion order or the restriction order mentioned in subsection (1)(b) is revoked, subsection (2) ceases to apply when the Scottish Ministers give the person mentioned in subsection (1)(c) the information that—

(a) the order has been revoked, and

(b) the decision to revoke it is final.

16B Person entitled to ask to be given information under section 16A

(1) The reference in section 16A(1)(c) to a person entitled to ask to be given information under that section is to—

(a) the natural person (“V”) against whom the offence mentioned in section 16A(1)(a) (“the relevant offence”) was perpetrated,

(b) if V is dead—

(i) any or all of the four qualifying persons highest listed in section 14(10), and

(ii) if V died before attaining the age of 16 years, any other person who cared for V immediately before the relevant offence was perpetrated, or

(c) if V has attained the age of 12 years and is incapable for the purposes of this section, the qualifying person highest listed in section 14(10).

(2) If a person (including V) who would be entitled to ask to be given information by virtue of subsection (4) has not attained the age of 12 years—

(a) the person is not entitled to ask to be given the information, and

(b) someone who cares for the person is entitled to ask to be given it instead.

(3) For the purposes of this section—

(a) the references to a qualifying person are to a person—

(i) whose relationship to V is listed in subsection (10) of section 14 (read with the other subsections of that section),

(ii) who is not incapable for the purposes of this section, and

(iii) who is not a person accused of, or reasonably suspected of being the perpetrator of, or having been implicated in the perpetration of, the relevant offence,

(b) when determining who is the qualifying person highest listed in section 14(10), if two or more persons have the same relationship to V they are to be listed according to age with the eldest being the highest listed of them,
(c) the expressions “cared for” and “cares for”, are to be construed in accordance with the definition of “someone who cares for” in paragraph 20 of schedule 12 to the Public Services Reform (Scotland) Act 2010,

(d) a person is to be considered incapable for the purposes of this section if the person would be considered incapable of making a victim statement by virtue of section 14(6)(b)(i) and (7).

16C Information to be given under section 16A

(1) This section sets out the information that is to be given under section 16A about the person referred to in that section as O.

(2) The following information is to be given in any case—

(a) that the compulsion order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(b) that the restriction order to which O is subject and which is mentioned in section 16A(1)(b) has been revoked,

(ba) where the order mentioned in paragraph (a) or the order mentioned in paragraph (b) has been revoked, that the decision to revoke it—

(i) is being appealed against, or

(ii) cannot competently be appealed against and is therefore final,

(c) the date of O’s death,

(d) that the compulsion order has been varied by way of a modification of the measures specified in it,

(e) that O has been transferred to a place outwith Scotland,

(f) that the Mental Health Tribunal has made an order under section 193(7) of the Mental Health Act conditionally discharging O,

(fa) the terms of any conditions imposed on O on conditional discharge under section 193(7) or section 200(2) of the Mental Health Act (including under section 193(7) as applied by section 201(3) or 204(3) of that Act),

(g) that the Scottish Ministers have recalled O to hospital under section 202 of the Mental Health Act.

(3) The following information is to be given in a case where the compulsion order authorises O’s detention in hospital—

(a) that O is unlawfully at large from hospital,

(b) that O has returned to hospital having been unlawfully at large,

(c) that a certificate has been granted, for the first time, under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,

(d) that the certificate mentioned in paragraph (c) has been revoked.

(4) The following information is to be given in a case where the order mentioned in paragraph (a) or the order mentioned in paragraph (b) of subsection (2) has been revoked and that decision is appealed against—
(a) that the Court of Session has decided to allow, or not allow, the appeal against the decision to revoke the order in question,

(b) that the Court of Session’s decision—
   (i) has been appealed against to the Supreme Court, or
   (ii) has not been appealed against to the Supreme Court before the expiry of the time allowed to appeal to the Supreme Court, and therefore if the Court of Session has not allowed the appeal the decision to revoke the order in question is final,

(c) that the Supreme Court has decided to allow, or not allow, the appeal against the Court of Session’s decision,

(d) if the Supreme Court’s decision means that the decision to revoke the order in question has not been set aside, that the latter decision is final,

(e) if the Court of Session’s decision or the Supreme Court’s decision means that O is once more subject to the order in question, that fact.”.

45 Right to make representations

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17A there is inserted—

“17B Mentally-disordered offender: victim’s right to make representations

(1) A person (“V”) who is to be given information about another person (“O”) under section 16 or 16A, must be afforded an opportunity to make representations—

   (a) in a case where O is subject to a hospital direction or a transfer for treatment direction, before a decision of a type described in subsection (4) is taken in relation to O,

   (b) in a case where O is subject to a compulsion order and a restriction order, before a decision of a type described in subsection (5) is taken in relation to O.

(2) Representations under this section must be about how the decision in question might affect V or members of V’s family.

(3) Subsection (1) does not apply unless V has intimated to the Scottish Ministers a wish to be afforded an opportunity to make representations about O under this section.

(4) For the purpose of section (1)(a), the type of decision is a decision by O’s responsible medical officer about granting for the first time a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement.

(5) For the purpose of subsection (1)(b), the types of decision are a decision—

   (a) by O’s responsible medical officer about granting for the first time a certificate under the Mental Health Act which suspends O’s detention and does not impose a supervision requirement,
(b) by the Mental Health Tribunal under section 193 of the Mental Health Act (including a decision under that section as applied by section 201(3) or 204(3) of that Act),

(e) by the Scottish Ministers under section 200 of the Mental Health Act about imposing, altering or removing a condition which is (or would be) relevant to V as described in section 18A(3).

(6) The Scottish Ministers need not afford V an opportunity to make representations before taking a decision of the type described in subsection (5)(e) if it is not reasonably practicable to afford V that opportunity.

17C Making representations under section 17B

(1) Representations under section 17B—

(a) may be made orally in relation to a decision of a type described in section 17B(5)(b), but

(b) otherwise, must be made in writing.

(2) The Scottish Ministers are to issue guidance as to how—

(a) written representations under section 17B should be framed, and

(b) oral representations under that section should be made.

17D Right to information after section 17B decision

(1) Subsection (2) applies where—

(a) before a decision was taken, a person (“V”) was afforded an opportunity to make representations under section 17B,

(b) the decision has since been taken,

(c) the Scottish Ministers are not required under section 16A to give any information to V as a result of the decision, and

(d) V has intimated to the Scottish Ministers a wish to receive information under this section.

(2) The Scottish Ministers must, unless they consider that there are exceptional circumstances which make it inappropriate to do so, inform V that the decision has been taken.

(3) Subsection (4) applies where—

(a) in accordance with subsection (2), the Scottish Ministers have informed V that the Tribunal has decided to make an order revoking a compulsion order or restriction order, and

(b) by virtue of section 196 of the Mental Health Act, the Tribunal’s order does not have effect because the Court of Session has made an order under section 323(1) of that Act.

(4) The Scottish Ministers must—

(a) inform V that the Court of Session has made an order under section 323(1) of the Mental Health Act, and
(b) give V the information that they would have had to give V by virtue of section 16C(4) had the Court not made that order.”.

Additional provisions

46 Information sharing

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 17D there is inserted—

“17E Information sharing in respect of mentally-disordered offenders

(1) Where the Scottish Ministers are subject to a duty under section 16 or 16A to give a person (“V”) information about another person (“O”), they must give notice to—

(a) O’s responsible medical officer, and

(b) if O is subject to a compulsion order, the Mental Health Tribunal.

(2) A notice under subsection (1) is to request that the recipient of the notice provide the Scottish Ministers with information in such circumstances as may be specified in the notice.

(3) The information that the Scottish Ministers may request in a notice under subsection (1) must be information about O which they will require in order to fulfil their duty to give information to V under section 16, 16A or 17D.

(4) The recipient of a notice under subsection (1) must provide the Scottish Ministers with the information requested in the notice in the circumstances specified in it.

(5) If the Scottish Ministers cease to be required to give anyone information about O under section 16 or 16A—

(a) they must intimate that fact to anyone to whom they sent a notice in relation to O in accordance with subsection (1), and

(b) on receiving that intimation, subsection (4) ceases to apply to the person who received the intimation.”.

47 Associated definitions

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18 there is inserted—

“18A Interpretation of Part

(1) In this Part—

“Mental Health Act” means the Mental Health (Care and Treatment) (Scotland) Act 2003,

“Mental Health Tribunal” means the Mental Health Tribunal for Scotland,

“transfer for treatment direction” means a direction made under section 136 of the Mental Health Act.

(2) A reference in this Part—
Mental Health (Scotland) Bill

Part 3—Victims’ rights

39

(a) to a certificate under the Mental Health Act which suspends a person’s
detention and does not impose a supervision requirement is to a
certificate under subsection (2) of section 224 of that Act, which does
not include a condition under subsection (7)(a) of that section,

(b) to such a certificate being granted for the first time is to such a certificate
being granted for the first time—

(i) since the person was detained under the particular order or
direction which authorises the person’s detention in a hospital (or
would do, but for the certificate’s being granted), or

(ii) in a case where the person, while subject to that order or direction,
has been recalled to hospital under section 202 of the Mental
Health Act, since the person was so recalled (or most recently so
recalled if it has happened more than once).

(3) For the purposes of sections 16A(3)(b) and 17B(5)(c), a condition is relevant to
a person (“V”) if—

(a) the condition is a restriction on the person referred to in the section in
question as O contacting an individual or being in a place, and

(b) V has made a valid request to the Scottish Ministers to be informed
about any condition which restricts O from—

(i) contacting that individual, or (as the case may be)

(ii) being in that place or any wider area within which the place in
question falls.

(4) The Scottish Ministers may treat a request as invalid for the purposes of
subsection (3) if or so far as—

(a) it is a request to be informed about any condition which restricts O from
being in a place, and

(b) the place referred to in the request—

(i) is not one which V or any member of V’s family is regularly at or
in, or

(ii) covers an unreasonably large area having regard to the places
where V and members of V’s family regularly go.”.

48 Power to make modifications

(1) The Criminal Justice (Scotland) Act 2003 is amended as follows.

(2) After section 18A there is inserted—

“18B Power to modify Part

(1) The Scottish Ministers may by order amend—

(a) sections 16A and 16B, by substituting for any age for the time being
specified in those sections a different age,

(b) section 16C, by adding descriptions of information,

(c) section 18A, by adding, amending or repealing definitions of terms used
in the descriptions of information in section 16C.”
(2) The Scottish Ministers may by order amend—

(a) section 16A, so that information may be given under that section in some or all cases where a person has been made subject to a compulsion order and either—

(i) the person has not been made subject to a restriction order, or

(ii) the restriction order to which the person was made subject has been revoked,

(b) section 17B, to specify types of decision in respect of which representations under that section may be made by persons who have a right to be given information under section 16A as amended by virtue of paragraph (a).

(3) In an order under subsection (2) which amends section 16A or 17B, the Scottish Ministers may make any amendment to the following enactments which they consider necessary or expedient in consequence of the amendment to section 16A or 17B—

(a) sections 16C, 17E and 18A,

(b) the Mental Health (Care and Treatment) (Scotland) Act 2003.”.

(3) In section 88 (orders), after “16(4)” there is inserted “, 18B”.

49 Amendments to the 2003 Act

(1) The Mental Health (Care and Treatment) (Scotland) Act 2003 is amended as follows.

(2) In section 193 (powers of Tribunal on reference or application under certain sections), after subsection (9) there is inserted—

“(9A) Where—

(a) a person ("V") is entitled to make victim’s representations before the Tribunal makes a decision under this section, and

(b) V has not been afforded the opportunity of making representations under subsection (8),

before making a decision about what (if any) conditions to impose on the patient’s conditional discharge under subsection (7), the Tribunal must have regard to any victim’s representations made by V.”.

(3) In section 200 (variation of conditions imposed on conditional discharge), after subsection (2) there is inserted—

“(2A) Before varying any conditions under subsection (2), the Scottish Ministers must have regard to any victim’s representations.”.

(4) In section 224 (patients subject to certain orders and directions: suspension of measure authorising detention), after subsection (6) there is inserted—

“(6A) Before deciding what conditions such as are mentioned in subsection (7) below to include in a certificate under subsection (2) above (if any), the responsible medical officer must have regard to any victim’s representations.”.

(5) In section 329 (interpretation), at the appropriate alphabetical place in subsection (1) there is inserted—
“‘victim’s representations’ means representations made under section 17B of the Criminal Justice (Scotland) Act 2003 in relation to the matter being considered;”.

PART 4

COMMENCEMENT AND SHORT TITLE

50 Commencement

(1) This Part and section 11ZA come into force on the day after Royal Assent.

(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.

(3) An order under subsection (2) may include transitional, transitory or saving provision.

51 Short title

The short title of this Act is the Mental Health (Scotland) Act 2015.
Mental Health (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Introduced by: Alex Neil
Supported by: Michael Matheson
On: 19 June 2014
Bill type: Government Bill