Health and Sport Committee

Stage 1 Report on Mental Health (Scotland) Bill
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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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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.³

9. In 2008 the Scottish Government commissioned a limited review of the civil provisions of the 2003 Act.⁴ 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.⁵

**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.”⁶

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.⁷
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”\(^{14}\).

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.\(^{15}\)

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.\(^{16}\)

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.\(^{17}\)

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.\(^{18}\) 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.”\(^{19}\)

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.\(^{20}\)

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.\(^{21}\)

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”.  

Health and Sport Committee  
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.
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.\textsuperscript{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.\textsuperscript{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).\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\(^\text{48}\)

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.”\(^\text{49}\)

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.\(^\text{50}\)

**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”\(^\text{51}\). 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”.\(^\text{52}\)

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”.\(^\text{53}\)

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.\(^\text{54}\) 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”. 59

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”. 60

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. 61

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 62, 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.

**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{54}

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”⁹¹ 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.⁹²

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.⁹³

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.”⁹⁴

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.”⁹⁵ 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
Mental Health Network Greater Glasgow that training and information resources for named persons should be developed.\textsuperscript{101}

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—

\begin{quote}
“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.”\textsuperscript{102}
\end{quote}

127. Joe Morrow highlighted the difference a family’s engagement could make to patients’ care and in delivering good outcomes for the patient.\textsuperscript{103}

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.\textsuperscript{104} 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.\textsuperscript{105}

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.\textsuperscript{106}

Awareness of role of named person

130. A number of witnesses\textsuperscript{107} 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.\textsuperscript{108}

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.\textsuperscript{109}

Young people

132. The Carers Trust Scotland,\textsuperscript{110} 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.”

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.  

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.”

143. Colin McKay sought to assure the Committee that the Mental Welfare Commission already held sensitive information about patients. However, the Scottish Human Rights Commission proposed that people should be able to choose the level of information held on them by the Commission.

144. A similar point was made by Carolyn Roberts, who raised concerns regarding the inclusion of the entire advance statement in the register. 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.

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.”
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.”

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”. 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. This suggestion was supported by the Scottish Human Rights Commission, SIAA and Inclusion Scotland.

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.

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. SAMH suggested that the forms relating to advance statements and named persons could be simplified and combined. 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.
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.  

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.

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. 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.”

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.

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.

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.”

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 would change from 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.\textsuperscript{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.\textsuperscript{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”.\textsuperscript{141} The Royal College of Psychiatrists also welcomed the proposed extension.\textsuperscript{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.\textsuperscript{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”.\textsuperscript{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.\textsuperscript{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)\(^1\). 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.\(^2\)

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”.\(^3\)

179. Social Work Scotland and Midlothian Council welcomed the changes and, in a view reiterated in many of the written submissions,\(^4\) 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.\(^5\)

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.\(^6\)

183. In contrast, a number of witnesses supported the approach taken in the Bill for exceptions to apply to those subject to the scheme.\(^7\) 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}

\textbf{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.”

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.

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.

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.

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.

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.”

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.

205. Shaben Begum suggested that the Mental Welfare Commission should have responsibility for monitoring the availability of access to independent advocacy.

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.
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.  

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.” 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 ECHR 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.”

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.\textsuperscript{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
the Health and Sport Committee, which is available on the Health and Sport Committee’s website (see Annexe C).

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.
SAMH. Written submission.


The Mental Health Tribunal for Scotland. Written submission.


The Mental Welfare Commission for Scotland. Written submission.


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.


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,
SAMH, East Renfrewshire Community Health and Care Partnership, SIAA and Fife Council Social Work Service
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 Zarthurus
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