HEALTH AND SPORT COMMITTEE

AGENDA

16th Meeting, 2017 (Session 5)

Tuesday 13 June 2017

The Committee will meet at 9.15 am in the James Clerk Maxwell Room (CR4).

1. **Subordinate legislation:** The Committee will take evidence on the Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [draft] from—

   Maureen Watt, Minister for Mental Health, Ruth Wilson, Senior Policy Advisor, Mental Health and Protection of Rights Division, and Ailsa Garland, Solicitor, Scottish Government.

2. **Subordinate legislation:** Minister for Mental Health to move—S5M-05753—That the Health and Sport Committee recommends that the Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [draft] be approved.

3. **Subordinate legislation:** The Committee will take evidence on the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft] from—

   Maureen Watt, Minister for Mental Health, Eleanor Stanley, Policy Officer, Nicola Paterson, Head of Protection of Rights Unit, Mental Health and Protection of Rights Division, and Fraser Gough, Parliamentary Counsel, Scottish Government.

4. **Subordinate legislation:** Minister for Mental Health to move—S5M-05951—That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft] be approved.

5. **Subordinate legislation:** The Committee will take evidence on the Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft] from—
Maureen Watt, Minister for Mental Health, Eleanor Stanley, Policy Officer, Nicola Paterson, Head of Protection of Rights Unit, Mental Health and Protection of Rights Division, and Fraser Gough, Parliamentary Counsel, Scottish Government.

6. **Subordinate legislation**: Minister for Mental Health to move—S5M-05950—That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft] be approved.

7. **Subordinate legislation**: The Committee will take evidence on the Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017 [draft] from—

Maureen Watt, Minister for Mental Health, Eleanor Stanley, Policy Officer, Nicola Paterson, Head of Protection of Rights Unit, Mental Health and Protection of Rights Division, and Fraser Gough, Parliamentary Counsel, Scottish Government.

8. **Subordinate legislation**: Minister for Mental Health to move—S5M-05752—That the Health and Sport Committee recommends that the Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017 [draft] be approved.

9. **Subordinate legislation**: The Committee will take evidence on the Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017 [draft] from—

Maureen Watt, Minister for Mental Health, Innes Fyfe, Team Leader, Mental Health and Protection of Rights Division, and Lindsay Anderson, Solicitor, Scottish Government.

10. **Subordinate legislation**: Minister for Mental Health to move—S5M-05949—That the Health and Sport Committee recommends that the Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017 [draft] be approved.

11. **Subordinate legislation**: The Committee will take evidence on the following negative instruments - SSI 2017/172 Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Amendment Rules SSI 2017/174 Mental Health (Conflict of Interest) (Scotland) Regulations 2017 SSI 2017/175 Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017 SSI 2017/176 Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017 from—

Maureen Watt, Minister for Mental Health, Innes Fyfe, Team Leader, Mental Health and Protection of Rights Division, and Lindsay Anderson, Solicitor, Scottish Government.

12. **Integration Authorities Engagement with Stakeholders and Draft Budget 2017-18**: The Committee will take evidence from—
Shona Robison, Cabinet Secretary for Health and Sport, Geoff Huggins, Director for Health and Social Care Integration, and Christine McLaughlin, Director of Health Finance, Scottish Government.

13. **NHS Governance**: The Committee will take evidence from—

Sir Robert Francis QC;

Cathy James, Chief Executive, Public Concern at Work;

Kirsty-Louise Campbell, Senior Manager of Strategy and Insight, and Laura Callender, Governance Compliance Manager, City of Edinburgh Council;

Robin Creelman, Non-Executive Director and Whistleblowing Champion, NHS Highland;

Morag Brown, Non-Executive Director, Co-chair of the Staff Governance Committee and Whistleblowing Champion, NHS Greater Glasgow and Clyde.

14. **Integration Authorities Engagement with Stakeholders and Budget 2017-18 (in private)**: The Committee will consider the evidence heard earlier in the meeting.

15. **NHS Governance (in private)**: The Committee will consider the evidence heard earlier in the meeting.

16. **Draft Budget 2018-19 (in private)**: The Committee will consider an approach paper.

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The papers for this meeting are as follows—

**Agenda item 1**

PRIVATE PAPER  
HS/S5/17/16/1 (P)

Note by the clerk  
HS/S5/17/16/2

Mental Health submissions  
HS/S5/17/16/3

**Agenda item 11**

PRIVATE PAPER  
HS/S5/17/16/4 (P)

Note by the clerk  
HS/S5/17/16/5

**Agenda item 12**

PRIVATE PAPER  
HS/S5/17/16/6 (P)

**Agenda item 13**

PRIVATE PAPER  
HS/S5/17/16/7 (P)

Sir Robert Francis - written submission  
HS/S5/17/16/8

**Agenda item 16**

PRIVATE PAPER  
HS/S5/17/16/9 (P)
Overview of instruments

1. There are a series of instruments for the Committee to consider at today’s meeting which relate to the Mental Health (Scotland) Act 2015

2. There are five affirmative instruments for consideration:

- Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017
- Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017
- Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017
- Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017
- The Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017

There are also four negative instruments for consideration (these are considered in a separate paper).

    Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017

Background

3. These Regulations amend the Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005 (“the 2005 Regulations”), and the Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008 (“the 2008 Regulations”).

4. The 2005 Regulations make provision in relation to patients who are subject to certain orders or directions made under the criminal justice system in Scotland, and who have absconded within Scotland. They specify persons who may take such patients into custody. Regulation 2 of this instrument adds persons authorised by the patient’s responsible medical officer to the list of specified persons in the 2005 Regulations.

5. The 2008 Regulations make provision in relation to persons in Scotland who have absconded from jurisdictions outside Scotland. Regulation 3 of this instrument
amends the 2008 Regulations, including to add member States of the EU to the jurisdictions listed as “relevant territories” for the purposes of the 2008 Regulations.

6. This instrument also inserts a series of provisions in the 2008 Regulations, that apply with modifications to certain sections of Part 16 (medical treatment) of the Mental Health (Care and Treatment) (Scotland) Act 2003. The sections of Part 16 are applied in relation to persons who have been examined by an approved medical practitioner, and who are subject to measures or requirements corresponding to listed measures or requirements in the 2003 Act or the Criminal Procedure (Scotland) Act 1995, which involve detention of the patient.

7. The Regulations are subject to the affirmative procedure. If approved by the Parliament, they would come into force on 30 June 2017.


9. The Committee is due to report by 20 June 2017.

**Delegated Powers and Law Reform Committee consideration**

10. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 23 May 2017. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.

**Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017**

**Background**

11. The Regulations make provision about the transfer to and from Scotland of mental health patients who are not subject to a detention requirement. They amend the principal 2008 Regulations with the same title. The 2008 Regulations set out the process for the transfer of patients on community-based orders between Scotland and England or Wales.

12. The Regulations are subject to the affirmative procedure. If approved by the Parliament, they come into force on 30 June 2017.

14. The Committee is due to report by 23 June 2017.

Delegated Powers and Law Reform Committee consideration

15. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 30 May 2017.

16. The Committee identified minor drafting errors with the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft] and the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft].

17. In its report the Committee noted: “Accordingly, as a very limited exception to the Committee’s normal approach, the Committee accepts the Scottish Government’s proposed approach of correcting the highly evident errors on the signing copy of these two mental health instruments.”

Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017

Background

18. This instrument amends the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 to take account of provisions in the Mental Health (Scotland) Act 2015. The 2005 Regulations set out the process for:

- transferring a patient who is detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or the relevant provisions of the Criminal Procedure (Scotland) Act 1995, from Scotland;
- transferring a patient who is not detained but who is in hospital for treatment for a mental disorder from Scotland to outwith the UK; and
- the reception of patients into Scotland from other UK jurisdictions, who are detained on a corresponding order.

19. The Mental Health (Scotland) Act 2015 makes amendments to the appeal rights that require to be included in Regulations. The instrument introduces a right of appeal for named persons against a decision to transfer the patient from Scotland. Where there is no named person and the person does not have capacity, the right of appeal is for the welfare guardian, welfare attorney, primary carer, or nearest relative. This is in line with provisions in the 2015 Act, as well as allowing for an onward appeal against the Mental Health Tribunal’s decision. It also extends the process for receiving a patient on a corresponding order, to those transferring from another EU member State.

20. The Regulations are subject to the affirmative procedure. If approved by the Parliament, they would come into force on 30 June 2017.
21. An electronic copy of the instrument is available at: http://www.scottish.parliament.uk/S5_HealthandSportCommittee/General%20Documents/A17365532.pdf The Policy Note on the regulations is available at Annexe C.

22. The Committee is due to report by 23 June 2017.

Delegated Powers and Law Reform Committee consideration

23. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 30 May 2017.

24. As referenced above the Committee identified minor drafting errors with the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft] and the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft].

25. In its report the Committee noted: “Accordingly, as a very limited exception to the Committee’s normal approach, the Committee accepts the Scottish Government’s proposed approach of correcting the highly evident errors on the signing copy of these two mental health instruments.”

Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017

Background

26. These Regulations make provision in connection with escorted mental health patients who visit Scotland while on leave of absence under the law of another EU member State.

27. The Mental Health (Scotland) Act 2015 amended the Mental Health (Care and Treatment) (Scotland) Act 2003, to allow regulations made under section 309A of that Act to make equivalent provisions for EU countries as is currently allowed for other UK jurisdictions.

28. The Regulations are subject to the affirmative procedure. If approved by Parliament, they come into force on 30 June 2017.


30. The Committee is due to report by 23 June 2017.

Delegated Powers and Law Reform Committee consideration
31. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 23 May 2017. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.

**The Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017**

**Background**

32. The Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) includes a power for nurses, in certain circumstances and for specified purposes, to detain a person who is in hospital for treatment. The nurse’s power to detain is exercised with a view to assessing whether the patient meets the criteria for the granting of an emergency or a short-term detention certificate.

33. The ‘community payback order’ was introduced by the Criminal Justice and Licensing (Scotland) Act 2010. It replaced probation orders, which were included in the 2003 Act. This Order clarifies that persons who are in hospital for mental health treatment by virtue of a community payback order can also be detained under that power contained in the 2003 Act (as amended).

34. This Order makes consequential amendments to section 299 of the 2003 Act, to clarify that this power will apply where a person is in hospital by virtue of a community payback order which includes a mental health treatment requirement. The Order will not affect the nurse’s power to detain a person who is in hospital for treatment by virtue of a probation order which includes a mental health treatment requirement. This is required because probation orders have remained available for persons convicted of offences committed before 1 February 2011.

35. The Mental Health (Scotland) Act 2015 made a change to a nurse’s power to detain pending medical examination, to simplify the period allowed to a maximum of 3 hours.

36. The Order is subject to the affirmative procedure. If approved by Parliament, it would come into force on 30 June 2017.


38. The Committee is due to report by 20 June 2017.

**Delegated Powers and Law Reform Committee consideration**

39. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 30 May 2017. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.
Annexe A

POLICY NOTE

The Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017

SSI 2017/XXX

The above instrument was made in exercise of the powers conferred by sections 309, 310 and 326(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). The instrument is subject to affirmative procedure.

Policy Objectives

This instrument is made using powers in the 2003 Act that are amended by the Mental Health (Scotland) Act 2015 (“the 2015 Act”). This instrument amends the Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005 (“the 2005 Regulations”) and the Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008 (“the 2008 Regulations”).

The 2005 Regulations

Section 310 of the 2003 Act gives power to make regulations in relation to patients who are subject to certain orders and directions who then abscond or otherwise fail to meet the requirements imposed upon them. Section 310, and regulations made under that section, only applies to such patients who abscond within Scotland. Section 310 is amended by the 2015 Act to allow those regulations to specify persons authorised by the patient’s responsible medical officer as being persons who may take such patients into custody and take other steps.

Regulation 2 of this instrument, then, adds to the list of specified persons in the 2005 Regulations to make provision for such authorised persons.

This regulation makes provision similar to that in section 303(3)(a)(iv) of the 2003 Act which applies for civil patients.

The 2008 Regulations

Medical treatment

The overriding intention in amending the 2008 Regulations is to allow medical treatment to be given to persons from elsewhere in the UK, the Isle of Man, the Channel Islands and other European Union (EU) member states who have absconded and are subsequently taken into custody in Scotland. Such treatment would be given to them prior to them being returned to the place from which they have absconded.

Where a patient absconds from a hospital or other such place in Scotland, the patient will be taken back to the hospital or other address in accordance with existing legislation and the
order or certificate to which they are subject continues to run. Accordingly, authority to treat
the patient continues under the original order or certificate and Part 16 of the 2003 Act will
apply to the giving of such treatment. However, there is no provision to authorise the giving
of treatment to a person who absconds from detention in another jurisdiction and who is in
custody pending return.

The 2015 Act amends the 2003 Act so that provision (through regulations) can be made to
allow for treatment of persons who have absconded to Scotland. Scottish Ministers may
make regulations applying sections of Part 16 with modifications, with the exception of
treatments in sections 234(2) or 237(3) i.e. electro-convulsive therapy and certain surgery.
They are expressly forbidden.

This instrument inserts a new regulation 8 into the 2008 Regulations which defines the
relevant corresponding measures or requirements that an absconding person must be subject
to, before consideration can be given to any form of treatment being provided under Part 16.
The categories all relate to the person being detained, because of a mental disorder, in the
home jurisdiction. There are also requirements in new regulation 8 for the person to be
examined by an approved medical practitioner who, among other things, needs to consider
that there would be risks (to the absconding person or to others) if treatment was not given.

In most cases, it is expected that the person will be returned to their home jurisdiction within
a few days. During that time, there may be a need to give medical treatment to that person to
treat their mental disorder. Part 16 of the 2003 Act covers medical treatment and was
introduced because there are some treatments for mental disorder where further safeguards
are justified particularly, but not only, in the circumstances where the treatment is given
without consent – this part makes provision for such safeguards of treatment. In applying
provisions from Part 16 the aim is to provide for any required medication or treatment to be
given so that the person is well enough to travel to the original jurisdiction.

New regulations 9 to 14 make modifications to the sections of Part 16 as they apply to
absconding persons.

New regulation 9 makes modifications in the application of section 233 which relates to the
role of medical practitioners who are used, for example, to provide independent second
opinions on matters relating to medical treatment. New regulations 10 to 12 make
modifications in the applications of sections 238, 240 and 241. These sections place
restrictions on how certain types of treatment can be given (section 240 covers medication
given for the purpose of reducing sex drive, provision of nutrition by artificial means and any
other medicine). These types of medical treatment can only be given with the person’s
informed consent (section 238) or under section 241 where the patient refuses to consent or is
incapable of consent with the approval of a second opinion by an independent medical
practitioner.

New regulation 13 makes modifications in the application of section 242 which covers
treatment not mentioned elsewhere under Part 16. It gives the medical practitioner authority
to treat either with consent or without consent, after having regard to the likelihood of the
treatment’s alleviating, or preventing deterioration in the person’s condition.

It is in line with the principles of the 2003 Act for the regulations to allow urgent treatment
under section 243, providing the treatment is necessary and would be to prevent the person’s
condition seriously deteriorating, self-harm or threat to others, saving the person’s life or to
alleviate serious suffering.

In such cases section 243, as modified, could be relied upon if the person is capable and does
not consent or is not capable of consent. The effect of new regulation 14 is that there is
provision for necessary urgent medical treatment.

Other amendments to the 2008 Regulations

Regulation 3(2) of this instrument amends the 2008 regulations so that jurisdictions covered
are extended to include member states of the EU (other than the UK). Regulation 3(3) of
this instrument makes minor amendments to regulation 7(e) of the 2008 regulations by
adding in the category of interim compulsory treatment order (ICTO). Regulation 7 of the
2008 Regulations makes modifications to section 303 of the 2003 Act as it applies to
absconding persons. Section 303 sets out the procedures to be followed once a patient has
absconded, including the taking into custody and return of the patient. The addition of
interim compulsory treatment order to this provision of the 2008 Regulations flows from an
amendment to section 303 made by the 2015 Act.

Code of Practice

Scottish Ministers are under a duty to prepare, publish and revise a Code of Practice (“the
Code”). Medical practitioners, mental health officers and others exercising statutory
functions, are under a duty to have regard to the Code. The revised Code is in draft and
includes updated and enhanced sections which relate to “absconding provisions”. In
particular clear guidance is giver that practitioners have a duty to inform a person and their
families of their rights.

Consultation

Public consultations took place during 2016.

The draft policy proposals were discussed with stakeholders before those proposals were
finalised. Given the nature and number of issues, it was not practicable to run a single
consultation. In order to maximise responses 2 separate consultations were conducted. The
aim was to minimise pressure on stakeholders given that there were over a dozen separate
issues which require consideration. By adopting this approach, respondents were afforded
appropriate time to prepare a full and considered response.

Part 2 of the consultation on implementation was open between 25 July and 17 October 2016
and proposals relating to absconders were included in that Part. For the most part,
respondents were generally supportive of the principles underpinning the proposals and many
supported detailed proposals. There was consensus that absconding persons’ rights need to
be protected. The intention was to replicate those safeguards currently in place for patients
who abscond from detention in Scotland and are subsequently detained within Scotland.

The responses to the public consultation contributed to the development of policy on specific
issues, as well as an understanding of practical impacts of legislative provisions and policy
decisions (both in relation to the impact on the absconding person and the service and cost
implications).
A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1.

Policy officials also set up a Reference Group which not only helped shape the form of the consultations but also focussed on the implementation of the 2015 Act itself. The Reference Group consists of a range of stakeholders (for example the Mental Health Tribunal for Scotland, Mental Welfare Commission for Scotland, professional groups, service providers, rights, advocacy and service user representation organisations) and has had a key role in providing advice and recommendations.

**Impact Assessments**

This instrument forms part of a package which will come into force on 30 June 2017.

Longer term mental disorder falls within the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will impact the protected characteristic of disability.

This particular instrument does not in itself result in any implications which should be considered in impact assessments.

**Financial Effects**

The provisions in this instrument were considered as part of the consultation process and this instrument is not expected to lead to costs or savings for business, third or public sector organisations, regulators or consumers.

Scottish Government
Population Health Directorate
11 May 2017
Annexe B

POLICY NOTE

THE MENTAL HEALTH (CROSS-BORDER TRANSFER: PATIENTS SUBJECT TO REQUIREMENTS OTHER THAN DETENTION) (SCOTLAND) REGULATIONS 2017

SSI 2017/xxx

The above instrument was made in exercise of the powers conferred by section 289 of the Mental Health (Care and Treatment) (Scotland) Act 2003. The instrument is subject to affirmative procedure.

Policy Objectives

This instrument amends the Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 to take account of provisions in the Mental Health (Scotland) Act 2015, alongside some amendments to the regulations to improve their operation. The 2008 regulations set out the process for the transfer of patients on community-based orders between Scotland and England or Wales.

Provisions derived from the Mental Health (Scotland) Act 2015

The 2015 Act allows for the regulations to extend provisions for receiving patients to Scotland to patients from other EU member states. The regulations allow the reception of patients from other UK and EU jurisdictions where the patient is subject to an order corresponding to a community-based order in Scotland.

Other changes

This instrument also makes changes which will improve the operation of cross-border transfers under these regulations, including minor and technical changes.

The 2008 regulations require that if the patient, or the patient’s named person (if the patient is not capable) notifies their Responsible Medical Officer (RMO) that they wish to be removed from Scotland, the RMO must determine whether to grant a warrant authorising removal. If the RMO decides not to grant the warrant, then this decision can be appealed by the patient or named person to the Mental Health Tribunal for Scotland. Changes in the 2015 Act mean that patients will have more choice as to whether to have a named person. To ensure that there is no disadvantage to any patient who does not have a named person, and then does not have capacity to make an appeal, in such circumstances the patient’s guardian, welfare attorney, primary carer or nearest relative would be able to initiate an appeal on their behalf. This is in line with provisions brought in by section 25 of the 2015 Act. A subsequent appeal against the decision of the Tribunal is also included.

Any patient transferring to Scotland under these regulations will be placed on a corresponding order, which will be treated as having begun from the date the order in the original jurisdiction was made. This means that the patient cannot apply to the Tribunal to have their order reviewed except within the first four weeks after the order is granted or until three months after the order was granted. The regulations remove the three month time bar.
This is to provide a safeguard to patients whose order may not have been granted with the same safeguards if it had been granted in Scotland, for example it may not have been granted by a court or Tribunal or equivalent. It also provides a safeguard where the patient does not consider the order they have been placed on in Scotland to be equivalent to their original order.

Regulation 28 of the 2008 regulations requires certain information to be shared with certain parties, such as the date of transfer and name and contact details of the patient’s RMO following transfer. When a person transfers to Scotland, they are unlikely to have yet chosen whether to have a named person or not. This regulation is amended so that this information is also shared with any guardian or welfare attorney and with the patient’s carer or nearest relative. This information will not be shared with the latter two parties if the patient objects.

The Mental Welfare Commission will no longer have a duty to visit a patient within six months of their reception into Scotland, but will still have the power to do so under the 2003 Act.

**Consultation**

Proposals for changes to cross-border transfer regulations were included in a public consultation which took place from 25 July and 17 October 2016. Policy officials also set up a stakeholder reference group which not only helped shape the form of the consultations but also focussed on the implementation of the Act itself. The first meeting of the group was on 18 December 2015 and further meetings took place during 2016, with a final meeting in May 2017. The reference group consists of a range of stakeholder organisations as set out on the Scottish Government mental health law webpages (for example the Mental Health Tribunal for Scotland, Mental Welfare Commission, professional groups, service providers, rights, advocacy and service user representation organisations) and has had a key role in providing advice and recommendations.

The consultation focused on proposed changes to the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 and the proposals put forward in the consultation were widely supported. The proposals put forward in the consultation were widely supported. As a result of comments in the consultation, some amendments were made, including those below.

The consultation proposed much narrower circumstances for the patient’s ability to appeal a decision to place them on a compulsory treatment order as brought in by amendments to regulation 20 of the 2008 regulations, as it set out a potential gap for transferring patients within three months of their order being granted. Consultation responses included a suggestion that a transferring patient should be able to appeal to the Tribunal the decision to place them on a compulsory treatment order as the equivalent order. There may not always be a clear equivalent if the patient had transferred from outwith UK jurisdictions and an appeal provision is an appropriate safeguard in that instance. Such an appeal provision overlaps, and is wider than, the narrow circumstances we had set out in the consultation. This single amendment to the appeal right provides a simple route that covers both circumstances.

The carer or nearest relative will not be notified under amended regulation 28 of the 2008 regulations if the patient objects. Consultation responses generally agreed that this would protect the patient’s right to autonomy and privacy.
A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1.

Impact Assessments

This SSI is part of a package of SSI to come into force on 30 June 2017. Impact assessments including a Privacy Impact Assessment (PIA), Equality Impact Assessment (EQIA); Child Rights and Wellbeing Impact Assessment (CRWIA) are to be concluded on the policy and will be provided with the second tranche of SSIs at the end of May 2017. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will particularly impact the protected characteristic of disability.

Financial Effects

A Business and Regulatory Impact Assessment (BRIA) is to be concluded and will be provided with the second tranche of SSIs at the end of May 2017. The impact of this policy on business is expected to be small.

Scottish Government
Population Health Directorate

11 May 2017
Annexe C

POLICY NOTE

THE MENTAL HEALTH (CROSS-BORDER TRANSFER: PATIENTS SUBJECT TO DETENTION REQUIREMENT OR OTHERWISE IN HOSPITAL) (SCOTLAND) AMENDMENT REGULATIONS 2017

SSI 2017/xxx

The above instrument was made in exercise of the powers conferred by section 290 of the Mental Health (Care and Treatment) (Scotland) Act 2003. The instrument is subject to affirmative procedure.

Policy Objectives

This instrument amends the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 to take account of provisions in the Mental Health (Scotland) Act 2015, alongside some amendments to the regulations to improve their operation. The 2005 regulations set out the process for transferring a patient who is detained under either the 2003 Act or the relevant provisions of the Criminal Procedure (Scotland) Act 1995 from Scotland; transferring a patient who is not detained but who is in hospital for treatment for a mental disorder from Scotland to outwith the UK; and the reception of patients into Scotland from other UK jurisdictions who are detained on a corresponding order.

Provisions derived from the Mental Health (Scotland) Act 2015

The 2015 Act makes amendments to the appeal rights that require to be included within the regulations under section 290. The instrument introduces a right of appeal for named persons against a decision to transfer the patient from Scotland and, where there is no named person and the person does not have capacity, for the welfare guardian, welfare attorney, primary carer, or nearest relative. This is in line with the new provisions in section 25 of the 2015 Act, as well as allowing for an onward appeal against the Tribunal’s decision. It also extends the process for receiving a patient on a corresponding order to those transferring from another EU member state.

Other changes

This instrument also makes changes which will improve the operation of cross-border transfers, including minor and technical changes.

Removal of patients from Scotland:

The 2005 regulations require certain parties to be notified of a decision and to allow them to make representations about the decision to transfer. These regulations extend the parties to be notified to include the patient’s named person, or if they do not have a named person, the patient’s primary carer or nearest relative (if known). This provides an additional safeguard for a patient who may be removed from Scotland.
The 2005 regulations set out timescales for the cross-border transfer process before and after the Scottish Ministers decision whether to grant a warrant or not. These timescales allow certain actions to take place, such as the patient or named person may make representations to the Responsible Medical Officer (RMO) or to Scottish Ministers before the decision, or an appeal to the Mental Health Tribunal for Scotland may be made after the decision. In some circumstances, all parties may agree to the transfer, and the patient may wish it to happen as quickly as possible. Although there is some provision for the statutory period after the decision is made to be reduced, in some cases it would be beneficial for the patient to be removed as soon as possible after the warrant is granted.

The regulations therefore introduce a fast-track process which allows for a quicker removal where the patient and named person agree to a fast-track transfer. The fast-track process includes certain safeguards to ensure this is only used where the patient wishes for a faster transfer, including that the application must include the written consent of the patient and named person and that an approved medical practitioner other than the RMO certifies that the patient is capable of agreeing to this.

Alongside this change, adjustments are made to the regulations setting out how a patient is removed in accordance with a warrant after the Scottish Ministers agree to the transfer or following any proceedings before the Tribunal etc. The practical process remains largely the same, but the timescales following any Tribunal hearing are set out more clearly.

Reception of patients into Scotland:

The regulations introduce an ability to appeal against the RMO’s decision to place the patient on a compulsory treatment order (if applicable) within the first three months of the order being made (the equivalent order in Scotland is treated as having been made on the date the order in the original jurisdiction is made). A patient can only appeal to the Tribunal about being subject to a compulsory treatment order within the first four weeks of the order being made and after three months of the order being made. The equivalent order in the original jurisdiction may not been subject to the same safeguards as in Scotland. The transferring patient could be disadvantaged in relation to a patient whose order was made in Scotland. There may also be disagreement as to whether a compulsory treatment order should be seen as the equivalent order. This appeal right also allows the Tribunal to consider whether the order should be varied or revoked in such a circumstance.

Regulation 41 of the 2005 regulations requires certain information (such as the date of transfer and name and contact details of the patient’s RMO following transfer) to be shared with certain parties. When a person transfers to Scotland, they are unlikely to have yet chosen whether to have a named person or not. This regulation is amended so that this information is also shared with any guardian or welfare attorney and with the patient’s carer or nearest relative. This information will not be shared with the patient’s carer or nearest relative if the patient objects.

The Mental Welfare Commission will no longer have a duty to visit a patient within six months of their reception into Scotland, but will still have the power to do so under the 2003 Act.

Consultation
Proposals for changes to these regulations were included in a public consultation which took place from 25 July and 17 October 2016. Policy officials also set up a stakeholder reference group which not only helped shape the form of the consultations but also focussed on the implementation of the Act itself. The first meeting of the group was on 18 December 2015 and further meetings took place during 2016, with a final meeting in May 2017. The reference group consists of a range of stakeholder organisations as set out on the Scottish Government mental health law webpages (for example the Mental Health Tribunal for Scotland, Mental Welfare Commission, professional groups, service providers, rights, advocacy and service user representation organisations) and has had a key role in providing advice and recommendations.

The proposals put forward in the consultation were widely supported. As a result of consultation some amendments were made, including those below.

The consultation proposed much narrower circumstances for the patient’s ability to appeal a decision to place them on a compulsory treatment order as brought in by amendments to regulation 33 of the 2005 regulations, as it set out a potential gap for transferring patients within three months of their order being granted. Consultation responses included a suggestion that a transferring patient should be able to appeal to the Tribunal the decision to place them on a compulsory treatment order as the equivalent order. There may not always be a clear equivalent if the patient had transferred from outwith UK jurisdictions and an appeal provision is an appropriate safeguard in that instance. Such an appeal provision overlaps, and is wider than, the narrow circumstances we had set out in the consultation. This single amendment to the appeal right provides a simple route that covers both circumstances.

The carer or nearest relative will not be notified under amended regulation 41 of the 2005 regulations if the patient objects. Consultation responses generally agreed that this would protect the patient’s right to autonomy and privacy.

A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1.

**Impact Assessments**

This SSI is part of a package of SSI to come into force on 30 June 2017. Impact assessments including a Privacy Impact Assessment (PIA), Equality Impact Assessment (EQIA); Child Rights and Wellbeing Impact Assessment (CRWIA) are to be concluded on the policy and will be provided with the second tranche of SSIs at the end of May 2017. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will particularly impact the protected characteristic of disability.

**Financial Effects**

A Business and Regulatory Impact Assessment (BRIA) is to be concluded and will be provided with the second tranche of SSIs at the end of May 2017. The impact of this policy on business is expected to be small.

Scottish Government, Population Health Directorate, 11 May 2017
Annexe D

POLICY NOTE

THE MENTAL HEALTH (CROSS-BORDER VISITS) (SCOTLAND) AMENDMENT REGULATIONS 2017

SSI 2017/xxx

The above instrument was made in exercise of the powers conferred by section 309A of the Mental Health (Care and Treatment) (Scotland) Act 2003. The instrument is subject to affirmative procedure.

Policy Objectives

The Mental Health (Scotland) Act 2015 amends the 2003 Act to allow regulations made under section 309A to make equivalent provisions for EU countries as is currently allowed for other UK jurisdictions. The current regulations make provision in connection with escorted mental health patients who visit Scotland while on leave of absence under the law of England and Wales, Northern Ireland, the Isle of Man or any of the Channel Islands and sets out the powers of escorts during such visits. The instrument amends these regulations to extend the provision to other EU jurisdictions.

Consultation

The consultation focused on proposed changes to the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005, and included a question on extending these regulations, alongside two cross-border transfer regulations to include patients from other EU jurisdictions. The proposals put forward in the consultation were widely supported and no specific comments about these regulations were made.

A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1.

Impact Assessments

This SSI is part of a package of SSI to come into force on 30 June 2017. Impact assessments including a Privacy Impact Assessment (PIA), Equality Impact Assessment (EQIA); Child Rights and Wellbeing Impact Assessment (CRWIA) are to be concluded on the policy and will be provided with the second tranche of SSIs at the end of May 2017. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will particularly impact the protected characteristic of disability.

Financial Effects
A Business and Regulatory Impact Assessment (BRIA) is to be concluded and will be provided with the second tranche of SSIs at the end of May 2017. The impact of this policy on business is expected to be small.

Scottish Government
Population Health Directorate

11 May 2017
POLICY NOTE

THE CRIMINAL JUSTICE AND LICENSING (SCOTLAND) ACT 2010
(CONSEQUENTIAL PROVISIONS) ORDER 2017

SSI 2017/xxx

The above instrument was made in exercise of the powers conferred by sections 201(2)(a) and 204(1) and (2) of the Criminal Justice and Licensing (Scotland) Act 2010. The instrument is subject to affirmative procedure.

Policy Objectives
The Mental Health (Care and Treatment) (Scotland) Act 2003 includes a power for nurses, in certain circumstances and for specified purposes, to detain a person who is in hospital for treatment. The nurse’s power to detain is exercised with a view to assessing whether the patient meets the criteria for the granting of an emergency or a short-term detention certificate.

The community payback order was introduced by the Criminal Justice and Licensing (Scotland) Act 2010 and replaced probation orders which were included in the Mental Health (Care and Treatment) (Scotland) Act 2003. It was important to put beyond doubt that persons in hospital for mental health treatment by virtue of a community payback order can also be detained in this way.

The amendments clarify that this power will apply where the person is in hospital by virtue of a community payback order which includes a mental health treatment requirement. The instrument will not affect the nurse’s power to detain a person who is in hospital for treatment by virtue of a probation order which includes a mental health treatment requirement.

The Mental Health (Scotland) Act 2015 makes a change to the nurse’s power to detain pending medical examination to simplify the period allowed to a maximum of three hours.

Impact Assessment
This SSI affects only persons with a mental disorder. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions could have on service users would particularly impact the protected characteristic of disability. However, this instrument does not extend the reach of the nurses holding power provision. Therefore, there is no impact on protected characteristics.

Financial Effects

There is no financial effect.

Scottish Government
Population Health Directorate
11 May 2017
On Friday 12 May the Committee issued a targeted call for views to all organisations on the Scottish Government’s Implementation Reference Group for the Mental Health (Scotland) Act 2015. The organisations were asked:

- Are you content with the proposals in these Scottish Statutory Instruments on the Mental Health (Scotland) Act 2015 or are there issues that you would wish the Committee to raise with the Scottish Government during its scrutiny of the instruments?

The Committee received submissions from the following organisations –

- Scottish Association for Mental Health (SAMH)
- Carers Trust Scotland
- Mental Welfare Commission
- Royal College of Psychiatrists
- Scottish Association of Social Work (SASW)
- The Health and Social Care Alliance Scotland, See Me, the Scottish Independent Advocacy Alliance and the Scottish Recovery Network – joint response
- The Law Society of Scotland
SAMH

Mental Health (Scotland) Act 2015, Scottish Statutory Instruments

SAMH

Summary:

- We urge the Committee to reject the regulations relating to absconding.

- We are content with the remaining regulations, although we want to see stringent guidance to protect the rights of patients and service users.

Absconding

Changes to the 2005 Regulations

Regulation 2 – the list of specified persons who can take persons into custody if they abscond within Scotland

SAMH set out concerns about this specific proposed legislative change in the consultation in 2016. The regulation as drafted allows the RMO to authorise any person to take someone into custody. This definition is too vague. It does not ensure that the person specified has appropriate qualifications or experience to fulfil these duties. This is especially important given that the person to be taken into custody may be distressed or confused, and may have been without their medication or other usual treatment and support for some time.

We believe there should be a prescribed list of people who can be authorised to take persons into custody.

As these regulations are subject to affirmative procedure, and cannot be amended, SAMH regrets that the wording of the regulation does not include the word ‘qualified’ in describing the person who can be authorised by the patient’s responsible medical officer; and calls for the Committee to lodge a motion to ask the Scottish Government to amend this part of the regulation.

Changes to the 2008 regulations

Medical treatment for people who have absconded from jurisdictions outwith Scotland.

SAMH believes this to be the most controversial and challenging aspect of the regulations.

We welcome the express prohibition of certain treatments in Sections 234(2) and 237(3) as they would be inappropriate in the circumstances being legislated for.

However, we believe that our concerns raised during the consultation process have not been addressed and that the changes proposed do not adequately safeguard the rights of patients absconding into Scotland. As these regulations stand, the
Scottish Government is proposing to treat people over several days without the same authorisation from mental health law that would be provided for someone resident in Scotland receiving treatment. People absconding into Scotland could be subject to prolonged detention and treatment without the right to appeal, which we regard as an infringement of their human rights. There is also an extension of treatment (regulation 14) beyond emergency care without observing the principle of reciprocity by extending more rights to the patient.

Through their exclusion of provision of treatment by authorisation of the 2003 or 1995 Acts, set out in these regulations 11, 12, 13 and 14, the Scottish Government proposes to provide treatment to patients without such protections. In other words, patients would be treated as if they were on a Short Term Detention Certificate but would not actually be on such an order. This means they would not have the legal right to challenge treatment, there would no requirement for a Mental Health Officer to review their case and there would be no right to appeal.

In our consultation response, SAMH highlighted the following judgement by the European Court of Human Rights in the X vs Finland case in 2012, where the latter had breached the appellant’s Article 8 rights. This should be noted by the Scottish Government in their proposed changes for the treatment of absconding patients from outwith Scotland:

“The Court considers that forced administration of medication represents a serious interference with a person’s physical integrity and must accordingly be based on a “law” that guarantees proper safeguards against arbitrariness. In the present case such safeguards were missing. The decision to confine the applicant to involuntary treatment included an automatic authorisation to proceed to forced administration of medication when the applicant refused the treatment. The decision-making was solely in the hands of the treating doctors who could take even quite radical measures regardless of the applicant’s will. Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication and to have it discontinued. [para 220]”

As the regulations are set out, and with the accompanying policy note, there is no appeals procedure outlined, no access to a Mental Health Officer for people who will not be familiar with the law, and no mention of independent advocacy. The Mental Health Act as it stands allows for the provision of treatment of someone who has absconded into Scotland in order to prevent deterioration. If further treatment over a longer period of time is required, we believe doctors must be required to issue Short Term Detention Certificate so patients can be treated safely and have access to appeals and other rights under this law. This is the current process and we have
SAMH

seen no evidence that it needs to change, particularly given the small number of people absconding into Scotland each year.

We therefore ask the Committee to reject these draft regulations.

Cross Border Transfers

SAMH is broadly content with the technical changes set out in these regulations, which provide for consistency for patients moving to Scotland or leaving Scotland for treatment, in terms of named person notification or moving to an area within the EU rather than within the UK. SAMH is content with these provisions but notes the impact of Brexit, and the need to ensure that the quality of care and treatment and provision of rights of people are protected as part of the Brexit process; this may need to be revisited as the UK leaves the European Union. We also note that the patient’s right to autonomy and privacy is protected as their permission will be sought and required before sharing information with carers or nearest relatives.

Reception of Patients into Scotland

SAMH notes that there will be a period of time set out before the patient can appeal following transfer into Scotland, and we welcome the decision to treat the commencement of the order as having begun in from the date it began in the original jurisdiction. We support this decision as the least restrictive option and appropriate in the circumstances.

However, SAMH is concerned that there will no longer be a duty placed on the Mental Welfare Commission to visit a patient within six months of their reception into Scotland; we note that the commission will still have the power to make such visits and we recommend that these visits take place, to ensure that the patient fully understands and can access their rights during their care and treatment.

Reception of Patients from Scotland

SAMH is content that there are sufficient safeguards in place for an agreed fast-track process. In the code of practice, we believe that there should be access to independent advocacy to improve communication and understanding at what could be a challenging and fast-moving time, and allow for the communication about last-minute changes of mind about a move. The consent and understanding of the patient should be paramount, and this must be demonstrated in such a move.

We also note the consistency of the changes bringing into line in terms of named person / family member notification, and are content with this.

We highlight the comment expressed in our original consultation response about the impact of leaving the European Union on these draft regulations in terms of the rights within ; and note this has also been highlighted by the Alliance, Scottish Recovery Network and Scottish Independent Advocacy Alliance, which we endorse.
SAMH

**Overall, we accept these regulations,** however, we believe that there needs to be stringent guidance in the Code of Practice to ensure that the rights of patients or service users are fully actualised, especially when someone is moving to Scotland and may not be aware of all their rights under Scottish law.

**Safeguards for certain informal patients**

SAMH notes this regulation allows for the provision of artificial nutrition to young people under the age of 16 who would be treated as ‘informal’ patients under the Mental Health (Care and Treatment) (Scotland) Act 2003.

We provided evidence to the Scottish Government during the first consultation about these draft regulations, and are generally content with the safeguards provided. In our submission we called for clear guidance in terms of the timescale and expertise of clinicians. We believe the proposal to be compliant with Articles 3, 5, 6 and 24 of the UN Convention on the Rights of the Child. It is right that the proposed safeguards are suitably stringent when these children will be treated. The provision of artificial nutrition is an intrusive and unpleasant procedure, so these safeguards must be met and shown to be met.

We welcome the Mental Welfare Commission’s role in the appointment of the DMP; we believe it would be helpful for the Commission to annually report on all cases of the provision of artificial nutrition to patients under the age of 16, with and without their consent.

SAMH believes that both the young people and their parents or carers should be given as much information, support and access to advocacy as possible, as well as signposted to supporting agencies. Young people could also be encouraged and supported to make personal and advance statements, which could help to inform their treatment and act as a tool in their recovery. It is crucial young people get access to early support for eating disorders, and that all professionals who come into contact with young people with eating disorders have relevant training on this issue.

It is crucial that the guidance is helpful to clinicians in the circumstances set out for these regulations. **With that caveat, we support this regulation.**
Are you content with the proposals in these Scottish Statutory Instruments on the Mental Health (Scotland) Act 2015 or are there issues that you would wish the Committee to raise with the Scottish Government during its scrutiny of the instruments?

Carers Trust Scotland welcomes the opportunity to comment on the newly published Scottish Statutory Instruments (SSIs) related to the Mental Health (Scotland) Act 2016.

We have some concerns which may impact onto role and support for carers of people experiencing mental health problems. We will only be responding on any impact onto carers, leaving other organisations, who support people experiencing mental health issues, to raise concerns relating to patients.

Safeguards for Certain Informal Patients

Carers Trust Scotland welcomes the additional safeguard for consenting to treatment for certain patients (under 16), but would issue caution on the likelihood that this could pose a disruption to family relationships. Parents (or those who have parental responsibilities) will require information to enable their understanding of what it means to provide consent to give nutrition by artificial means. Very often this is asked for when a situation has deteriorated to such an extent that life is at threat, and we recognise the important safeguard of asking for parental consent at this time. However, we also recognise the conflict which parent/carers may face at such time and would ask the Committee to look into the issue of what would happen if parental consent was withheld; would that decision need to wait for the Designated Medical Practitioner, and can this be overridden if there is imminent danger to life?

Cross Border Transfer

We note that it remains the position not to inform the carer or nearest relative if patient objects to that.

“The carer or nearest relative will not be notified under amended regulation 28 of the 2008 regulations if the patient objects. Consultation responses generally agreed that this would protect the patient’s right to autonomy and privacy.”

Whilst we agree that this could preserve the right of the patient to autonomy and privacy, we remain concerned that carers, who in many cases will be left to provide much of the informal support to such patients, are being marginalised out of having their views heard. We would have expected this issue to be strengthened by an emphasis on seeking the views of carers, one of the principles underpinning the Act.

This seems to be the only part of the Regulations in which the patient can object, and there is no mention anywhere else concerning consent of the patient. We are...
Carers Trust Scotland

concerned that this could leave vulnerable people without a voice; a voice which could be safeguarded by carer input.

Carers Trust Scotland believes that the named person/carer should be provided with information about the new legal framework and what their rights are in terms of appeals.

We also believe that unpaid carers should be provided with clear information about their possible role as a listed person.

We are also concerned about the return of the patient to countries where mental health services are not delivered in a similar way to Scotland, therefore support may not be as readily available, and that support would also include family and carer support.

Carers Trust Scotland ask the Committee to draw to the attention of Scottish Ministers the issue of clarifying how the principle of carer participation in the legal process can be ensured so that the voice of carers can be heard.

Leaving the EU

Carers Trust Scotland note that The Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 makes reference of permitting UK and EU nationals to receive treatment. We would urge the Committee to seek clarity from Scottish Ministers what will happen to this Regulation after the UK leaves the EU.

Communicating Changes to Carers

We remain concerned overall about how carers will be made aware of the provisions outlined in the amendments and ask the Committee to question Scottish Ministers about provision of information around rights of named person, and role of carers and nearest relatives where patient is unable to make a choice about named person.

We would also ask Committee to question Scottish Ministers about how parents, and those with parental responsibilities, are provided with sufficient information and support to enable the informed giving of consent for artificial nutrition as specified by Mental Health (Safeguards for Certain Informal Patients) Amendment Regulations 2017.

Carers Trust Scotland urges that consideration is given to how information is presented for carers in a way which is not overly legalistic or frightening. Ensuring the rights of service users and carers are safeguarded requires sharing of information about legislative changes and we remain concerned that this does not get forgotten about in the pursuit of issuing updated legislation and regulations.
Health and Sport Committee call for views – Mental Health (Scotland) Act 2015

This is a response on behalf of the Mental Welfare Commission to the call for views on a series of SSIs which have been laid in the Scottish Parliament, in relation to the bringing into force of the Mental Health (Scotland) Act 2015.

The Committee asked: Are you content with the proposals in these Scottish Statutory Instruments on the Mental Health (Scotland) Act 2015 or are there issues that you would wish the Committee to raise with the Scottish Government during its scrutiny of the instruments?

We confirm that we are generally content with the SSIs. We have been consulted on the policy intentions behind the regulations, and our comments have generally been taken into account. However, we have a few points which we invite the Committee to consider raising with the Scottish Government.

Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017

These regulations widen the application of regulations to deal with ‘absconding’ patients, i.e. those who are subject to compulsory treatment in another jurisdiction and have come to Scotland without permission. The current regulations apply to the UK, and these regulations extend that to the rest of the EU.

We agree that it is helpful to have a mechanism to return people who need treatment and are subject to compulsory measures to another EU country, but there need to be adequate safeguards. We are not convinced that those safeguards are sufficiently clear in the regulations.

During its consultation, the Scottish Government said that:

‘Orders in other EU jurisdictions may not be fully equivalent with those in Scotland, for example they may have different criteria for detention. We would not expect any patient to be detained if they did not also meet the criteria for detention under the 2003 Act and we are considering if the regulations should set out any specific safeguards.’

There do not appear to be any such safeguards in the regulations, and the Committee may wish to seek clarification from the Government as to why they believe they are not necessary. Not every EU jurisdiction has mental health legislation which is as modern and rights-based as the Scottish Act.

An even greater concern is that there appears to be no safeguard against the patient being returned to their host country in situations where there may be serious
concerns about the quality of care in the home country or suspicion of abuse, ill-treatment or unlawful detention.

We accept that it is reasonable that patients subject to mental health detention in the UK be returned home, as already happens. But we are not sure this should apply across the EU without at least a backstop safeguard. We suggest that Ministers should be empowered to prevent the patient being returned in situations where further investigation is required.

The regulations make provision to authorise medical treatment to be given to people who have absconded to Scotland from elsewhere in the EU. Where medication is given for mental disorder without the patient’s consent, the treatment will normally require to be authorised by a Designated Medical Practitioner (DMP) appointed by the Mental Welfare Commission.

We do not oppose this, but the Committee might want to ask the Scottish Government about the situations where they believe the safeguard will be of value.

In most cases, the absconding patient will be returned to their home jurisdiction within a few days. This would generally not be enough time to arrange for a DMP visit. If the responsible doctor believes treatment is urgently necessary, there is authority to do this without DMP approval under section 243 of the Act, as applied by regulation 14.

Where the patient will be in Scotland for a longer period, and treatment is felt to be necessary but not sufficiently urgent to meet the s243 test, the doctor appears to have an alternative route, of detaining the patient under a Scottish short-term detention (Part 6 of the 2003 Act), which would provide a treatment authority without the need for DMP approval.

**Mental Health (Safeguards for certain Informal Patients) (Scotland) Amendment Regulation 2017**

We support these regulations in principle. They provide the additional safeguard of a DMP authorisation in the case of a child who may be too immature to consent to naso-gastric feeding, where that treatment is authorised on the basis of parental consent.

However, we think that the drafting has created a difficulty. Regulation 5 provides that, where the treatment is extremely urgent, and the child is resisting or objecting, the treatment may proceed without prior DMP consent. But if the child is not resisting or objecting, there seems to be no means to avoid the requirement for DMP consent, however urgent the situation. This appears to be a perverse and unintended outcome. It is unlikely to apply often, but could cause difficulties in some rare but urgent cases.

Regulation (2B) allows notification to the Commission to be dispensed with in urgent cases. We would like some reassurance that the Code of Practice will make it clear that, in such cases, we should be notified after the treatment has been given.
Mental Welfare Commission

Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017

Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital (Scotland) Amendment Regulations 2017

Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017

We are generally content with these regulations, which will smooth the path in relation to patients who require urgent transfers to other jurisdictions, particularly where highly specialised care is needed.

We have occasionally come across cases where urgent transfers have been held up while awaiting the approval of Ministers. We do not suggest the regulations need amending, but the Committee might wish to ask Ministers what assurances they can give that transfers will be processed expeditiously.

The Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017

These regulations appear to correct an earlier oversight: that references in the Mental Health (Care and Treatment) (Scotland) Act to probation orders were not amended when those orders were replaced by community payback orders. We have no issues with making this correction.
We have canvassed RCPsych in Scotland members and no issues were raised.
SASW (Scottish Association of Social Work)

Mental Health (Scotland) Act 2015, Scottish Statutory Instruments

SASW (Scottish Association of Social Work)

Part 1

Thank you for inviting SASW, the Scottish Association of Social Work (part of BASW UK) to comment on the above Act and associated instruments.

We received the first batch of attachments on 12 May and further extensive material on 15 May.

We received these messages and forwarded them on May 18 (as we were out of office) to members of our Mental Health Officers Forum, these are two reps based in every local authority across the country, asking them to forward to the local network of MH social workers.

We received some replies suggesting the timescales were impossible to adhere to, so asked if an extension was available and were advised two more days, leading up to today, the 24th was granted.

We have had three responses from the MHOs:

1. My first comment is that if The Health & Sports Committee of the Scottish Parliament are genuinely looking for comments from MHOs on the instruments or issues that MHOs would wish the Committee to raise with the Scottish Government then to give MHOs so few working days within which to do this is completely inappropriate and unrealistic.

2. Unfortunately I am unable to read and formulate a comprehensive response within these short timescales. I would like to raise my concerns that this is a new piece of legislation but that there is to be no national training, and training locally will have to be undertaken using a draft codes of practice which will not be available until 30 May. We have also not yet been provided the new forms to consider how these are to be used. For example, will there will be a specific template for named person to agree to the role, or will this have to be created locally. I query whether this approach will lead to inconsistencies across Scotland and query whether MHOs will be competent to utilise the new legislation with the lack of national training, provision of only a draft code of practice, and the short timescale from this draft being available and the new act going live.

3. have looked through the draft regulations and cannot find anything obviously wrong – however I would have much preferred to have time to discuss with other MHOs but have been unable to do so

I have personally also looked through the many attachments and on first glance can’t see any glaring omissions, however I would agree with the few respondents that a more comprehensive review allowing the views, observations and suggestions of frontline MHO workers would have been infinitely preferable. It is very disappointing that this was not the case.
SASW (Scottish Association of Social Work)

SASW has facilitated an Annual MHO Forum Study Day in October of every year which was supported by Scottish Government until 2015, when the funding was withdrawn because of other priorities, including “training in the new- i.e. 2015- Act”. There were two free places per LA, and further places could be bought at a very competitive rate (£60).

We have subsequently formed an MHO Collaborative with partners in the Scottish Social Services Council, Social Work Scotland, Mental Welfare Commission, Learning Network West and support from a senior lecturer from Glasgow Caledonian University and managed to continue this (once a year only) significant event for MHOs, as it is the only place where MHOs from across Scotland and the various Health and Social Care Partnerships and local authorities are able to come together to discuss practice. It has also been the event where over more than a decade Scottish Government were able to consult with frontline practitioners on policy and legislation. We are currently planning for the October 2017 Conference and will be inviting Government to present or have input.

Part 2
A General Comment:
Changes to legislation will be required when the UK is no longer part of the EU.

Overall having so many statutory instruments and regulations in different places is confusing and impractical, especially when having to check the requirements when dealing with a crisis, or high risk situation.

We are very concerned about the Act being introduced without any provision of training or training materials. Further that the Codes of Practice may only be in draft form on the implementation date.

**MH [Absconding] [Miscellaneous Amendments] [Sc] Regulations 2017**

Policy Note

P2 paragraph 3 - A few days to return the patient to their home area may not be realistic, e.g. if their home area is reluctant to accept them or if the person is too unwell to transport, especially if they originate from out with the UK.

**MH [Absconding] [Miscellaneous Amendments] [Sc] Regulations 2017**

Sections 9 – 14 - These sections need to be more clearly detailed. It is protracted having to refer to numerous sections and different Acts to elicit the meaning of a regulation. It is also unrealistic that this can be achieved when dealing with a crisis [which often occur out of hours when MHOs do not have colleagues to consult with and legal services are not available].

**MH[Cross-Border Visits][S]Amendment Regs 2017** – No specific comment

**MH [Cross-Border Transfer: Patients Subject to Detention Requirement or Otherwise in Hospital] [S] Amendment Regs 2017** – We agree that there is a need to protect a patient’s right to autonomy and privacy and not notify the carer or nearest relative, however we think this needs to be balanced with elements of risk/concerns and not have a blanket approach.
MH [Cross-Border Transfer: Patients Subject To Requirements Other Than Detention [S] Regs 2017 – No specific comment.

MH [Safeguards for Certain Informal Patients][S]Amendment Regs 2017
Treatments ‘extended to nutrition by artificial means, to increase protections for patients under 16’ – The concerns that restraint may be used to prevent e.g. nasogastric tubes being removed by patient, when not in agreement/mentally unwell.
Are you content with the proposals in these Scottish Statutory Instruments on the Mental Health (Scotland) Act 2015 or are there issues that you would wish the Committee to raise with the Scottish Government during its scrutiny of the instruments?

We welcome the opportunity to highlight concerns related to the newly published Scottish Statutory Instruments (SSIs) related to the Mental Health (Scotland) Act 2016. We would, however, note the Committee’s short timescale and the limitations of consulting solely with organisations who have been co-opted into the Mental Health (Scotland) Act 2015 Implementation Reference group.

Collectively we are concerned that some elements of the proposed changes to administrative duties in isolation of the person and their rights could have unintended consequences for people who have mental health problems in Scotland. Generally, we are concerned that the new Act does not match the wider drive towards person-centeredness in the health and social care system. Our response lists some of our key concerns and proposes a number of questions the Committee could consider asking the Scottish Government.

**Cross border transfer**

Consent is not mentioned in the regulations, however we are concerned that there may be some circumstances through which people have arrived in Scotland for a particular reason, e.g. that they are receiving treatment without their consent in another country. We believe that further emphasis should be placed on the empowerment of people’s voices as a key part of the decision making process.

We are also concerned that there may be some circumstances in which people would be returned to a country which has standards of support for people with mental health problems that we would not recognise. Where this is in doubt, we believe that the Scottish Government has a moral obligation to ensure that the person’s rights are not in danger of being undermined on their return.

- What level of consent is required from the individual whilst making a decision related to cross-border transfer?
Joint response – the Health and Social Care Alliance Scotland, See Me, the Scottish Independent Advocacy Alliance and the Scottish Recovery Network

- What level of support (e.g. independent advocacy) will be made available to people from other countries to ensure that their views and concerns are adequately heard and represented whilst a cross border transfer is arranged?

- What is the Scottish Government’s view on returning people who have mental health problems to countries where the standards of support for people with mental health problems restrict their human rights?

**Leaving the European Union**

The Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 make reference to allowing “medical treatment to persons from elsewhere in the UK… and other European Union (EU) member states who may have absconded and are subsequently taken into custody in Scotland.” We are concerned that on leaving the European Union, such a right would be undermined and would seek clarity from the Scottish Government on its position with regards to this matter.

- What are the implications of the United Kingdom’s decision to leave the European Union for these regulations?
- Can we expect further amendments to this legislation after the United Kingdom leaves the European Union?

**Independent Advocacy**

Throughout the development of the legislation, we have called for further reference to independence advocacy throughout these proposals as a means to safeguard the rights of people with mental health problems. In our view, independent advocacy has a significant role to play in supporting people with mental health problems

We note, however, that independent advocacy has not been further enhanced by this legislation and remains at risk of being watered down by a lack of local prioritisation and financial support. This has the potential to undermine the gains made by having included “the right of access to independent advocacy” in the 2003 Act.

- How are independent advocates involved at pivotal points in the process (e.g. when cross border transfer is being arranged, when provision of nutrition by artificial means is being considered)
- What is the Scottish Government doing to further embed, promote and support the right of access to independent advocacy support across Scotland?
Communicating these changes

We are keen to see more of an emphasis placed on communicating the changes outlined in the legislation more clearly to people who use support and services and third sector organisations. To date, the emphasis has been placed on delivery organisations and third sector bodies communicating the changes in the law directly with people who are currently detained or who have an advance statement or named person.

- How does the Scottish Government intend to directly communicate these changes directly to people who use support and services?
- Does the Scottish Government intend to publish a plain English version of the SSIs that clarify what the changes are and how they will be put into practice?

This response is supported by the Health and Social Care Alliance Scotland (the ALLIANCE), See Me, the Scottish Independent Advocacy Alliance (SIAA) and the Scottish Recovery Network (SRN).
Introduction

The Law Society of Scotland is the professional body for over 11,000 Scottish solicitors. With our overarching objective of leading legal excellence, we strive to excel and to be a world-class professional body, understanding and serving the needs of our members and the public. We set and uphold standards to ensure the provision of excellent legal services and ensure the public can have confidence in Scotland’s solicitor profession.

We have a statutory duty to work in the public interest, a duty which we are strongly committed to achieving through our work to promote a strong, varied and effective solicitor profession working in the interests of the public and protecting and promoting the rule of law. We seek to influence the creation of a fairer and more just society through our active engagement with the Scottish and United Kingdom Governments, Parliaments, wider stakeholders and our membership.

The Society’s Mental Health and Disability Sub-committee (“the committee”) welcomes the opportunity to consider and respond to the Health and Sport Committee of the Scottish Parliament’s call for views on Scottish Statutory Instruments under the Mental Health (Scotland) Act 2015. The committee is generally content with the terms of the SSIs and, given the short timescale, has only mentioned matters which are of significant concern.

Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017

We have a general concern about the assumption that procedures and conditions for compulsory mental health treatment in all EU countries are and will be sufficiently equivalent to Scottish standards (and sufficiently compliant with human rights requirements) for it to be safe to order the return of absconding patients without any requirement to ascertain that procedures in the original country are adequate and have been properly followed, and that conditions there are satisfactory.

During the Scottish Government’s consultation, they said:

“Orders in other EU jurisdictions may not be fully equivalent with those in Scotland, for example, they may have different criteria for detention. We would not expect any patient to be detained if they did not also meet the criteria for detention under the 2003 Act and we are considering if the regulations should set out any specific safeguards.”
In the past there have been substantial variations in procedures and conditions across the EU and, while progress towards harmonization is likely to have led to improvements, elements of variation are likely to remain. Issues may also arise should new countries enter the EU. In order to sufficiently mitigate any potential risks in this regard it is important that appropriate safeguards are not dispensed with. We consider that such safeguards are essential in order to ensure human rights compliance and, therefore, the validity of the regulations among other things.

**Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017**

A mechanism or provisions are required to avoid delays in cases of urgent transfers where there is delay in receiving the approval of Ministers.
Overview of instruments
1. In addition to the affirmative instruments for consideration there are also a series of negative instruments for the Committee to consider at today’s meeting which relate to the Mental Health (Scotland) Act 2015

2. The four negative instruments for consideration are:

   - SSI 2017/172 The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Amendment Rules 2017
   - SSI 2017/174 The Mental Health (Conflict of Interest) (Scotland) Regulations 2017
   - SSI 2017/175 The Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017
   - SSI 2017/176 The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017

Delegated Powers and Law Reform Committee consideration of the four instruments
3. The Delegated Powers and Law Reform (DPLR) Committee have not yet considered the four Scottish Statutory Instruments detailed in this paper. They are due for consideration at the Committee’s meeting on 13 June.

4. The Health and Sport Committee is therefore invited at its meeting today to consider the policy issues raised in the instruments with the Minister for Mental Health.

5. The Committee is invited to agree to consider the instruments again at a later meeting following the DPLR Committee’s report on the instruments.

   SSI 2017/172 The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Amendment Rules 2017

Background
6. The purpose of this instrument is to amend certain rules within the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 under which the Mental Health Tribunal for Scotland operates.

7. The Policy Note on the regulations is available at Annexe A.
8. The Regulations are subject to the negative procedure. No motion to annual has been received. The Regulations are due to come into force on 30 June 2017.

9. The Committee is due to report by 11 September 2017.

SSI 2017/174 The Mental Health (Conflict of Interest) (Scotland) Regulations 2017

Background
10. This instrument specifies the circumstances when a conflict of interests may exist in relation to certain medical examinations being carried out. This instrument aims to ensure that medical examination of a patient is carried out by a medical practitioner who is independent. The instrument sets out circumstances where there is to be considered a conflict of interest.

11. The Policy Note on the regulations is available at Annexe B.

12. The Regulations are subject to the negative procedure. No motion to annual has been received. The Regulations are due to come into force on 30 June 2017.

13. The Committee is due to report by 11 September 2017.

SSI 2017/175 The Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017

Background
14. This instrument sets out who can witness a nomination or revocation of a nomination of a named person under the 2003 Act.

15. The Policy Note on the regulations is available at Annexe C.

16. The Regulations are subject to the negative procedure. No motion to annual has been received. The Regulations are due to come into force on 30 June 2017.

17. The Committee is due to report by 11 September 2017.

SSI 2017/176 The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017

Background
18. There are a number of statutory forms which are required under the 2003 Act and in some circumstances Responsible Medical Officers (RMOs) are required to issue a certificate. These Regulations make changes to these forms and certificates with the aim of making them clearer and easier to complete.
19. The Policy Note on the regulations is available at Annexe D.

20. The Regulations are subject to the negative procedure. No motion to annual has been received. The Regulations are due to come into force on 30 June 2017.

21. The Committee is due to report by 11 September 2017.
Annexe A

POLICY NOTE

THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND (PRACTICE AND PROCEDURE) (NO. 2) AMENDMENT RULES 2017

SSI 2017/172

The above instrument was made in exercise of the powers conferred by sections 21(4), 326 and paragraph 10 of schedule 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). The instrument is subject to negative procedure.

Policy Objectives

The purpose of this instrument is to amend certain rules within the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (“the 2005 Rules”) under which the Mental Health Tribunal for Scotland operates.

The listed initiator

The Mental Health (Scotland) Act 2015 (“the 2015 Act”) removes those provisions in the 2003 Act which mean that where a patient does not choose their ‘named person’, one was appointed for them by default. The main concerns expressed about those provisions were around patients’ autonomy and privacy. To ensure that this change did not impair patients’ right to make an application or appeal in relation to their detention, by leaving those without the capacity with no recourse, the 2015 Act also introduced a list of persons who may initiate an application or appeal to the Tribunal. In addition, and in relation to appeals of cross border transfers, similar provision is included in secondary legislation. This gives the nearest relative, carer, guardian or welfare attorney the ability to apply to the Mental Health Tribunal for Scotland where there is no ‘named person’ and the patient does not have capacity to make the application on their own behalf.

This instrument amends the 2005 Rules to set out the requirements for such an application or appeal which ensures that the listed initiator conditions have been met.

The requirements include a statement by the person making the application or appeal which sets out:

- what category they fall within (nearest relative, carer, guardian or welfare attorney);
- that they have not been precluded from using the ability by the patient; and
- that the patient is over 16 and has no named person.

In addition, the application must be accompanied by a statement by an approved medical practitioner (which in practice will ordinarily be the patient’s responsible medical officer) that the patient is incapable of initiating an application or appeal.

In order to fulfil the policy objectives of privacy and autonomy, once the appeal or application has been made by a listed initiator, that person does not become a party.

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1 This is by way of amendments to S.S.I.2005/467 and S.S.I. 2008/356.
to the proceedings. Rather, a curator ad litem may be appointed by the Tribunal to represent the interests of the patient.

Compulsory treatment
There was a practical issue where two sets of notification could have been required in relation to Tribunal proceedings concerning compulsory treatment (one in relation to the making of an interim compulsory treatment order and one in relation to the making of a compulsory treatment order). The 2005 Rules are amended to clarify that when the persons specified in rule 6 of the 2005 Rules are being given notice and invited to make representations or lead or produce evidence etc., that is in relation to the making of a compulsory treatment order, or an interim compulsory treatment order.

Decisions
The Tribunal sends notice of the decision to the parties and such other relevant person as the Tribunal may direct. A difficulty in practice has arisen because on occasion persons who have a right of appeal against the decision of the Tribunal do not have a statutory right to obtain a copy of the decision, as they are not a party to the case and have not returned a notice of response or sought to be added as a party or relevant person. The 2005 Rules are amended to ensure that the patient’s responsible medical officer and mental health officer will always receive a copy of the decision of the Tribunal.

Consultation
The amendments to the 2005 Rules are in response to the changes introduced by the 2015 Act and taking account of experience and practice of the Mental Health Tribunal for Scotland in operating the 2005 Rules.

Policy officials set up a stakeholder reference group which not only helped shape the form of the consultations but also focussed on the implementation of the 2015 Act itself. The first meeting of the group was on 18 December 2015 and further meetings took place during 2016, with a final meeting in May 2017. The reference group consists of a range of stakeholder organisations as set out on the Scottish Government mental health law webpages (for example the Mental Health Tribunal for Scotland, Mental Welfare Commission for Scotland, professional groups, service providers, rights, advocacy and service user representation organisations) and has had a key role in providing advice and recommendations.

Impact Assessments
This SSI is part of a package of SSIs to come into force on 30 June 2017. Impact assessment reports including a Privacy Impact Assessment (PIA) and Equality Impact Assessment (EQIA) will be published in June 2017. The 2005 Rules affect only persons with a mental disorder. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will particularly impact the protected characteristic of disability. However, the effects of this SSI will not have an adverse impact on this protected characteristic.
Financial Effects

A Business and Regulatory Impact Assessment (BRIA) report will be published in June 2017. The impact of this policy on business is that a new category of person will have the ability to make appeals and applications to the Tribunal. However, they only have this ability when an existing category of person, the named person, is not involved. Therefore, there is no financial effect.

Scottish Government
Population Health Directorate

22 May 2017
Annexe B

POLICY NOTE

THE MENTAL HEALTH (CONFLICT OF INTEREST) (SCOTLAND) REGULATIONS 2017

SSI 2017/174

The above instrument was made in exercise of the powers conferred by section 291A of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). The instrument is subject to negative procedure.

Policy Objectives

The purpose of this instrument is to specify the circumstances where it is, and is not, to be taken to be a conflict of interest in relation to certain medical examinations carried out under provisions of the 2003 Act.

The provisions within the 2003 Act are in relation to examination of for the purposes of:

- section 44(1) (short term detention in hospital);
- section 47(1) (extension of short-term detention in hospital);
- section 57(2) (mental health officer’s duty to apply for compulsory treatment order);
- section 77(2) (first mandatory review);
- section 78(2) (further mandatory reviews);
- section 139(2) (first review of compulsion order);
- section 140(2) (further review of compulsion order); and
- section 182(2) (review of compulsion order and restriction order).

The policy objective is to ensure that, subject to limited exceptions, medical examination of a patient is carried out by a medical practitioner who is independent.

The instrument sets out circumstances where there is to be considered a conflict of interest. The schedule to the instrument lists the prohibited degrees of relationship where they exist between an approved medical practitioner and the patient or exist either between the medical practitioners or between one of them and the patient. The relationships listed include immediate family members: parent, child, sister, brother, grand-parent and grandchild. Also included are family members through marriage and relationships which are similar for non-married couples.

Where a medical examination of a patient is required, it should not be carried out by a medical practitioner who is related in any way by blood, marriage or cohabitation to the patient or to another examining practitioner. Where two medical examinations are required, at least one of those is to be carried out by a practitioner who does not work in an NHS hospital where the patient is or may be detained. Alternatively, to take account of arrangements in rural settings, if one examination is undertaken by a consultant, the other examination can be carried out by another doctor in that hospital but there must be no supervisory relationship between them. Where the
doctor carrying out a medical examination for a review of certain orders is employed in an independent health care service in which the patient is or will be detained, there must be a second examination by a doctor not so employed.

Consultation

A public consultation took place from 7 March to 30 May 2016.

A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1. It includes: the MWCS; Royal College of Psychiatrists; Scottish Association for Mental Health as well as service providers and individual members of the public.

The responses to the public consultation contributed to the development of policy on specific issues, as well as an understanding of practical implications of legislative provisions and policy decisions. The responses to policy proposals highlighted the experience of patients, organisation of services and system cost implications.

Policy officials also set up a stakeholder reference group which not only helped shape the form of the consultations but also focussed on the implementation of the Act itself. The first meeting of the group was on 18 December 2015 and further meetings took place during 2016, with a final meeting in May 2017. The reference group consists of a range of stakeholder organisations as set out on the Scottish Government mental health law webpages (for example the Mental Health Tribunal for Scotland, MWCS, professional groups, service providers, rights, advocacy and service user representation organisations) and has had a key role in providing advice and recommendations.

Impact Assessment

This SSI is part of a package of SSIs to come into force on 30 June 2017. Impact assessment reports including a Privacy Impact Assessment (PIA) and Equality Impact Assessment (EQIA) are to be published in June 2017. This SSI affects only persons with a mental disorder. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions could have on service users would particularly impact the protected characteristic of disability. However, this instrument replaces existing restrictions on professionals carrying out examinations of people with mental disorder. Therefore, there is no impact on protected characteristics.

Financial Effects

A Business and Regulatory Impact Assessment (BRIA) report will be published in June 2017. The impact on business will be where independent approved medical practitioners are required for medical examination of patients who are detained (or will be detained) in an independent health care service. There will be a cost in providing these additional examinations. However, the number of Scottish independent psychiatric inpatient beds, only a proportion of which will be taken up by detained patients, is low.

Scottish Government
Annexe C

POLICY NOTE

THE MENTAL HEALTH (PATIENT REPRESENTATION) (PRESCRIBED PERSONS) (SCOTLAND) REGULATIONS 2017

SSI 2017/175

The above instrument was made in exercise of the powers conferred by section 250 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). The instrument is subject to negative procedure.

Policy Objectives

The Mental Health (Patient Representation)(Prescribed Persons) (Scotland) (No. 2) Regulations 2004 sets out the prescribed classes of person who can witness a nomination or revocation of a nomination of a named person under the 2003 Act.

This instrument revokes and replaces the existing regulations to take into account changes made by the Mental Health (Scotland) Act 2015 (“the 2015 Act”).

Firstly, the 2015 Act requires a person nominated as named person to agree in writing to take on the role and for this agreement to be witnessed by a prescribed person. The 2015 Act also allows a patient to make a declaration (and withdraw such a declaration) precluding their nearest relative or carer from initiating certain applications or appeals on their behalf if they have no named person and they are incapable of doing so on their own behalf; the 2015 Act introduces this ability for the nearest relative or carer. Any such declaration or withdrawal must be witnessed by a prescribed person.

Unlike the 2004 regulations, this instrument does not prescribe classes of persons who can witness a declaration by the patient that a person should not be the patient’s named person, as this section is repealed by the 2015 Act.

The instrument also adds independent advocates, speech and language therapists, physiotherapists, arts therapists and dietitians to the list of prescribed persons. This will allow a wider range of practitioners who might work with the patient and be supporting them in their decision about representation to witness the documents described.

Consultation

Consultation on these regulations was included within Part 1 of the consultation on implementation of certain sections of the Mental Health (Scotland) Act 2015 and associated regulations, which was open between 7 March and 30 May 2016.

The vast majority of respondents agreed with the proposal to extend the existing list of prescribed persons to those who can witness agreement to being a named person. In addition, suggestion was made to add independent advocates, and all allied professionals to the list of prescribed persons. The regulations therefore
extends the list of prescribed persons to independent advocates, along with those allied professionals not previously listed who work with mental health service users - speech and language therapists, physiotherapists, arts therapists and dietitians.

A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website on 12 January 2017 with ISBN 978-1-78652-727-1.

Impact Assessments

This SSI is part of a package of SSI to come into force on 30 June 2017. Impact assessment reports including a Privacy Impact Assessment (PIA) and Equality Impact Assessment (EQIA) are to be published in June 2017. These rules affect only persons with a mental disorder. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users will particularly impact the protected characteristic of disability. The effects of this SSI will not have an adverse impact on this protected characteristic.

Financial Effects

A Business and Regulatory Impact Assessment (BRIA) report will be published in June 2017. The circumstances in which a prescribed person must witness a document were set out by the 2015 Act. This instrument will also have the effect that a small number of additional classes of persons will be able to witness certain documents and the financial impact of this is expected to be small.

Scottish Government
Population Health Directorate

25 May 2017
Annexe D

POLICY NOTE

THE MENTAL HEALTH (CERTIFICATES FOR MEDICAL TREATMENT) (SCOTLAND) REGULATIONS 2017

SSI 2017/176

The above instrument was made in exercise of the powers conferred by sections 245(2), 246(1) and 325 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). The instrument is subject to negative procedure.

Policy Objectives

The 2003 Act makes provision at section 325 to prescribe statutory forms. The 2003 Act requires a certificate to be given by the responsible medical officer or other medical practitioner under certain circumstances. Under section 245(2) and 246(1) a certificate shall contain such particulars as prescribed in regulations.

Revision to these prescribed forms is required as part of a package of changes to forms used to administer certain processes under the 2003 Act. In light of practice and experience in using these certificates, certain amendments were needed to the prescribed forms, including:

- More details are provided on each certificate in relation to the Responsible Medical Officer
- What was previously one form has been split into two forms in order to specify the certification of treatment under section 237(3) of the 2003 Act as separate from certification of treatment under section 240(3) of that Act. This has been done in relation to situations where the patient consents to treatment (forms T2A and T2B) and where the patient is incapable of consenting (forms T3A and T3B).

The aim of these changes is to make the forms clearer and easier to complete.

Consultation

There are a range of forms recommended for use under the 2003 Act in addition to these prescribed forms. The Mental Welfare Commission worked with the Mental Health Tribunal for Scotland, NHS boards and Local Authorities to consider feedback from practitioners and administrators on the use of the existing prescribed forms and other forms.

Impact Assessment

This SSI affects only persons with a mental disorder. Mental disorder is included in the definition of the protected characteristic of disability under the Equality Act 2010. Therefore it is likely that any effects that the SSI provisions have on service users would particularly impact the protected characteristic of disability. However, the
changes are to update forms use by professionals treating persons with a mental disorder. There is no effect on protected characteristics.

**Financial Effects**

The forms are produced by the Mental Welfare Commission for Scotland as part of a wider revision and update to forms associated with the 2003 Act. There is no additional financial effect from this instrument.

Scottish Government
Population Health Directorate

24 May 2017
STATEMENT OF SIR ROBERT FRANCIS QC FOR THE HEALTH AND SPORT COMMITTEE OF THE SCOTTISH PARLIAMENT AT THEIR HEARING ON 13 JUNE 2017

I, SIR ROBERT ANTHONY FRANCIS, say as follows:

Personal

1. I am grateful for the invitation by the Committee to attend their hearing and offer this statement as an introduction to my perspective on whistleblowing, or as I prefer to call it, freedom to speak up, in the National Health Service. I make this statement in a personal capacity and nothing in it should be understood to be endorsed by or made on behalf of any organisation with which I am involved, including those to which I expressly refer below.

2. By way of background, I am a barrister in self-employed practice at the Bar of England and Wales. I was called to the Bar in 1973, and took silk in 1992. I have been a Recorder since 2000, and am authorised to sit as a Deputy High Court Judge. I am a governing Bencher of the Honourable Society of the Inner Temple. Between 2003 and 2005 I was chairman of the Professional Negligence Bar Association. For many years I have specialised in medical law, in particular clinical negligence, in which I regularly act for claimants and defendants, professional regulation, in which I have generally assisted registered practitioners, medical ethical decision-making on behalf of those lacking capacity to make their own decisions. I am not a specialist in employment law in general or public interest disclosure in particular, but have a general knowledge of the area developed through the work I will describe below.

3. I have appeared professionally for core participants at a number of important public inquiries in England, including the Bristol Royal Infirmary Inquiry [report 2001], the Royal Liverpool Children’s Inquiry [report 2001], and the Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [report 2004]. I have chaired three independent inquiries into the care and treatment of persons who have been convicted of homicide while under the care and treatment of mental health services.

4. Of more central relevance to the Committee’s considerations I was appointed by the Rt Hon Andy Burnham, then Secretary of State for Health to chair the Independent Inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust [report February 2010], and the Rt Hon Andrew Lansley, his successor, to chair the subsequent Mid-Staffordshire NHS Foundation Trust Public Inquiry [report February 2013] and lastly by the Rt Hon Jeremy Hunt, the current Secretary of State to lead the Freedom to Speak Up Review [report March 2015].

5. Following on from this work I am now a non-executive director of the Care Quality Commission. I also have the honour of being the President of the Patients Association, Patron of the Florence Nightingale Foundation, and a trustee of the Point of Care Foundation, a charity dedicated to enhancing the capability of healthcare staff to provide high quality care to patients through support such as Schwartz Rounds,\(^4\) a Heads Of Patient Experience [HOPE] network and support for experienced based co-design.\(^5\) I am an honorary Fellow of the Royal College of Surgeons (England), the Royal College of Anaesthetists and the Royal College of Pathologists.

**Perspective derived from the Mid Staffordshire inquiries**

6. The story of the appalling experiences suffered by too many patients at Stafford Hospital shocked all who read about it, and the experience of meeting patients and their families as they shared their stories with me has motivated my continued involvement in the healthcare sector ever since. I have often been asked how such a departure from acceptable standards had gone undetected for so long. The answer is that in fact many people were aware of parts of the picture, but in adequate action was taken to address the concerns that many of them raised.\(^6\) There was evidence that over a number of years staff had repeatedly reported incidents which they attributed to inadequacies in staffing.\(^7\) Not only was an impression that feedback – and therefore encouragement to raise concerns – was rare, there was also highly worrying evidence of a culture of fear promoted by some staff resulting in some of those who raised concerns being victimised. The most striking example came from the evidence of Helene Donnelly who reported being pressurised by senior colleagues to falsify discharge times in A&E records in order to give an appearance of compliance with target waiting times. Her evidence of the impact of this on her is worth recalling. She told me the following:

> The culture in the department gradually declined to the point where all of the staff were scared of the Sisters and afraid to speak out against the poor standard of care the patients were receiving in case they incurred the wrath of the Sisters. Nurses were expected to break the rules as a matter of course in order to meet target, a prime example of this being the maximum four-hour wait time target for patients in A&E. Rather than “breach” the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going along with this if the wait time was only being breached by 5 ... or 10 minutes and the patient had been treated ... [but] when wait times were being breached by 20–30 minutes or more and

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\(^4\) Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. They are increasingly used by NHS providers to assist in the support of the well-being of their staff.

\(^5\) Experience-based co-design (EBCD) is an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership. The approach is different to other service improvement techniques

\(^6\) For a full chronological account of the warning signs I found, please see chapter 1 of the Public Inquiry report [vol 1 pp47 et seq]

\(^7\) See Chapter 2 paras 2.324-332 of the Public Inquiry report [Vol 1 pp222-225]
the patient had still not been seen, I was not prepared to go along with what was expected. I was concerned about the terrible effect that our actions were having on patient care. I did raise this with Sisters [X] and [Y], however their response was extremely aggressive basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players.\(^8\)

The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged. I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.\(^9\)

When she did report her concerns she was abused and threatened:

... [T]he first sister ... made it very clear that she was very displeased with me and the fact that I’d spoken out ... [T]hreats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me in – trying I think in a helpful way to tell me to, I quote “watch my back”, ... and people were saying, “Oh, you shouldn’t have done this, you shouldn’t have spoken out.” And then physical threats were made in terms of people saying that I needed to – again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.\(^10\)

7. I made recommendations all of which were intended to assist in changing the negative culture which persisted in too many places in the NHS through a combination of emphasis on putting the patient at the centre of healthcare, regulation, leadership development, support for staff and, above all, increased openness, transparency and candour about matters of concern. Among the recommendations I made were those designed to bring about:

- An obligation on staff to report safety concerns and to give including action taken or reasons for not acting [R12][
- A legal duty of candour to patients [organisations and professionals] [R173-183][
- Banning of “gagging clauses” in “compromise” agreements [R175][
- Assessment of nursing applicants for compatible values and compassion [R188, 191][
- Enhancement of nurse leadership capability at all levels[R195-197][
- Strengthening of nursing professional voice [R201-206].

8. The great majority of my recommendations were accepted and steps taken to implement them. I draw particular attention to the following developments:

\(^8\) Chapter 1 para 1.197 of the Public Inquiry report [Vol 1 p 108]
\(^9\) Chapter 2 para 2.374 of the Public Inquiry report [Vol 1 p 235]
\(^10\) Chapter 22 para 22.18 of the Public Inquiry report [Vol 3 p 1504]
a. The creation of a legal duty of candour, aligned with obligations under commissioning arrangements. Compliance is overseen by the CQC.
b. An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office.
c. An improved system of inspection and rating of all NHS providers by CQC. A significant amount of information on which assessments are made derives from staff.

The Freedom to Speak Up Review

9. In 2014 Jeremy Hunt asked me to undertake a review of whistleblowing in the NHS, principally as a result of a number of reported experiences of staff who had suffered serious adverse consequences as a result of raising concerns. Although I received some helpful contributions from sources in Scotland, my remit was limited to considering the situation in England. On considering the evidence submitted to me I found that:

- raising concerns could be a “harrowing and isolating process with reprisals”;
- bullying and oppressive behaviour were common;
- there was a lack of support for staff and confidence that there would be any effective action when concerns were raised;
- concerns were often handled poorly;
- people who spoke up too often suffered a devastating impact as a result of doing so;
- employers often felt challenged in how to separate safety concerns from disciplinary issues, culpability and responsibility;
- the area was not helped by an adversarial legalistic culture

The accounts offered by staff and former staff were often of considerable concern. A small selection of quotes form the evidence included in the report make the point

- I have often been so depressed by this experience that I have often considered suicide. I live in fear that the hospital will carry out its threat to sue me and take my home from me if I don’t pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers).
- ...false allegations made under the cover of whistleblowing have left myself and a number of my colleagues deeply traumatised.
- Colleagues often quietly agreed with my concerns but refused to speak out in fear of reprisals
- (There is) a culture of delay, defend and deny.

10. I set out 20 Principles which I considered should inform and support a change of culture to make speaking part of the normal business of healthcare rather than a dangerous activity resulting in little action other than detrimental treatment for the member of staff brave enough to raise a concern. In summary they were:
1. Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

2. Raising concerns should be part of the normal routine business of any well-led NHS organisation.

3. Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

4. All employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.

5. Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from improvements made in response to the issues identified.

6. There should be opportunities for all staff to engage in regular reflection of concerns in their work.

7. All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

8. When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigation to establish the facts.

9. Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

10. Every member of staff should receive training in their organisation’s approach to raising concerns and in receiving and acting on them.

11. All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

12. Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

13. All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

14. Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for
   a. Poor practice in relation to encouraging the raising of concerns and responding to them
   b. The victimisation of workers for making public interest disclosures
   c. Raising false concerns in bad faith or for personal benefit
   d. Acting with disrespect or other unreasonable behaviour when raising or responding to concerns.
   e. Inappropriate use of confidentiality clauses.
15. There should be an independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:
   a. Review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice.
   b. Advise NHS organisations where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect.
   c. Act as a support for local Freedom to Speak Up Guardians
   d. Provide national leadership on issues relating to raising concerns by NHS workers
   e. Offer guidance on good practice about handling concerns
   f. Publish reports on the activities of this office.

16. There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

17. CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

18. All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

19. All principles in this report should apply with necessary adaptation in primary care.

20. Legal protection for those who make public interest disclosures should be enhanced by extension of the prescribed bodies for this purpose and the extension of protection to student in nursing and medicine.

11. Implementing the recommendations associated with these principles not been as expeditious as some expected, but in my view there has been significant progress:
   a. I believe that every NHS Trust has now appointed a Freedom to Speak Up Guardian. A variety of approaches has been taken to the functions of the post, the experience and background of the persons appointed and the support offered. Time will help in the assessment of which approaches work better than others.
   b. The post of National Freedom to Speak Up Guardian has been set up and is funded and appointed jointly by CQC, NHS Improvement and NHS England. While the post is hosted by CQC the Guardian works independently. An appointment has been made: Dr Henrietta Hughes. I respectfully suggest that she is asked to offer the Committee a summary of the work she has been undertaking, but it includes a number of events bringing together the local Guardians enabling them to share good practice, challenges, and to set up self-support networks.
   c. NHS England is working on a support scheme for staff who have lost their jobs as a result of speaking up.
d. Many trusts have reviewed their whistleblowing policies to ensure consistency with the Principles.

e. The case review function of the National Guardian’s Office is being developed and may be expected to commence operation in the near future.

Conclusion

12. I hope this short statement indicates the areas in which I may be of assistance to the Committee and I am naturally content to be asked to expand on any particular point.

6 June 2017

SIR ROBERT FRANCIS QC