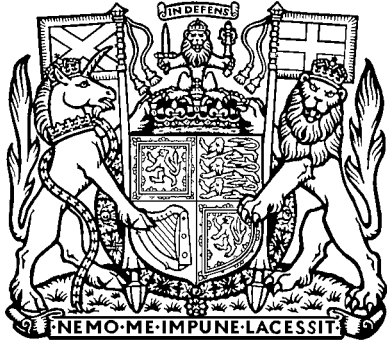


New Directions

Report on the Review of the
Mental Health (Scotland) Act 1984

Chairman: Rt. Hon. Bruce Millan



SCOTTISH EXECUTIVE

REVIEW OF THE MENTAL HEALTH (SCOTLAND) ACT 1984

Laid before the Scottish Parliament by the Scottish Ministers

January 2001

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MEMBERSHIP OF THE COMMITTEE

Chair:

The Rt Hon Bruce Millan

Sheriff Douglas Allan,	Edinburgh
Dr Caroline Blair,	Consultant Clinical Psychologist, Young People's Unit, Royal Edinburgh Hospital
Dr David Blaney,	Director of Postgraduate General Practice Education, Lister Postgraduate Institute
Dr Lindsay Burley,	Chief Executive, Borders Health Board
Mr James Connechen,	Director of Nursing, Dumfries & Galloway Community Health Care NHS Trust
Dr James Dyer,	Director and Medical Commissioner of the Mental Welfare Commission for Scotland
Mr James Kiddie,	former Convener, Scottish Users' Network
Ms Linda Headland,	Director, ELCAP
Mr Malcolm McEwan,	Head of Social Work, Midlothian Council
Mr Roger Maxwell,	former Chairman of Relatives/Users Action Forum, Forth Valley Primary Care NHS Trust
Mr Graham Morgan,	Advocacy Development Worker, Highland Users Group, Highland Community Care Forum
Ms Hilary Patrick,	Honorary Fellow, Faculty of Law, The University of Edinburgh
Dr James Strachan,	Consultant Psychiatrist, Royal Edinburgh Hospital and Honorary Senior Lecturer, The University of Edinburgh
Dr Maureen Sturrock,	Consultant Forensic Psychiatrist, Greater Glasgow Primary Care NHS Trust
Mr George Thorley,	Chief Executive, South Ayrshire Council
Ms Mary Weir,	Chief Executive, National Schizophrenia Fellowship (Scotland)

Adviser to the Committee –

Dr Anne Douglas,	Consultant Clinical Psychologist, Greater Glasgow Primary Care NHS Trust
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We were appointed on 22 February 1999 with membership as on page ix.

Dr Caroline Blair

We were shocked by the tragic death in a car accident in February 2000 of one of our members, Dr Caroline Blair. Caroline had not only brought to the Committee a special expertise in areas of mental health affecting young people but also an enthusiastic commitment to our work generally. Her contributions to our discussions were marked by a strong sense of humanity and of natural justice towards those affected by mental health problems. We were greatly saddened by her death.

Dr Anne Douglas subsequently accepted our invitation to assist the Committee and she has made a significant contribution to our work in her field of clinical psychology and more widely, for which we are very grateful.

Terms of reference

The remit given to the Committee was:

"In the light of developments in the treatment and care of persons with mental disorder, *to review the Mental Health (Scotland) Act 1984*, taking account of issues relating to the rights of patients, their families and carers, and the public interest; and having particular regard to:

- ◆ the definition of mental disorder;
- ◆ the criteria and procedures for detention in and discharge from hospital;
- ◆ leave of absence and care outwith hospital;
- ◆ the role of the Mental Welfare Commission for Scotland;
- ◆ the findings of the Committee set up to review the arrangements for the sentencing and treatment of serious violent and sexual offenders, including those with personality disorders;

and *to make recommendations.*"

Summary of Work of the Committee

Meetings

The Committee first met on 4 March 1999 and subsequently met in full Committee on 24 occasions, including a final meeting on 29 November 2000. This included two-day meetings on two occasions.

The Committee also divided into sub-groups which were charged with considering specific elements of the remit and making recommendations to the full Committee. The first three sub-groups met on a total of 10 occasions from October to December 1999. A further four sub-groups held a total of 11 meetings from February to April 2000. In addition, sub group members met with representatives of the Mental Welfare Commission and members of the MacLean Committee reviewing the sentencing and treatment of serious violent and sexual offenders.

A small drafting group met on 15 occasions to consider drafts of papers, prior to their consideration by the full Committee, and this proved to be extremely valuable in the preparation of the final report.

Visits

Committee members undertook 37 visits to services and facilities in Scotland and England including forensic and secure mental health services, user groups and advocacy services, learning disability facilities, community-based mental health services, psychiatric hospitals, Sheriff Courts and Mental Health Review Tribunals. (See Annex 3.)

The Committee was anxious to consult as many of those with an interest in mental health as was feasible, in order to get a clearer picture of what people around Scotland would wish from a new Mental Health Act. We therefore carried out a range of consultation exercises.

The consultation process consisted of:

First Consultation

- ◆ The Committee's first Consultation document, over 1,000 copies of which were distributed to organisations and individuals with an interest in mental health, learning disability, dementia, legal issues, human rights and related issues. 157 responses were received. (See Annex 2)
- ◆ A shorter consultation document aimed at users and informal carers, over 11,000 copies of which were distributed, via statutory and users and carers organisations, to individuals with personal experience of mental health legislation. Two hundred and two responses were received. (See Annex 5)
- ◆ A consultation document aimed at people with learning disabilities. Around 600 copies of "Have Your Say" were distributed via statutory and learning disability organisations, and 101 responses were received. (See Annex 5)

Consultation events

- ◆ Three consultative events for mental health service users and their carers, held in three different Scottish cities. (See Annex 5)
- ◆ Three day-long symposia on specific issues of interest: one on learning disability, one on dementia, and one on children's issues. (See Annex 6.)

Oral evidence

- ◆ Three days of oral evidence sessions with a selection of organisations representative of a range of different interests in mental health issues. (See Annex 4)
- ◆ A meeting with members of organisations with an interest in ethnic minorities. (See Annex 4)
- ◆ Oral presentations at Committee meetings on developments in mental health services, principles of mental health law reform and international comparisons, research into the operation of courts, the literature review and analyses of consultation exercises. (See Annex 4)
- ◆ A video conference with Professor Warren Brookbanks, University of Auckland, to discuss proposed new legislation in New Zealand for people with a learning disability. (See Annex 4)

Second Consultation

When we had considered information and responses arising from the above, a second Consultation document was issued, setting out preliminary proposals. Over 700 copies were distributed, and 196 responses were received. (See Annex 2)

Our consultation documents were also made available on the Internet.

Literature Review and Research

We also commissioned a literature review, and research into the operation of the Courts and detention under the Mental Health (Scotland) Act 1984. (See Annexes 7 and 8.) The research and literature review are being published alongside this report.

The amount of work we had to do in a limited time meant that we were not in a position to visit or take evidence from jurisdictions overseas, other than at the video conference with New Zealand. However, the secretariat of the Richardson Committee, which reviewed the English Mental Health Act, kindly let us have access to papers from two international seminars they organised, which looked at mental health law in other Commonwealth and European jurisdictions, and we were able to benefit from that.

Executive Summary

An Executive Summary of this Report is available from Public Health Division 1.4, Room 3ES, St Andrews House, Regent Road, Edinburgh.

Acknowledgements

In conducting this review, we faced a complex and difficult task, within a limited time period. The task was made considerably easier by the contributions of a number of people, to whom we would wish to express our gratitude.

Dr Allyson McCollam and her colleagues at the Scottish Development Centre for Mental Health Services greatly assisted us in carrying out analyses of the responses to our first and second Consultation papers, and in organising consultative events for users and informal carers.

ENABLE, Children in Scotland and Alzheimer Scotland - Action on Dementia organised the three very useful special events which focused on learning disability, children and dementia.

FAIR provided invaluable help and advice in drafting our consultation leaflet for people with learning disabilities, and Dr Kirsten Stalker carried out a thorough analysis of responses.

We conducted an extensive visiting programme, and we are grateful to all those who assisted in the organisation of these visits. Everywhere we went, we were made to feel welcome, and the visits provided us with a most valuable source of information and ideas.

We would also wish to express our thanks to all who responded to our consultation documents, attended consultative events, or gave oral evidence. We were impressed by the time and trouble people took in contributing their views, which were of tremendous assistance to us in reaching our own conclusions.

Finally we would wish to express our thanks to our Secretariat. We were appointed in February 1999 and the MacLean Committee on Serious Violent and Sexual Offenders a month later. The Secretariat served both our committee and the MacLean Committee until that committee reported in June 2000. The workload was therefore particularly strenuous and we were very fortunate that despite that, the demands we put on the Secretariat were invariably met timeously and with work of a very high standard. Our sincere thanks therefore go to Alison Bell, Gavin Russell, Bette Francis and Luke McGarty as well as administrative staff who helped from time to time. A special word of thanks is, however, due to Colin McKay who had the capacity to turn out, often at short notice, an impressive number of well informed and thoughtful contributions to our work, which considerably lightened our task.

Introduction to the Report

1. There has not been a fundamental review of mental health law in Scotland for more than 40 years. We believe that it is time for the law to respond to the new directions which have emerged in mental health care: of more community based services; greater involvement of users and carers in decisions concerning treatment; and greater awareness of the need to respect human rights.

Principles

2. Fundamental to our approach has been our view that a new Act should be based on principles stated on the face of the Act itself. We have set out the basic principles which we believe should underlie mental health law, and have sought to apply them in our detailed recommendations.

Compulsion only where absolutely necessary

3. Most patients (nearly 90% of those admitted to hospital at present) are treated on an informal basis. We wish to see compulsion kept to a minimum but the law must provide for the minority of patients where compulsion proves necessary.
4. One of the most significant of our principles is therefore that of the *Least restrictive alternative*. This principle reflects the fact that any use of compulsion under mental health law represents a significant curtailment of the human rights of the patient, and should only be permitted when, and to the extent that, it is absolutely necessary. Accordingly, our recommendations seek to ensure that any compulsory intervention is tailored to the particular needs and circumstances of the individual. This is a fundamental change from the current legislation where the powers granted on detention are always the same, regardless of the circumstances.
5. A principled approach also requires that the law should set out as precisely as possible the circumstances in which particular individuals should be made subject to compulsion. We have therefore recommended more specific criteria than are present in the current Act and we also make proposals to increase the extent to which compulsory interventions are subject to scrutiny and review.
6. We believe that the new arrangements require a new legal forum which is able to address in a more considered way the particular issues which arise in mental health cases, and we propose the creation of a system of mental health tribunals to replace the present role of the sheriff courts. We use the term 'tribunal' in this context throughout our report.
7. However, formal rights are not, in themselves enough. People must feel able to use these rights. It is a matter of concern that so few patients at the moment feel able to appeal against detention. Furthermore, formal rights to challenge decisions are not a substitute for involving the patient as fully as possible in decisions about his or her care. We therefore recommend greater access to advocacy, better

information for patients, and new ways in which patients can identify their wishes, and have them taken into account.

The rights of service users

8. Questions of mental health do not relate only to compulsion. As we have said, the vast majority of patients are and should be treated on an informal basis. However, informal patients are also, in many cases, vulnerable. They may be subject to treatment to which they have not given their full consent, or may not get the care and support they need. We have therefore included this wider group in many of our recommendations, particularly in relation to advocacy. We have also considered the duties placed on local authorities to provide aftercare and other services, and made proposals designed to update and clarify these.
9. There is also a need to modernise those parts of the present Act which are intended to protect mentally disordered people from neglect or ill treatment, including arrangements for intervention when a vulnerable person appears to be at risk. We recommend considerably extending the powers of the Mental Welfare Commission in this and other areas, and a new legal framework for intervention to protect vulnerable adults.
10. The principles of *Equality* and *Respect for diversity* have guided our considerations of groups whose needs deserve particular attention, including women, children, members of minority ethnic communities and people with disabilities.
11. People with mental disorders who come into contact with the criminal justice system also have a right to have their needs met, in a way which also takes account of the interests of the public. Our recommendations in this area are intended to promote a more coherent framework for doing this.

Respect for carers

12. Throughout, we have had regard to the position of informal carers and family members. Too often, they are left without adequate support, and feel distressed and powerless, particularly when a relative is detained. There need to be stronger mechanisms to ensure carers can be appropriately involved and informed, especially when legal steps are taken. Carers also need greater rights to ensure that the needs of a service user who may be approaching a crisis are taken into account. We believe our proposals will considerably improve the position of carers.

Improving the system

13. At our consultative events, we were disturbed to hear many service users and carers speak of negative experiences of the mental health system. Undoubtedly, a lack of adequate services was the root cause in many instances. However, some of the problems may also reflect what might be described as the culture of some services, which can contribute to a lack of trust and of mutual respect between service users and professionals. We make no apology for seeking to improve the

legal rights of service users but we would not wish to encourage distrust between service users, carers and professionals. Indeed we hope our proposals will help to improve relationships.

The role of professionals

14. There are many dedicated professionals working for and with people with mental disorders. We recognise that some of the reforms we recommend will mean extra work for them. At the same time, we are conscious of the great pressures which many of these are under and their own concern that these pressures often prevent them from doing as good a job as they would wish. Wherever possible, we have sought to integrate the procedures relating to the Act with more general best practice. We hope that, in implementing new procedures, the need for simplicity and practicality will be borne in mind, and the need also for greater support for front-line professionals. More time needed addressing Mental Health Act issues may necessitate additional medical and social work recruitment for busy service providers.

Resources

15. Our terms of reference do not cover questions of resources. However, we feel compelled to say something on this. We agree with the comment in the Annual Report of the Mental Welfare Commission for 1999-2000: 'While legislation is very important, it is services, or the lack of them, which make the most immediate impact on patients and their welfare.'
16. That Report highlights a persisting under-investment in maintaining the fabric of inpatient units, the poor quality of environment for patients in intensive psychiatric care units, and a dearth of therapeutic and recreational activities for many service users. The Commission also reports that too many patients remain in hospital when there is agreement that their needs would be better met elsewhere.
17. The Accounts Commission in their Report on Adult Mental Health Services, 'A Shared Approach'¹ found that no area in Scotland had a comprehensive range of social and healthcare services for adults with mental health problems. They also noted that expenditure on mental health services in recent years had been rising more slowly than expenditure on the NHS as a whole.
18. These reports reinforce the evidence received by the Committee, from professionals, service users and families, which was often of overstretched and inadequate services. Much of the burden of coping with the deficiencies in services rests on families. If there are inadequate services in the community, and great pressure on beds, it is difficult to see how the more flexible forms of care which have been the aim of Government for many years, and which we fully support, can operate successfully.
19. It is for others to say how the necessary improvement in services should be realised, but we have no doubt that the aspirations which underlie our

1 Accounts Commission for Scotland, *A shared approach, Developing adult mental health services*. October 1999

recommendations for new mental health law will not be fully met unless services and facilities are adequate to meet the demands placed on them.

Conclusion

20. We have tried to put forward a comprehensive set of proposals. There are a few areas where we believe further work is needed, for example in relation to provision for people with learning disability. These, however, need not delay the introduction of a new Mental Health Act, which we hope will be given early consideration.
21. We would also hope that a new Act might help to reduce the stigma which, unfortunately, through ignorance and prejudice, still attaches to mental disorder. This is all the more unfortunate since most of us at some time in our lives will be affected, directly or indirectly, through mental illness in our family or among our friends. The law has only a small part to play in improving public understanding, but a new Act may reinforce the need for efforts by Government to deal with this issue.
22. Our committee was broadly based, and included members from medicine, nursing, social work, the law, psychology, local authorities and the voluntary sector, as well as carers and service users. In our discussions, there were differences of emphasis and perspective, but this report reflects a consensus view and our recommendations have been agreed by us all. When we issued our second Consultation, setting out our preliminary views, we were pleased to find widespread support for them. We believe that this report fairly reflects the evidence we received, and sets out a coherent and practical basis for a new Mental Health Act.

SECTION 1

FRAMEWORK OF A NEW MENTAL HEALTH ACT

CHAPTER 1

THE NEED FOR REFORM

Introduction

1. In Annex 1 we provide a brief description of the 1984 Act, its origins and subsequent developments. As we indicate there, many of the provisions in the 1984 Act can be traced back to proposals made in the late 1950s which were amended in the 1980s.
2. The 1983 amending Bill and 1984 consolidation Act were not extensively debated in Parliament. It is therefore reasonable to say that this committee has the opportunity to undertake the first fundamental review of the legislation for 40 years.
3. That in itself does not mean that the Act is fundamentally out of date. Although many of the respondents we consulted argued for a new Act, it was striking that many of the proposals suggested to us were for essentially incremental improvements to the current position, rather than a wholesale recasting of the law. It is also the case that some of the proposals were not intended to alter current practice in a major way, but to ensure that the legislation reflected and supported current best practice: for example in promoting the involvement of service users in decisions about their own care.
4. Nevertheless, we were persuaded that the 1984 Act should be replaced with a wholly new Act, for three reasons: major changes in mental health care over the last two decades have meant that some of the fundamental assumptions of the Act no longer hold; changes to the Act and to other related legislation have meant that the legislation is often confusing in its effect and sometimes anomalous; and there are significant practical problems with the interpretation and operation of the Act. In our view, the combined effect of these is such that it would not be right to proceed again with the approach previously adopted of amending the existing law. A fresh start is required, through a new Act.

Changes in mental health care

5. The current Act has been criticised as being more concerned with buildings than people¹. In particular, Part V of the Act is concerned with when patients can be compulsorily admitted to hospital. This reflects an assumption that people with severe mental disorders will require care in a hospital setting. This does not reflect modern practice.

¹ For example by Ward, A. Report on Consensus for Change conference (SAMH 1996)

6. In learning disability services, there has been a policy under successive governments to move people from hospital settings to the community. The numbers of people with learning disability in hospital have reduced from nearly 6,500 in 1980 to fewer than 2,450 in 1998. The recently published Scottish Executive review of learning disability services suggests that health boards should have plans to close all remaining long stay hospitals for people with learning disabilities by 2005. It proposes that even those who require continuing care should live, so far as possible, in their own homes or in small domestic settings. The total number of estimated in patient places required is 300-400, including those currently subject to detention. The report suggests that changes to mental health legislation 'may lead to other care options'². The Scottish Executive has endorsed the report's recommendations in principle and is currently analysing responses to the recently completed consultation on how to implement the recommendations.
7. In respect of mental illness, there has been a marked reduction in Scotland in the number of hospital beds available in recent years. The average number of staffed general psychiatry beds available in the year ending 31 March 1986 was 12,191. By March 2000, this had reduced to an average of 3835 staffed beds.
8. It has been the stated aim of Government that the reduction in hospital places would be accompanied by a transfer of resources to community based mental health services, although we received evidence from many quarters that neither service was adequately resourced. Together with changes in medication, these developments mean that it is now possible for many more people, even with severe mental illnesses, to live with support in the community.
9. This does not mean that the need for people to be admitted to hospital under mental health legislation has lessened. Indeed, statistics from the Mental Welfare Commission show that the number of admissions under the Act has increased over recent years. The number of episodes of long term detention increased from 661 in the period covered by the 1991 Annual Report, to 1011 in the period April 1999- March 2000.
10. Taken together, these trends suggest that fewer people are being detained in hospital for lengthy periods, but there are, and may well continue to be, a rising number of people who live in the community most of the time, but may require compulsory measures of care in crisis situations. This pattern has a number of implications for mental health law.
11. The possibility of treating people, even when acutely unwell, in the community, raises the issue of whether the link between compulsory care and detention in hospital is still appropriate.
12. The fact that people are more likely to be living in the community also highlights the need to clarify the rights of carers and relatives- both to participate in decisions, and to have support for their own needs.

² 'The same as you?' A review of services for people with learning disabilities (Scottish Executive 2000)

13. This relates to another significant development: the growth in recognition of the rights of service users to greater involvement in decisions concerning them. One aspect of this has been the increasing strength of the advocacy movement. In 1984, formal advocacy services for patients did not exist. Such services are now being developed throughout health and social work services in Scotland.
14. There is also increasing interest in other mechanisms to support the involvement of service users in their own care, such as 'contracts for care' or advance statements, which allow people to set out, when well, the care that they would wish to receive should they become unwell.
15. One aspect of this recognition of user rights has been the development of the concept of 'reciprocity': that society owes some duty to provide appropriate services and support to those who have been required to accept treatment against their will. Such a right was strongly supported by many of the submissions we received, but is not formally recognised in the current Act.
16. Another significant change has been in the roles and responsibilities of different professionals. Nurses, including community psychiatric nurses, play a more significant part in the delivery of mental health care than before. The greater degree of movement between hospitals and the community suggests a need to increase the involvement of mental health officers in decisions concerning compulsory care. The nature of General Practice in medicine has changed greatly. Innovations such as separate out of hours services mean that assumptions in the Act about the personal knowledge of a patient by his or her GP may no longer hold.
17. Mental health and learning disability services have also been affected by wider societal changes, such as the greater recognition of the needs of different communities. While the Act mentions the need to have regard to the religious persuasion of patients, it is silent about other issues of culture and ethnic background.

Changes in legislation

18. The complex interaction between the 1984 Act and other legislation has meant that our task - to review the 1984 Act - has not been a straightforward one. We have had to consider the Act's provisions alongside other related legislation.
19. The changes which have been made to the 1984 Act, described in Annex 1, have been felt by the UK Parliament and, latterly, the Scottish Parliament, to be necessary to deal with problems perceived as arising from the Act. However, they have in some cases created their own anomalies.
20. An example is the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. This has amended the definition of mental illness to include personality disorder. Whatever view one takes of whether personality disorder should be included

within mental health law, the almost universal consensus in psychiatry is that it cannot be characterised as a mental illness.

21. New disposals, particularly the community care order, have increased the complexity of the law, but appear to be rarely used.
22. Similarly, amendments to the Criminal Procedure Acts have introduced new disposals such as the supervision and treatment order and the hospital direction, although until recently, we understand there had only been two hospital directions.
23. The passing of the Adults with Incapacity (Scotland) Act 2000 has had a very significant impact on mental health law. It has replaced several sections of the 1984 Act, and has fundamentally reformed the law concerning medical, personal and financial decision making for people who are unable to make decisions on their own behalf.
24. The Adults with Incapacity (Scotland) Act was not intended to reform the procedures concerning detention under mental health law, but there are clearly significant areas of overlap. Both Acts allow certain kinds of medical treatment to be administered without the consent of the patient, and both Acts allow third parties to determine that the patient will reside in a particular place, again without his or her consent. Both Acts contain special provisions for exceptional treatments. It is clearly desirable that the two legal frameworks are complementary.
25. The incorporation of the European Convention of Human Rights (ECHR) into domestic law, as a result of the Scotland Act 1998 and the Human Rights Act 1998 is also highly significant. There have in the past been changes to the Mental Health Act to accommodate European Human Rights case law, such as the introduction of a right of appeal by restricted patients to a sheriff. However, the evidence of the first few months of the domestic application of the Convention suggests that legislation such as the Mental Health Act, which is intimately concerned with the civil rights of individuals, is likely to come under sustained scrutiny.
26. If a new Act is to survive for any length of time, it will be important that it reflects the developing norms of human rights law. This supports the introduction of a new Act based around clear principles and positive rights.
27. There are other legislative developments which do not affect the terms of the 1984 Act, but place mental health law and practice in a different context. One example is the Disability Discrimination Act 1995. This seeks to outlaw discrimination against disabled people, including people with a mental illness or learning disability.
28. The key principle of non-discrimination in the 1995 Act is twofold in its application. A person with a disability should not be treated in a worse way than a non-disabled person, but also reasonable adjustments should be made to accommodate the needs of disabled people. Such a perspective may help to

clarify when it may be appropriate for a person with a mental health problem to be subject to measures which would not be applied to someone with no mental disorder.

29. The notion of reasonable adjustment may also act as a guide to ways in which the protections of mental health law can be made meaningful to people with various kinds of mental disability, for example, in making access to an appeal procedure meaningful for a person with learning disability.
30. Other legislative developments which may influence the way in which mental health law should be drafted include the statutory recognition of assessment and care planning in the NHS and Community Care Act 1990, and the development of statements of principle in legislation such as that in the Adults with Incapacity (Scotland) Act 2000.

Problems with the 1984 Act

31. In addition to the changes in practice and legislation which have led to a need to review the 1984 Act, there are significant criticisms which can be made of the legislation itself. Some of these reflect fundamental issues of principle, but there are also a large number of more technical difficulties which need to be addressed. These would not necessarily be repeated in a new Act, but we highlight a number of them below, in order to ensure that this is the case.
32. Among the fundamental issues of principle is that of the basis of detention. As we discuss in Chapter 5, the grounds for detention, as set out in section 17 of the Act, are in many respects circular. They are largely based on the criteria of 'necessity' and 'appropriateness', rather than any more clearly articulated justification for detention.
33. There has been relatively little case law to guide interpretation of the Act. The main area in which there has been a significant degree of judicial interpretation is in relation to patients, often with personality disorder, subject to hospital orders with restrictions. This has particularly concerned the interpretation of the 'treatability' test in section 17(1) of the Act, but cannot be said to have made the Act easier to understand or apply.
34. We also received evidence, both from the research that we commissioned, and from our consultations, that the protections afforded by the Act may not always work effectively. For example, very few patients use their right to appeal to the sheriff against renewals of detention. Accounts we received suggested that many patients do not perceive the appeal procedure as offering them a real opportunity to challenge formal interventions in their lives.
35. The Act is of course not solely concerned with detention. In relation to the social work duties set out in Part III, there have been criticisms that terms such as 'after-care' are wholly lacking in definition, and are hard to apply in the much more fluid

model of mental health care that now operates. In relation to the protective provisions of Part XI, the offences intended to protect women with learning disabilities from abuse have been said to restrict freedoms inappropriately, and the Scottish Law Commission has recommended the replacement of the powers set out in s117 to protect people at risk of abuse and neglect by a new legal code for vulnerable adults.

36. The concerns about the grounds for detention, and the review procedure, do not lead us to believe that there are significant numbers of people being detained under mental health law who should not be detained. Both the professional practice of doctors and social workers, and the sheer pressure on resources such as hospital beds, mean that most people who are currently detained are undoubtedly in need of measures of care. What may be necessary is to improve the procedures, both to ensure that alternatives to compulsion are available and considered whenever possible, and that any procedures for compulsion respect both the rights and needs of patients and carers.
37. There is also the problem of people who need care and may not receive it timeously. Many of the submissions we received from carers highlighted situations where a person with a mental illness has deteriorated over a long period, with intervention only taking place when the deterioration becomes a crisis. Some of these experiences may reflect problems with the level and availability of services, but we feel it is important to ensure that mental health law helps to avoid such situations occurring.
38. We also have great concern for the situation of people who are not formally detained, but who are not freely consenting to the decisions being made about their care. A number of people commented to us about the situation of patients who accept treatment reluctantly, because they are threatened, or feel threatened, with detention if they do not co-operate. It has also been suggested that the Adults with Incapacity Act is not, in itself, adequate to safeguard people who are not able to protect their own interests.
39. The 1960 Act took a considerable step forward in removing the stigma of mental illness and learning disability by ending the routine requirement for 'certification' for those receiving treatment for a mental disorder. We fully support this, and we would wish the new Mental Health Act to reflect the principle, which is currently enshrined in section 17(2) of the 1984 Act, that nothing in the legislation should prevent a person from receiving treatment on a voluntary basis. Nevertheless, we are concerned that more may need to be done to protect the interests of 'informal' patients.
40. Turning to more specific difficulties, we received helpful submissions from the Mental Welfare Commission and the Law Society detailing a number of these. We highlight below some of the most significant comments.
41. The definition of 'nearest relative' in section 53 contains no adequate provisions to remove a nearest relative who is unsuitable for the role - even in those cases

where they have been implicated in abuse of the patient. We note further that the definition of the term in the Adults with Incapacity Act, which was originally based on the 1984 Act, has been amended to give greater recognition to unmarried and same sex partners; and the definition in the Mental Health Act applying to England and Wales has been found to be inconsistent with the European Convention on Human Rights.

42. There is an apparent gap in the ‘nurse’s holding power’ in section 25 of the Act. This power allows a nurse to detain a patient, already in hospital as a voluntary patient, who appears to require detention for up to 2 hours, pending the arrival of a doctor. The problem is that it is not clear what power there is to continue to detain the patient between the time the doctor arrives (and the holding power appears to end), and the time the doctor completes an assessment and decides whether emergency detention is warranted. It is also not clear whether it is possible to hold the patient pending the arrival of a mental health officer to consent to an emergency 72 hour detention.
43. The Act contains no provision for a patient’s detention to be reviewed when the category of mental disorder from which they are deemed to suffer is changed.
44. There are uncertainties about the powers to transfer remanded prisoners to hospital for assessment of their mental state. We understand that this has led, on a small number of occasions to petitions to the *nobile officium*: the power of the Court of Session to correct gaps in the law. This is clearly undesirable when the Act should set out a comprehensive statutory code.
45. There are other difficulties with the current Act which we address in the following chapters. These support our view that a new legislative framework is required.

Recommendation 1.1

The Mental Health (Scotland) Act 1984 should be repealed and replaced with a new Act of the Scottish Parliament

CHAPTER 2

THE SCOPE OF A NEW MENTAL HEALTH ACT

Is a Mental Health Act necessary?

1. The various considerations that we have set out in the preceding chapter would seem to suggest that an enquiry as to the need for a Mental Health Act could have only one answer. Nevertheless, it has been suggested³ that there is in fact no need for separate mental health law, and that the provisions the current Act contains could either be done away with or distributed amongst other pieces of legislation dealing with health care, treatment of incapable adults and so forth.
2. Indeed, this could be seen as the completion of a process which was begun by the reforms of mental health law introduced in Scotland in 1960. The Percy Commission considered the question of the purpose of special legislation related to mental disorder⁴. It found that the legislation had historically served five main purposes:
 - ♦ Authorising the regulation of conditions of care in private establishments
 - ♦ Establishing the duties of public authorities to provide services for patients
 - ♦ Laying down procedures to be applied to individual patients receiving compulsory care
 - ♦ Authorising special measures for offenders who have mental disorders
 - ♦ Dealing with arrangements for the administration of patients' property.
3. The Commission went on to recommend that the first two purposes should be dealt with by general health and welfare law, although this was only partially achieved, since Parts III and IV of the 1984 Act retain provisions concerning local authority services and the regulation of private hospitals.
4. Since then, the Adults with Incapacity (Scotland) Act has replaced the provisions of Part IX of the Act concerning the management of patients' property. It has been argued by some that the justification for compulsory measures under mental health law should also be incapacity and, on that basis, that these provisions could also be incorporated in an amended Adults with Incapacity Act.
5. Given that large parts of the special measures affecting offenders with mental disorder are already contained in the Criminal Procedure (Scotland) Act 1995, it is possible to envisage that much of Part VI of the 1984 Act could be transferred to the criminal law. Indeed, it is even possible to argue that there may be no need for special measures in relation to offenders with mental disorders. Those who are

³ Szmukler, G and Holloway, F. (November 1998) Mental Health Legislation is now a harmful anachronism' *The Psychiatric Bulletin*, p662.

⁴ *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-7*, Cmnd 169: paras 128-145

held to be criminally responsible could be subject to the same criminal sanctions as other offenders, with administrative arrangements to allow transfer to hospital for treatment where appropriate. Where there is felt to be a need to detain a person because of risk to others, the justification for the detention could be explicitly stated as risk, not a particular diagnosis.

Views of consultees

6. No-one who submitted evidence to us suggested that there was no need for a legal framework to allow treatment without consent in some circumstances. However, there was a range of views as to the scope and limits of mental health law.
7. As was pointed out by the National Schizophrenia Fellowship (Scotland) (NSF (Scotland)), such legislation is only appropriate if one accepts, as they do, a medical construct of mental illness. One response, from a philosopher, argued, however, that it was necessary to go beyond this and say in what way mental illness was different from physical illness, and in what circumstances the ethical duty of respect for autonomy could be overridden.
8. A number of responses to our first Consultation, including those of the Scottish Association for Mental Health and the British Psychological Society, did suggest that separate mental health law may not be necessary in the light of legislation for adults with incapacity, especially if incapacity were to be the basis for compulsion. Others such as NSF (Scotland) and the Glasgow Association for Mental Health felt that separate mental health law was appropriate. NSF (Scotland) suggested that it helped to give a focus to mental health in the organisation of services, even though it did not guarantee that sufficient resources would be forthcoming.
9. There was a considerable amount of support for a greater integration between mental health and incapacity legislation, with many respondents advocating that a single piece of legislation should deal with both issues. The British Association of Social Workers proposed a 'Care and Protection of Adults' law, based on the example of the Children (Scotland) Act 1995, which brought together areas of child law which had previously been separate.
10. Some respondents questioned the assumption that mental health law should mainly be a framework for compulsion. It was suggested by some that the law should contain safeguards for all mentally disordered patients. However, there was a tension between this desire for an inclusive approach, and the concern that, without boundaries, mental health law would encroach unnecessarily on areas better dealt with elsewhere.
11. Several respondents, including People First, argued that mental health legislation should not only contain rights, but processes to ensure that people had effective access to those rights.

What the new Act should contain

12. We were not persuaded by the argument that mental health law should be abolished, or, more accurately, assimilated into other legislative provisions. We believe that there is a continuing need for special mental health legislation. The primary focus of this legislation should remain, as now, compulsory measures of care and treatment for mental disorder. To remove such legislation would, in our view, risk causing neglect of this important area, without necessarily affording greater respect to the human rights of service users.
13. We accept that there is a need to harmonise provision relating to compulsory measures of care with the provisions of incapacity legislation, and we make proposals in that regard at paragraphs 24-30.
14. We also believe that a Mental Health Act should continue to make provision for offenders with mental disorders. We did not receive any evidence to suggest that eliminating separate mental health disposals for offenders would either improve the quality of care received by mentally disordered offenders, or enhance public safety. We do however give further consideration to the overlap between the 1984 Act and the Criminal Procedure (Scotland) Act 1995 in Chapter 24, and make a number of detailed recommendations concerning the legislation which deals with offenders with mental disorders in Chapters 24 - 30.
15. Another important function of the 1984 Act is to create a statutory basis for the Mental Welfare Commission for Scotland. We are of the view that the Commission should remain and, indeed, its powers should be strengthened in certain respects. We make recommendations regarding this in Chapter 23.
16. There remains the question of the other provisions which are currently part of the 1984 Act, but are not concerned with detention. These include:
 - ♦ the local authority duties set out in Part III
 - ♦ the registration of private hospitals in Part IV
 - ♦ certain administrative arrangements concerning the State Hospital in Part IX
 - ♦ the offences against mentally disordered people contained in Part XI.
17. In Chapter 22, we recommend that the provisions regarding private mental hospitals in Part IV be removed from mental health law, and consolidated with the proposals for regulation of other private health care. In Chapter 35 we propose that all the legislative provisions concerning the State Hospital be contained in the legislation regarding the organisation of the NHS.
18. As regards the provisions for local authority duties and those relating to offences, it is for the Scottish Parliament, rather than this committee, to consider exactly how these should fit into the overall statutory framework. We are satisfied that these provisions are important, and should be retained in legislation, subject to the proposals for reform which we make in Chapters 13-21.

19. We have also considered whether the new Act should be extended to cover matters not contained in the 1984 Act. We heard considerable evidence of ways in which mental health care could be improved. While we are anxious that the Mental Health Act should not be an obstacle to good quality care, we were not convinced that it should be seen as the cure for all of these problems. It is, and should continue to be, a piece of legislation dealing mainly with certain issues specific to mental disorder, notably compulsory treatment.
20. We have largely resisted imposing new legal duties in respect of voluntary patients, who will continue to be the great majority of those receiving mental health care. We believe however that recommendations we make in Chapters 12 to 18, such as those regarding the promotion of advocacy, will be of benefit both to voluntary patients and those subject to compulsory measures.
21. An area where we make new recommendations is in relation to the protection of vulnerable people from abuse and neglect (Chapters 19-21). Many of our proposals in this regard are drawn from the Scottish Law Commission's 1997 report on Vulnerable Adults.
22. Overall, we hope that our recommendations will allow a new mental health act to take its place in a comprehensive legal framework which will provide for the range of legislative needs, including:
 - ♦ provision for people whose health and wellbeing is at risk
 - ♦ protection of vulnerable people from exploitation and abuse
 - ♦ protection of the public from those who may pose a risk to others
 - ♦ provision for decision making on behalf of those who are not able to act on their own behalf
 - ♦ a framework for the provision of appropriate services
 - ♦ arrangements to monitor the quality of such services and promote good practice
 - ♦ procedures for redress and appeal for those who are dissatisfied with their care.
23. Our aim is not only that the legislation should be clearer and more effective, but that it will serve to promote good relationships between service users and professionals, and the greater involvement of service users and their carers in decisions concerning their care.

Interaction with the Adults with Incapacity (Scotland) Act

24. The Adults with Incapacity (Scotland) Act 2000 received Royal Assent on 9 May 2000. The Act will be implemented progressively in stages from April 2001 to April 2002. Among the areas of overlap with mental health law are the following provisions:

- ♦ powers and responsibilities of the Mental Welfare Commission
- ♦ the definition of mental disorder
- ♦ provisions for non consensual medical treatment
- ♦ safeguards for exceptional treatments
- ♦ provisions to require adults to reside in specified places without their agreement.

25. The Adults with Incapacity Act also replaces parts of the 1984 Act by new provisions, particularly in relation to guardianship and the management of patients' funds.
26. The new Act has been extensively debated, within the Scottish Parliament and elsewhere. We gave comments to the Executive on aspects of the Act at various stages of its progress. We do not consider it necessary to propose substantial amendments to such a recent piece of legislation. However, we are aware that the Act was deliberately drafted in a way which did not encroach on core aspects of mental health law. If, as we recommend, mental health law is substantially revised, it is essential that the two Acts form part of the coherent framework which we wish to see.
27. Many of the recommendations which we make bear directly on the Adults with Incapacity Act. We note that Ministers gave undertakings to consider regulations made under the Act, such as those for exceptional treatments, in the light of the recommendations of our committee, and also to revisit, if necessary, provisions in the Act itself such as the definitions of mental disorder and nearest relative.
28. We have attempted, throughout our report, to ensure that, wherever appropriate, our recommendations are consistent with the framework of the Adults with Incapacity Act. For example, the principles we recommend for the new Mental Health Act, although not identical to those in section 1 of the Adults with Incapacity Act, are influenced by them.
29. We feel that it is vital that there should be no gaps between the two pieces of legislation, which might prevent appropriate steps being taken to protect the interests of vulnerable people. Where there may be overlaps, it is important that this does not lead to safeguards in one Act being negated by the inappropriate use of the other Act. For example, there are concerns that the procedures to authorise treatment under the Adults with Incapacity Act might contain fewer safeguards than those under mental health law, but could be used in respect of similar treatment decisions.
30. We consider specific areas of overlap in more detail at relevant parts of this report. It is our view that, in due course, the two pieces of legislation should be brought together into a single Act. It is a matter for the Executive and Parliament as to how this might be achieved. We suggest that, after the introduction of a new Mental Health Act, consideration should be given to the consolidation of the two pieces of legislation.

Recommendation 2.1

The new Mental Health Act should, so far as possible, be consistent with the Adults with Incapacity (Scotland) Act 2000. In due course, mental health and incapacity legislation should be consolidated into a single Act.

The name of the Act

31. We received a number of representations suggesting that the “Mental Health Act” was an inappropriate name for the legislation in question.
32. It was pointed out that the Act is not about promoting good mental health, which is a separate matter. Instead, it is an Act which is concerned with dealing with mental illness and mental disability, and particularly more severe forms of mental illness and disability.
33. The name was felt to be particularly inappropriate by organisations concerned with learning disability. People with learning disabilities are not mentally ill, and it was felt to be confusing to include them within an Act with a title which relates to mental health and mental illness. This may serve to perpetuate the notion that the Act is primarily concerned with mental illness, and that learning disability is included as an after-thought.
34. Against that, the name is one which has been used for 40 years, and the same term is used in England and Wales. It may be difficult to devise an alternative which is short enough to be easily remembered, yet encompasses the scope of the legislation.
35. If, as we recommend, mental health legislation is consolidated with incapacity legislation, the name will require to be changed.
36. We considered whether, in the meantime, there was any alternative name which we could recommend. Suggestions put to us included:
 - ♦ The Mental Disorder Procedures Act
 - ♦ The Mental Health Protection Act
 - ♦ The Mental Welfare Act
37. However, no particular suggestion commended itself to the Committee as being preferable to the ‘Mental Health Act’. We therefore make no recommendation, while recognising the difficulties with the current name. This is a matter that can be returned to if, as we recommend, a consolidation measure is introduced in the future.

CHAPTER 3

PRINCIPLES OF THE NEW ACT

Introduction

1. The Mental Health Act deals with fundamental questions of personal liberty, including the balance to be struck between the right not to be subjected to intervention against one's will, and the right to receive proper care and treatment. We feel that it is important that the principles by which the legislation should be operated should be clearly articulated, on the face of the Act itself.
2. Until recently, it was uncommon for legislation to include a formal declaration of underlying principles. No such statement appears in the 1984 Act.
3. In recent years, declarations of principles have become more common. The drafting of the Children (Scotland) Act 1995 was influenced by the principles of the UN Convention on the Rights of the Child, and included a key principle that the welfare of the child should be the paramount consideration in determinations concerning a child⁵. The Adults with Incapacity (Scotland) Act 2000 sets out in its first section a series of general principles, to be given effect in any intervention made under or in pursuance of the Act.
4. The Review of the Mental Health Act 1983, which is the English equivalent of our 1984 Act, by the Richardson Committee also recommended that underlying principles should be articulated in the statutory framework and should influence its eventual implementation⁶. The Green Paper issued by the Department of Health endorses this approach, although it does not accept that all the principles set out by the Richardson committee should appear on the face of the Act⁷.
5. In our discussions and consultation, we have found widespread acceptance that principles should underpin mental health law, and broad agreement as to the nature of these principles.

Recommendation 3.1

The Mental Health Act should contain a Statement of Principles.

Benefits of a statement of principles

6. We believe that such a statement will be of benefit to all those who have to operate the Act or have an interest in its operation. The principles should influence the

⁵ Children (Scotland) Act 1995, section 16(1)

⁶ Review of the Mental Health Act 1983-Report of the Expert Committee (Dept. of Health 1999) Chapter 2

⁷ Reform of the Mental Health Act 1983-Proposals for Consultation (Dept. of Health 1999) Chapter 3

drafting of the Code of Practice - which should in turn show how the principles can be put into practical effect.

7. The statement of principles set out in the Adults with Incapacity (Scotland) Act is intended to guide judicial bodies making orders under that Act. We believe that the same purpose would be served by our proposed statement of principles in the new Mental Health Act. At the moment, sheriffs, for example, have little to guide them in making decisions about issues such as compulsory detention. Our proposals will involve more detailed consideration of a range of issues when making rulings regarding compulsory care and treatment, and a statement of principles will assist in giving these various factors due weight.

Recommendation 3.2

Interventions under the Act, and the Code of Practice, should have regard to the stated Principles.

8. The principles would be of particular relevance to the Mental Welfare Commission. Currently the Commission has a general duty to 'exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests'⁸. We believe that the principles set out in the Act should be the touchstone for the work of the Commission; indeed the Commission should see itself as the guardian of those principles. We deal with this point further in Chapter 23 (paragraph 47).
9. Finally, we have sought to apply the principles in developing our own recommendations, and reference to them is made at appropriate points throughout the report.

Views of consultees

10. Our consultation process found strong support for a statement of principles within the Act. As would be expected, a wide range of principles were suggested, but there were some that received widespread support. These included:
 - ♦ interventions should be the least restrictive consistent with achieving the desired aim
 - ♦ promotion of user autonomy and empowerment
 - ♦ reciprocity and the right to an acceptable standard of care
 - ♦ any interventions should be in the best interests of the individual
 - ♦ deprivation of liberty should be determined by the degree of assessed risk
 - ♦ measures should enshrine the right of appeal and to regular review
 - ♦ measures should protect individuals from abuse and neglect.

⁸ 1984 Act, sn 3(1)

11. We include many of these within our recommendations. Many respondents specifically endorsed the principles contained in the Adults with Incapacity (Scotland) Act, although some commented that the principles would require some modification for mental health law. In light of our wish that incapacity and mental health legislation should be consistent, and ultimately consolidated, we have drawn on the principles of the Adults with Incapacity (Scotland) Act where appropriate.

A framework for principles

12. There is a danger that statements of principles become unwieldy, by incorporating large numbers of recommendations which are better described as statements of good practice. We have sought to avoid this by concentrating on core principles, which we believe will continue to be relevant over the lifetime of the Act.
13. Within medical ethics, there are often said to be four key underlying principles, namely *justice*, *autonomy*, *beneficence* (seeking to do good), and *non-maleficence* (avoiding doing harm). Each of our recommended principles can be seen as reflecting one or more of these underlying principles.

Recommended principles

Justice

♦ *Non discrimination*

People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.

Although this concept of equality is something which has come to the fore in recent years, it is in some respects a development of the aim of the reforms introduced in 1960, that treatment for mental health needs should be consistent with other forms of health care.

♦ *Equality*

All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

We address issues concerning groups with specific needs in chapter 18.

♦ *Respect for diversity*

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds

and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

This adds to the above principle of equality, by making a positive statement of the requirement to reflect individual needs, rather than merely treat all service users in the same way.

♦ *Reciprocity*

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

This principle received strong support, including that of key agencies such as the Law Society of Scotland, the Royal College of Psychiatrists and the Scottish Association for Mental Health. It is potentially the principle with the most significant consequences for services, since it implies that those subject to compulsion should have, unlike others, a legal right to receive appropriate treatment.

Some concern was expressed that the principle could have undesirable consequences. There could be incentives for professionals not to take compulsory measures when appropriate, for fear that they could not provide the necessary resources. Conversely, some professionals could pursue compulsion, or service users refuse voluntary care, in the hope that this will make it more likely that resources will be forthcoming. It was argued by some that such a principle was in itself discriminatory, in that it gives those subject to compulsion priority over voluntary patients.

Because of these concerns, we specifically asked in our second Consultation whether the advantages of a principle of reciprocity outweighed the disadvantages. A large proportion of those who responded said that they did, although, unsurprisingly, responses from bodies representing statutory service providers were more ambivalent. After careful consideration, we feel that the inclusion of such a principle is justified. It seems to us wrong that the state should be entitled to restrict the liberty of people in order to provide care, without undertaking some responsibility for providing such care.

Autonomy

♦ *Informal care*

Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

This important principle is currently recognised in the statement in section 17(2) of the 1984 Act that nothing in the Act should prevent a patient from receiving treatment without being detained under the Act. However, as we discuss in

Chapter 12, there are concerns that this can in certain circumstances leave people effectively subject to a restriction of their rights, without being formally detained. It is helpful, in that context, to make it clear that the justification of this principle is not to minimise the use of the Act, but to maximise the autonomy of patients, by ensuring that they are not subject to restrictions which are unnecessary.

♦ *Participation*

Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

At the moment, the Act contains provisions intended to ensure that information is given to detained patients (e.g. s110), but not necessarily to ensure that the patient has a strong voice in relation to decisions affecting him or her. The Adults with Incapacity (Scotland) Act recognises the important point that, even where a person is not able to make a decision for himself or herself, the person still may have views which should be ascertained and to which others should have regard. The same principle should apply in relation to mental health law, and underlies many of the recommendations we make, including those concerning advocacy (Chapter 14), tribunal procedures (Chapter 9) and advance statements (Chapter 15).

♦ *Respect for carers*

Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

This principle reflects the fact that carers have an important role to play, and their right to participation in decisions affecting them should be respected. Respecting the role of carers also reflects the principle of beneficence, in that it is likely that doing so will improve the quality of life of the service user.

The principle is similar to the principle within the Adults with Incapacity (Scotland) Act that account should be taken of the views of those involved with the adult, including primary carers and nearest relatives.

Beneficence and non-maleficence

♦ *Least restrictive alternative*

Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner

and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

This principle is reflected in the Adults with Incapacity (Scotland) Act, which requires that interventions be the 'least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention'⁹. It reflects the principle of non-maleficence, sometimes expressed in the Hippocratic injunction to doctors: 'first, do no harm.' It also seeks to respect autonomy, by limiting any breach of autonomy to the minimum necessary.

That said, it is important that the principle is not understood to mean that one should do as little as possible for the patient. Those who are subject to compulsory measures are as entitled as other patients to the highest quality of care.

♦ *Benefit*

Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

This also reflects an important principle of the Adults with Incapacity (Scotland) Act¹⁰. The principle should help to focus the minds of those who implement the Act or adjudicate upon it towards the question of what will be achieved by an intervention from the point of view of the mentally disordered person. The Children (Scotland) Act 1995 also provides that a court order relating to parental responsibilities should not be made unless it is considered that it would be better for the child that such an order be made than that none should be made at all.

♦ *Child welfare*

The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

This principle is intended to ensure that the same regard for the welfare of the child pertains in relation to an intervention under the Mental Health Act, as would be required for an intervention under the Children (Scotland) Act.

Of course, in all cases concerning use of the Act, the welfare of the patient should be a fundamental consideration, but we feel it is important to stress this principle in relation to children; both to clarify that the child's welfare takes precedence over the rights of others, including parents, and to ensure consistency with child care law.

Applying the Principles

14. Our purpose, in recommending such principles, is not to set out rules which can simply be followed to find a correct course of action. They must be applied reflectively. In some circumstances, the principles may even appear to be in

⁹ Adults with Incapacity (Scotland) Act 2000 section 1(3)
¹⁰ Adults with Incapacity (Scotland) Act 2000 section 1(2)

conflict with each other. Considering the underlying purposes of the individual principles (respect for autonomy, justice and so forth) may help to resolve some of these conflicts. Sometimes, conflict will remain. Even in such cases, we believe the principles will help to draw out what are the important issues to which people operating the Act should have regard.

Alternative suggestions

15. Our recommendations are not an exhaustive list of the principles which were suggested to us. However, many of the suggestions are, in our view, incorporated to some degree in the above principles, albeit in different language.
16. Other suggested principles, such as that the Act should protect people from abuse and neglect, and should enshrine the right of appeal and regular review, are given effect by our recommendations, notwithstanding that they are not contained in the stated principles.
17. There is a third group of suggested principles which have some merit, but which we have not addressed directly. These include a suggested principle of equity across Scotland, and that the Act should reflect evidence based practice. In our view, these are more appropriately considered as desirable aims of health care in general, rather than specific principles of mental health law.

Recommendation 3.3

The Principles should be as follows

1. *Non discrimination*

People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.

2. *Equality*

All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.

3. *Respect for diversity*

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. *Reciprocity*

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

5. *Informal care*

Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

6. *Participation*

Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

7. *Respect for carers*

Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. *Least restrictive alternative*

Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. Benefit

Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

10. Child welfare

The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

CHAPTER 4

WHO WOULD BE COVERED BY THE NEW ACT

Mental disorder in the 1984 Act

1. Section 1 of the current Act states that its provisions ‘have effect with respect to the reception, care and treatment of persons suffering, or appearing to be suffering, from mental disorder’. The presence, or at least appearance, of ‘mental disorder’ is thus crucial to the question of whether the Act can be said to apply to an individual.
2. Section 1 goes on to define ‘mental disorder’ as meaning ‘mental illness or mental handicap however caused or manifested’. The terms ‘mental illness’ and ‘mental handicap’ are not themselves further defined.
3. Section 1 also contains definitions of mental impairment and severe mental impairment, although they are only of relevance in relation to questions of detention. We go on to discuss them later.
4. Following the introduction of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, the words ‘including personality disorder’ were included after the words ‘mental illness’: in other words, the term mental illness, when used in the Act, is taken to include personality disorder.
5. This approach differs somewhat from the English Mental Health Act 1983, which includes a separate category of ‘psychopathic disorder’. The different approach can be traced back to 1960, when the Scottish Dunlop Committee recommended a different approach to the English Percy Commission, on the basis that the term ‘psychopathic’ did not have a clear meaning and that most such patients who could benefit from psychiatric treatment or care could be included in the categories of ‘mental illness’ or ‘mental deficiency’¹¹.
6. Section 1 also contains provisions to exclude certain categories from the definition of mental disorder, stating that ‘no person shall be treated under this Act as suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs’.
7. The definition of mental disorder in the 1984 Act has been referred to in a wide range of other legislative measures, including the Adults with Incapacity (Scotland) Act 2000, the Criminal Procedure (Scotland) Act 1995, and the Social Work (Scotland) Act 1968.

¹¹ *First Report of the Dunlop Committee on Mental Health Legislation*, (March 1958), paragraphs 5-10.

Mental disorder as the basis for compulsion

8. The presence of mental disorder brings a person within the general scope of the 1984 Act, but in order to be subject to detention the mental disorder must be encompassed within the provisions of s17 of the Act. The types of mental disorder covered by s17 are
 - ♦ mental illness
 - ♦ mental impairment
 - ♦ severe mental impairment
 - ♦ 'a persistent mental disorder manifested only by abnormally aggressive or seriously irresponsible conduct'.

We discuss these in more detail below.

Issues relating to 'mental disorder'

9. In responses to our consultations, some criticism was made, particularly by a number of service users, about the term 'mental disorder', which was seen as a pejorative and unhelpful label. Against that, about two thirds of those who responded to our first Consultation expressed qualified support for the term, although many felt that it should be further defined. In general, respondents who favoured change still supported the general approach of broad categories rather than specific diagnostic groups.
10. There is a degree of uncertainty over whether some particular conditions are covered by the term 'mental disorder' in the 1984 Act. The problem of personality disorder is considered at paragraphs 75-113. Conditions such as autism and Asperger's syndrome are also problematic. These are lifelong conditions which manifest themselves in childhood, and are not normally considered as mental illnesses. Some people with autism would undoubtedly fall within the category of mental handicap, but there are some people with autistic spectrum disorders who would not be so described, yet who may behave in a way which might justify intervention under mental health law. We discuss autistic spectrum disorders at paragraphs 65-68.

Retention of mental disorder

11. We believe that it is appropriate to have a broad and inclusive term which would delineate those to whom mental health legislation may apply. The broad term would set out those to whom the powers and duties of the Mental Welfare Commission would relate. This definition would also serve to delineate those to whom local authorities owe duties by virtue of mental health legislation, and would be a prior condition of the criteria for compulsory care and treatment.
12. We favour the retention of the term 'mental disorder' as the general term for inclusion in the Act. Although some respondents found the term undesirable, we

did not receive any alternative proposal which we considered would be an improvement. The problem of stigma is one which could potentially apply to any term which is used in such legislation, and we feel this problem is better tackled by attempts to reduce the general stigma associated with mental illness and learning disability (see Chapter 17 for further discussion of this issue).

13. The term 'mental disorder' has a number of advantages. It is already in the legislation, and appears in the English Mental Health Act. It makes no assumptions as to the cause or permanency of the disability. Because it is not bound strictly by any particular diagnostic classification system, it is flexible enough to encompass changes in diagnostic practice.
14. We believe that the term 'mental disorder' should encompass three categories: mental illness, learning disability and personality disorder.
15. With all three terms, we do not believe that further detailed definition in the Act would be desirable, but it would be helpful for the Code of Practice to set out guidance as to how the terms can be applied in practice. The great majority of those who responded on the point in our second Consultation supported a broad definition of mental disorder in the legislation, with the diagnostic basis of the term outlined in guidance.
16. In England and Wales, the Richardson Committee has recommended that a broad definition of mental disorder be retained¹². That Committee also recommended that the term be defined according to the Law Commission's proposed definition as 'any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning'¹³. The Department of Health has accepted this recommendation in principle.
17. Some of the respondents to our first Consultation supported this definition. We are aware that it was proposed during the debates on the Adults with Incapacity Bill. As the Richardson Committee state, the adoption of the same definition both sides of the border would seem desirable.
18. On balance, we nevertheless believe it is better to retain the term mental disorder, without further definition, other than the sub-division into three categories of mental illness, learning disability and personality disorder. Adding an additional definition of mental disorder would potentially create confusion as to the inter-relationship between this definition and the three sub-categories. The separate categories are useful because aspects of our recommendations apply to particular categories, particularly the proposals we make later in this chapter for a further review of the position of learning disability and the recommendation of an automatic review, should the category applying to a patient change.
19. We considered whether there should be a narrower definition of those who may be subject to compulsion but concluded, on balance, that this was not appropriate. We consider in this context the particular issues of learning disability and personality disorder below.

¹² *Review of the Mental Health Act 1983: Report of the Expert Committee* (Dept. of Health, 1999) paragraphs 4.4-4.8

¹³ *Law Commission (1995) Mental Incapacity* (Law Com 231), paragraphs 3.8-3.13

Recommendation 4.1

The provisions of the new Mental Health Act should apply where there is the presence of mental disorder.

Recommendation 4.2

There should be three categories of mental disorder: mental illness, learning disability and personality disorder.

Recommendation 4.3

These terms should not be defined further in the legislation, but guidance should be given as to their application in the Code of Practice.

Recommendation 4.4

It should only be possible for a person to be subject to compulsory measures of care under the Mental Health Act where the person has a mental disorder.

Alternative approaches

20. There are standard diagnostic manuals for the classification of mental disorder, of which the two most important are the World Health Organisation's International Classification of Diseases, currently in its 10th edition, and the Diagnostic and Statistical Manual of the American Psychiatric Association, currently in its 4th edition. One psychiatrist who responded to our second Consultation criticised our rejection of a formal link with such systems, arguing that these were the most secure and best evidenced basis for identifying mental disorder.
21. Nevertheless, we do not believe that such a link is helpful. Apart from the fact that these manuals include conditions which we would not wish to include within the scope of mental health law, they are subject to regular revision. A new Act, which repeated definitions contained within a diagnostic manual, would be out of date as soon as the manual was revised. It would also not be desirable to link the legislation to a manual as it was updated from time to time, since this would mean the law changing by a mechanism which was outwith Parliamentary scrutiny.
22. Another approach would be to move away from diagnostic criteria and attempt to include people on the basis of need, rather than a particular diagnostic label. There was some support for this idea, particularly from social work respondents.

This may reflect general practice, in social work legislation, which refers to “persons in need” (in the Social Work (Scotland) Act 1968) and “children in need” (in the Children (Scotland) Act 1995).

23. Although this idea has attractions, we were not persuaded that it could be applied practically to mental health law. Legal respondents in particular argued strongly for definitions which were clear and understandable to those who have to operate the Act. We were not satisfied that a sufficiently clear definition based on needs rather than diagnosis could be devised.
24. In relation to compulsory measures, the presence of mental disorder would be crucial for compliance with Article 5 of the European Convention on Human Rights (the right to liberty and security of person). This would not prevent a definition based on need rather than diagnosis being applied to other aspects of mental health law. However, we felt that a definition which did not focus on the presence of mental disorder might serve to dilute the responsibilities of agencies, including the Mental Welfare Commission, to the core group of people with significant mental illnesses and disabilities.

Mental illness

25. Mental illness is clearly included within s17, without qualification. The term ‘mental illness’ is not further defined in the Act. We are aware of no Scottish case law on the meaning of the term. The Court of Appeal, in the leading English case, *W v L*,¹⁴ suggested that the words ‘mental illness’ are ordinary words of the English language, with no special medical or legal meaning, which should be construed ‘in the way that ordinary sensible people would construe them’¹⁵. However, this test has been criticised by academic commentators as too broad, and it is not clear that a Scottish court would give such a wide interpretation of the term. The requirements of the European Convention on Human Rights, as interpreted by the European Court in the *Winterwerp* case, include the existence of a true mental disorder, established by objective medical expertise, as a justification for detention.
26. Notwithstanding this case law, it would seem in practice that psychiatrists are comfortable with the term ‘mental illness’, and feel able to give evidence to the courts as to whether it is present in a particular case. As with the term ‘mental disorder’, we do not believe that further statutory definition would be helpful. Nor do we believe that the term requires any particular qualification or additional definition in relation to considerations of compulsory care and treatment.
27. This category would cover psychotic disorder such as schizophrenia, but also non psychotic conditions such as disorders of mood, severe obsessive compulsive disorder and anorexia nervosa. It would also cover dementia and acquired brain injury with associated mental symptoms. This broad scope was generally supported in our second consultation.

¹⁴ *W v L* [1974] Q.B. 711

¹⁵ per Lawton L.J. at 719

28. A few respondents to our first Consultation particularly mentioned attention deficit hyperactivity disorder as a condition which should be included in the Mental Health Act. We are aware that this is a controversial diagnosis, and we do not recommend that it be specifically mentioned in the Act. However, we believe that such a condition might fall within the category of mental illness in exceptional cases.
29. In our second Consultation, there was a preference, on balance, for retaining the term 'mental illness' to describe this category. Alternative suggestions included 'mental health problems', 'severe mental health problems' and 'severe mental illness'. We do not believe that these terms are an improvement on 'mental illness', and it may be confusing to introduce the issue of the degree of severity of the condition into the broad categories covered by the Act.

Recommendation 4.5

Mental illness should be taken to include psychotic conditions, and non-psychotic mental illnesses such as anorexia nervosa, obsessive compulsive disorders, and disorders of mood. It should also include dementia and acquired brain injury with associated mental symptoms.

Learning disability

Should learning disability be in the Act?

30. A number of organisations representing the interests of people with learning disabilities made strong representations that this group was inappropriately placed in an Act which was predominantly drafted to meet the circumstances of people with mental illness. This included bodies such as ENABLE and People First. Against that, some medical respondents felt that inclusion within the Act was an appropriate means of providing care in some circumstances, and removing learning disability from the Act would place some people with learning disabilities at greater risk of harm, or of being inappropriately subject to imprisonment or other criminal justice disposals.
31. Research has recently been carried out into the use of the Act for people with learning disabilities¹⁶, which may provide a context for consideration of this question.
32. As at 1 April 1999, the researchers found 178 people who were detained in hospital and had a diagnosis of learning disability. Forty-four of these were in the State Hospital. One hundred and twenty one patients were detained under the Mental Health Act, and 57 under the Criminal Procedure (Scotland) Act.
33. The grounds for detention were stated on 177 of the forms (the remaining person was on an emergency order, which does not require the grounds to be stated).

¹⁶ Russell, J and Robertson, P (1999) *The use of Scottish mental health legislation for people with learning disabilities*

Fifty-one patients were detained because of a mental illness, either alone, or associated with another diagnosis. The other 126 were detained because of abnormally aggressive or seriously irresponsible behaviour associated with a learning disability, but of these 21 were subsequently found to have some form of mental illness.

34. Fifteen of the 177 patients were categorised as having 'severe mental impairment'. In 132 of the cases, the degree of learning disability was classed as borderline or mild.
35. The research suggests that the most common reasons why people with learning disabilities might be detained include
 - ♦ a co-existing mental illness (not always identified at the time of detention)
 - ♦ as an alternative to a prison disposal in criminal cases
 - ♦ to manage problematic behaviour, particularly aggression, sexually inappropriate behaviour and arson.
36. On average, the duration of detention for people with learning disabilities is significantly longer than that for people with mental illness. In 57 cases, it was recorded that the patients could have been looked after in conditions of lesser security in the community but suitable facilities were not available.

Arguments against inclusion

37. The arguments against inclusion in the Act suggest that many of the underlying assumptions of the legislation, particularly in relation to detention, do not hold for people with learning disabilities. The Act is based on the idea that people who may require treatment, but do not accept the need for it, may be detained in hospital, under the care of a psychiatrist, to receive such treatment.
38. Unlike mental illness, learning disability is a lifelong condition, which cannot be cured or alleviated by medication, although an improvement in functioning can often be achieved by other measures. People may require care and support, but the trend over a number of years has been against the 'medicalisation' of learning disability.
39. Some people with learning disabilities may well have a mental illness, but such people can be detained if necessary, under mental health law, whether or not they have a learning disability.
40. Except where a mental illness is also present, psychiatrists are unlikely to take the lead role in providing care and support for people with a learning disability. Insofar as there are interventions directed at alleviating problems caused by a person's learning disability, these will more commonly be psychologically based. The Act contains no specific safeguards in relation to such interventions. Furthermore, the evidence of the effectiveness of interventions which are authorised under mental

health law is limited. Challenging behaviour may reflect inappropriate or inadequate services, and the answer should be to provide the right services, rather than place the client under greater constraints.

41. Learning disability hospitals are in the process of closure. The review of services for people with learning disabilities, commissioned by the Scottish Executive, recommended that health boards should have plans in place for the closure of all remaining long stay hospitals by the year 2005¹⁷. Where such hospitals have closed, there have been practical problems in accommodating people with learning disabilities who are subject to detention. In some cases, special health care facilities have been developed, but this can lead to these patients having fewer options for their care than others with similar needs.
42. The introduction of the Adults with Incapacity (Scotland) Act provides an alternative legal framework for the care and treatment of adults with learning disabilities who are not able to consent to necessary medical treatment, or require some form of guardianship.
43. Finally, it is argued that the continued inclusion of learning disability in mental health legislation perpetuates the marginalisation of learning disability, and confusion between mental illness and learning disability.

Arguments for inclusion

44. Those who support the continued inclusion in the Act of learning disability accept that, for the great majority of people with learning disability, detention will not be necessary or appropriate. (The figure of 178 detained patients can be seen in the context of there being around 2,450 people with learning disabilities being cared for in hospital in 1998, and around 5,400 in care homes or supported accommodation.¹⁸) However, they suggest that it is not uncommon for people with learning disability also to have some form of mental illness. Diagnosis in such cases can be difficult, and may require close observation in a controlled setting over a substantial period of time.
45. They also suggest that removal from the Act would leave people with learning disabilities who commit criminal offences subject to the full rigours of the criminal law. This might mean more people with learning disabilities going to prison. This would not only be inhumane, but would be unlikely to address the causes of the offending behaviour, meaning that people may well commit further offences on release.
46. There are also a small number of people with learning disabilities who have not been convicted of a criminal offence, but whose behaviour may be inappropriate to a serious degree or even dangerous. Some framework is required to allow such people to be looked after safely, both to protect others and to allow interventions intended to modify the inappropriate behaviour.

¹⁷ *The same as you? A review of services for people with learning disabilities* (Scottish Executive 2000) Recommendation 12

¹⁸ *The same as you? A review of services for people with learning disabilities* (Scottish Executive 2000) Page 38

Offenders with learning disability

47. It is common ground that, for offenders who have learning disabilities, a humane alternative to prison may be necessary. However, it is debatable whether the Mental Health Act provides the best mechanism to achieve this.
48. At the event organised by ENABLE for our Committee (see Annex 6), we received information regarding the relationship between learning disability and offending behaviour. The majority of people with learning disabilities who offend are young men with mild to borderline learning disabilities. In general, the range of offences they commit, and the reasons for offending, are similar in many respects to those of other offenders.
49. Although the Mental Health Act does allow alternatives to normal penal disposals, it was suggested that the way in which the criminal justice system dealt with this group was often inconsistent and even arbitrary. Some offenders with a diagnosis of learning disability would be best served by being made subject to the normal processes of the criminal law, but were diverted out of the system, while others, who should receive special treatment, sometimes ended up in prison. The decision on whether a person's offending behaviour should be dealt with by the mental health system, the criminal justice system, or informally, depended on a range of factors, most of which had little to do with the needs of the individual offender.
50. There are also problems about the use of mental health law to detain, on the basis of risk to others, people with learning disabilities who have not been convicted of a criminal offence. If treatment under the Act has little direct effect on the behaviour which causes concern, this could amount to a form of preventive detention. This arguably discriminates against people with learning disabilities.

The experience of New Zealand

51. Most of those who opposed the continued inclusion of people with learning disabilities in mental health legislation accepted that some provision might be needed to deal with the issues of offending or dangerous behaviour, but argued that such legislation should be framed specifically for people with learning disabilities. We therefore took steps to obtain information about the situation in New Zealand, where learning disability has been removed from mental health law.
52. In 1992, the Mental Health (Compulsory Assessment and Treatment) Act was passed. This excluded intellectual disability (the term used in New Zealand for learning disability) from the scope of the Act. This reflected a view that there was a fundamental difference between learning disability and mental illness. Although this approach is still widely supported, the removal from mental health law did create a gap, to the detriment of a number of people with learning disabilities.
53. One effect of the change was that a number of people who had been in hospital were discharged, including some people with an offending history who then went

on to commit further offences. Doubt was cast on whether people with an intellectual disability could be treated by the criminal courts as ‘unfit to plead’, although the courts eventually ruled that this was still possible.

54. In view of the gap that had been created and the difficulties arising from that, steps are now being taken to make separate provision for people with learning disabilities. The Intellectual Disability (Compulsory Care) Bill was introduced in 1999. This Bill provides for the compulsory care of individuals with an intellectual disability

- ♦ charged with an imprisonable offence and convicted or found unfit to stand trial or acquitted on the grounds of insanity, or
- ♦ whose behaviour poses a serious risk of danger to themselves or others and who will not voluntarily access the care and support services needed for their own or others’ protection.

55. It is estimated that around 200 people in New Zealand (out of a population of 3 ½ million) might require care under this Bill. The framework for compulsory care is similar to that provided under mental health legislation, but is tailored to the particular population covered by the Bill. At the moment, appropriate services for this group are limited, but it is hoped that the legislation would facilitate their development. It is intended that services would not only be based around in-patient care, but that community services would also be provided under the legislation.

Our proposals

56. The arguments that people with learning disabilities are not well served by the current Act have considerable force. Some of the recommendations we make elsewhere in the report may alleviate this problem to some degree. For example, the possibility of compulsory care being provided in a range of settings, rather than only in hospital, and the requirement that compulsory treatment be based on an agreed plan of care, may allow greater scope for interventions tailored to the particular needs of individuals with learning disabilities. We also recommend in Chapter 10 (paragraphs 35-37) that consideration be given to additional protection for behavioural treatments. In Chapter 26, we make recommendations regarding greater involvement of psychologists and mental health officers in criminal proceedings, which may improve the assessment of the appropriate option in such cases.
57. However, we believe that more needs to be done. Although we have sought to take account of the situation of people with learning disabilities, this is in the context of an overall review which has had to consider many other issues. It would be wrong for people with learning disabilities simply to be swept along in legislative change which is mainly directed at mental illness.
58. Learning disability services face huge change over the next few years. This has been given impetus by the recent Scottish Executive review of learning disability

services. We believe there is a need to provide a mechanism to look, in the round, at what legislative framework would help to support high quality services for people with learning disabilities, and protect their human and civil rights. This should take account of the implications of the Adults with Incapacity (Scotland) Act, as well as mental health law.

59. In our second Consultation, we proposed that further work be undertaken, by a new body with appropriate expertise, to consider what compulsory measures of care might be appropriate for people with learning disabilities and, in particular, whether, over the medium to long term, learning disability should be removed from the Mental Health Act, and whether separate legislation for people with learning disabilities should be framed.
60. This proposal received widespread support. Most of those who responded to the question supported consideration being given to a separate legal framework for compulsory measures in relation to learning disability. Social work and voluntary bodies were particularly in favour of this. ENABLE strongly supported a completely separate legal framework. Against this, several medical organisations, such as the Royal College of Psychiatrists, felt that learning disability should be retained as a category of mental disorder within mental health law. Some organisations, such as the Law Society of Scotland, suggested that if learning disability were to remain within the Mental Health Act, there should be a specific part of the Act dealing with this group.
61. We believe it would be premature to remove learning disability from mental health law. To do so might result in some people with learning disabilities being denied necessary care and support. The necessary infrastructure of services which might support an alternative legislative approach is not yet in place, particularly in relation to people with learning disabilities who commit offences, or present a risk to others.
62. However, we remain of the view that the possibility of legislation specifically directed at learning disability should be considered further. The review should consider the experiences of people with learning disabilities who have been detained, and legislation from other jurisdictions. It should pay particular regard to ways of improving the arrangements for dealing with people with learning disabilities who offend, or who are at risk of offending. We would wish to see such a review take place at an early date.

Recommendation 4.6

There should be an expert review at an early date of the position of learning disability within mental health law. This review should consider

- ♦ *the implications of the Scottish Executive review of learning disability services for legislation affecting people with learning disability, including mental health law*
- ♦ *experiences from jurisdictions with different arrangements in respect of learning disability and compulsory care*
- ♦ *whether it is feasible and desirable to make separate provision for the compulsory care of people with learning disabilities, outwith the Mental Health Act*
- ♦ *the experiences of people with learning disabilities who have been detained under the 1984 Act, including their treatment and outcomes*
- ♦ *what measures might be taken to ensure that arrangements for people with learning disabilities who offend meet the needs of the offenders and society.*

Recommendation 4.7

Pending any change arising from such a review, there should continue to be provision for learning disability within the Mental Health Act.

Recommendation 4.8

The definition of mental disorder for the purposes of compulsory measures of care should include learning disability.

Definition of learning disability

63. We believe that 'learning disability' should replace the term 'mental handicap'. Many respondents to our first Consultation felt the term 'mental handicap' was outmoded. It has been replaced by learning disability for many official purposes. For example, the recent review of services conducted by the Scottish Executive employed the term 'learning disability'.
64. We see the use of the term 'learning disability' in the new Act as being broadly synonymous with the use of mental handicap in the 1984 Act. It would include those with intellectual disabilities caused by genetic conditions, such as Down's syndrome, as well as those whose intellectual impairment has no identifiable cause.
65. As we suggest above, there are some conditions, such as Asperger's syndrome and other autistic spectrum disorders, where it is not totally clear that they fall within the term 'mental handicap'. The same might apply to the term 'learning disability'. These conditions affect an individual's ability to interact socially, although other aspects of

intellectual functioning are not always seriously impaired. We would intend that such conditions should bring a person within the general scope of the Act.

66. It is our understanding that the term 'learning disability' is not restricted to a straightforward measurement of intelligence such as an I.Q. test, but would take account of aspects of social functioning. Even were one to seek to define learning disability by reference to intelligence alone, we heard evidence to the effect that the threshold between what might be characterised as low normal intelligence and learning disability is not fixed, and different thresholds have been used at different times. As with mental illness then, diagnosis of such a condition is something which should take account of current clinical norms and understanding, rather than be unduly constrained by a rigid statutory definition.
67. The Scottish Executive's review of learning disability services contains a discussion of definitions of learning disability¹⁹. It makes reference to the following definition:
- " A learning disability is a significant, lifelong condition which has three facets:
- ♦ reduced ability to understand new or complex information or to learn new skills
 - ♦ reduced ability to cope independently; and
 - ♦ a condition which started before adulthood (before the age of 18) with a lasting effect on the individual's development."
68. We believe that this definition is consistent with our approach. We do not believe that it is necessary for it to be spelled out in these terms in the legislation, but such a definition may usefully be included in the guidance on the operation of the Act, and in the Code of Practice.

Recommendation 4.9

Learning disability should include autistic spectrum disorders.

'Mental impairment' and 'severe mental impairment'

69. 'Mental impairment' is defined in s1 of the Act as
- 'a state of arrested or incomplete development of mind not amounting to severe mental impairment which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned',
- and 'Severe mental impairment' is defined as
- 'a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'.

19 *The same as you? A review of services for people with learning disabilities* (Scottish Executive 2000) Appendix 3

70. For a person with mental impairment to be detained, it is necessary that he or she be 'treatable': the treatment to be provided under detention must be likely to alleviate or prevent deterioration in his or her condition. This requirement does not apply to severe mental impairment.
71. In short, then, a person with a learning disability (and no additional mental illness) can only be detained if
- (a) he or she manifests abnormally aggressive or seriously irresponsible behaviour,
and either
 - (b) he or she is treatable,
or
 - (c) the degree of impairment is severe.
72. The definitions of mental impairment and severe mental impairment in the current Act are, in our view, unhelpful. Although they may have been intended as safeguards against detention being overused in relation to people with learning disabilities, in practice they would seem to add little to the other criteria for detention in s17. Furthermore, they create an unfortunate association between mental handicap and aggressive or irresponsible behaviour.
73. We recommend in Chapter 5 (paragraphs 46-49) that there should be a 'benefit' test which would apply in all cases of patients subject to compulsion, and in the same chapter (paragraph 58-68) that the present specific provision on treatability relating to certain categories of patient should be repealed. If this were to be done, the distinction between different degrees of mental impairment would be unnecessary.
74. We therefore believe that the terms 'mental impairment' and 'severe mental impairment' should be abolished. As with mental illness, there should be a simple term setting out the broad category of people who may, if the necessary criteria are met, be subject to compulsory care. Nearly all of those who responded to our second Consultation agreed with our suggestion that the terms 'mental handicap', 'mental impairment' and 'severe mental impairment' should be replaced by the single term 'learning disability', and we so recommend.

Recommendation 4.10

The categories of 'mental impairment' and 'severe mental impairment' should be abolished.

Personality disorder

Nature of personality disorder

75. Although personality disorder is an accepted medical diagnosis, the term is one which excites considerable controversy. It may be helpful if we set out our general understanding of the term.
76. Personality disorder is a term used to describe a wide range of conditions where a person manifests behaviour, and responses to personal and social situations, which represent extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. Often, but not always, the person will experience distress and problems in social functioning and performance.
77. There are various sub-categories of personality disorder. Some, such as borderline personality disorder, are close to accepted forms of mental illness. These may involve bizarre and self-destructive behaviour and significant distress to the sufferer. Others, particularly anti-social personality disorder, have been criticised as being diagnosed largely through anti-social behaviour, and so could be seen as simply describing violent or dangerous people, rather than mental disorder.
78. The total numbers of people with personality disorder to some degree is thought to be fairly high – one estimate is 11% of the adult population²⁰. Personality disorders are often associated with a high degree of involvement with medical and social services, and an increased incidence of ill-health and early death. People with personality disorder may have other problems such as substance misuse. It should be emphasised that the potentially dangerous group of people with a severe anti-social personality disorder is only a small subset of the wider group of people with personality disorders; most of whom present no risk to others.
79. Personality disorders are distinguished from mental illness by being seen as reflecting the individual's underlying personality. However, diagnosis is difficult, and many people are diagnosed with both a personality disorder and a mental illness (or in some cases a learning disability), or the diagnosis may shift from one to the other.
80. There is controversy over whether personality disorders can be successfully treated. The consensus, such as it is, is that some treatments are of benefit to some sufferers, particularly with less severe conditions, but normally require the co-operation of the patient. Most treatments involve some form of psychotherapy (such as cognitive behavioural therapy) although drug treatment is sometimes used.

The current legislative position

81. Prior to the introduction of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, personality disorder was not specifically mentioned in the Act. However,

²⁰ de Girolamo, G and Reich, JM (1993) *Personality Disorders*, (World Health Organisation)

section 17(1) of the Act imposes a requirement that a person whose mental disorder is 'a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct' should only be detained if treatment is likely to alleviate or prevent a deterioration in his condition. This is the so-called 'treatability test'. The terminology used is consistent with the English definition of psychopathic disorder. The fact that the treatability test is required at all can only be on the basis that such people can, at least in some cases, be said to suffer from mental disorder as defined in section 1 of the Act. However, the test will not encompass all patients who might be said to have a primary diagnosis of personality disorder.

82. Currently, personality disorder is included within the definition of 'mental illness' in s1 of the 1984 Act, as a result of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. It was stated at the time of the passing of the legislation that this was not intended to change psychiatric practice in relation to personality disorder, or to lead to an increase in the number of detentions.
83. It is not clear precisely how this change in the law relates to patients within the category of mental disorder set out in section 17 (1) (a) (i) of the Act but it seems that the present position is, in effect, that people with personality disorders can be detained under the Mental Health (Scotland) Act if they meet the normal tests of 'appropriateness' and 'necessity', which we discuss in Chapter 5, but that for some people with personality disorder, a treatability test also applies.

The inclusion of personality disorder within the Act

84. We have given considerable thought to whether people with personality disorder should be subject to compulsory treatment, solely on the basis of such a disorder, and we discuss this further in paragraphs 94-113. However, we are clear that the treatment of personality disorder is an important aspect of mental health care, particularly in relation to those aspects not dealing with compulsion, such as the responsibilities of the Mental Welfare Commission and local authorities.
85. In both our first and second consultation documents, we asked whether personality disorder should be included in the Mental Health Act. On both occasions, a clear majority of respondents supported inclusion, although health professionals and organisations were generally less in favour of inclusion than social work and voluntary sector responses.
86. The Law Society of Scotland supported inclusion, arguing that patients' diagnoses often shift between mental illness and personality disorder, and exclusion might make it more difficult for needs to be assessed and met. The Scottish Association for Mental Health expressed concern that explicitly to exclude this group might result in some people experiencing mental distress being denied help. The National Board for Nursing, Midwifery and Health Visiting for Scotland strongly supported the inclusion of personality disorder within mental health law, provided the condition was well defined and related to treatability. Greater Glasgow Health Board also supported inclusion, whilst endorsing the view of the Committee that social control should not be a matter for health agencies.

87. Against this, responses to our second Consultation from the Royal College of Psychiatrists and the State Hospitals Board argued that there was no need for a separate category of personality disorder in relation to detention. This would not prevent the compulsory treatment, where appropriate, of an associated mental illness, or treatment for personality disorder being given on a voluntary basis. The State Hospitals Board suggested that the principle of voluntary treatment for behavioural problems associated with personality disorder might be extended to transferred prisoners. The British Medical Association also opposed inclusion, arguing that the term 'mental illness' was sufficiently flexible to allow the detention in an emergency of a person with personality disorder.
88. Some respondents advocated different approaches to the problem. The British Psychological Society did not wish personality disorder to be included as an explicit category in the Mental Health Act. However, they advocated that the term 'mental illness' be replaced by a term such as 'mental, emotional or behavioural dysfunction', which would also seem to encompass forms of personality disorder. The British Association of Social Workers (BASW) suggested that the sub-division of 'mental disorder' into three different categories of mental illness, learning disability and personality disorder was unhelpful, since in practice people may have a mixture of difficulties. BASW suggested instead that the focus should be on the person's cognitive ability, which could be affected by social or emotional experiences, as well as mental illness or learning disability. This interpretation would therefore potentially include personality disorder, amongst other conditions, within the scope of the Act.
89. We heard a considerable amount of evidence about the problematic nature of the term 'personality disorder'. Several people argued that it was commonly used, not as a positive diagnosis, but as an exclusionary label: a means of removing people from the concern of mental health professionals. Others criticised the term itself, as one which was deeply stigmatising and unhelpful to the service user. To some, the term implies that the person's problems lie at the core of their personality. In other words, they are the problem, not a condition from which they suffer.
90. The term is also problematic in encompassing a wide range of conditions - some of which appear to shade into mental illness, while others are arguably synonyms for anti-social behaviour.
91. Against this, standard diagnostic manuals such as the ICD-10 and DSM-IV do accept personality disorder as a category of mental disorder. Diagnosis is difficult, and we heard of many people who have experienced changes in diagnosis from personality disorder to schizophrenia, and vice versa. In that context, we would be concerned if people were denied the protections contained in the Act, such as the oversight of the Mental Welfare Commission, because of a label of personality disorder rather than mental illness having been applied.
92. Much attention is now being paid to developing a better understanding of personality disorders and their treatment. So far as we can ascertain, this is unlikely to lead in the near future to a substantial re-categorisation of personality

disorder in general, or the different types of personality disorder which have been identified.

93. Taking account of the evidence we have received, we have concluded that personality disorder should appear as a separate category, and not be subsumed in the category of mental illness, as is currently the case. In line with our general approach, it should not be defined further in legislation.

Recommendation 4.11

Personality disorder should be specified as a category of mental disorder in the Mental Health Act, separate from mental illness and learning disability.

Personality disorder and compulsion

94. The number of people detained on the basis of the definition set out in section 17(1)(a)(i) is very small. In the period 1 April 1998 to 31 March 1999, 'persistent aggressive or seriously irresponsible behaviour resulting in the need for treatment' was the reason for detention in only two of the 1055 s18 orders granted. In the 1960s, a significant number of people were held in the State Hospital with a primary diagnosis of personality disorder, but this has reduced to less than 5% of the patient population.
95. The figures, however, may not tell the whole story. Some of the people detained under the other categories of mental illness, mental impairment and severe mental impairment will also have a personality disorder. In other cases, diagnosis might shift over time from personality disorder to mental illness, and vice versa.
96. The primary reason why there are few detentions of people on the basis of personality disorder alone is perhaps that, in most cases, the view is taken that detention is unlikely to be of benefit. Compulsory medication is generally not indicated, except sometimes as a response to a short-term crisis. Most effective treatments are psychotherapeutic in nature, requiring the co-operation of the service user, and so cannot be delivered without consent.
97. We accept that this is the case, and would not support a more extensive use of compulsory measures for people with personality disorders. However, we found the question of whether personality disorder should be excluded altogether from the provisions of the Act which relate to compulsory care a difficult one, with strong arguments on either side.

Arguments for possible compulsion

98. Personality disorder is a recognised mental disorder (or group of disorders). It is arguable, therefore, that it should be treated in the same way as other mental disorders. Compulsion might only rarely be justified, but the same can be said for

some mental illnesses, and for learning disability. Inclusion of personality disorder does not, by itself, mean that individuals with personality disorder can be detained. The law at present contains other criteria which must be satisfied before compulsion can take place and the same will be true if our proposals for compulsory intervention in Chapter 5 are adopted. If the criteria are met, in the case of an individual with personality disorder, there is no reason why compulsion should not be possible.

99. Much of the debate about personality disorder has concerned a small group of people classified as having anti-social personality disorder, who have committed serious crimes. However, there are many other people with, for example, borderline personality disorder, who are much more likely to harm themselves, perhaps seriously. This is a group who may require compulsory intervention, even if on a short term basis to deal with a crisis.
100. Although it may be impossible to force effective treatment on someone with a personality disorder, in some cases a compulsory framework may provide a structure which will assist in negotiating a treatment plan. Personality disorder may not differ greatly in this respect from certain conditions within the mental illness category, such as anorexia nervosa. The possibility of compulsion may, for example, allow some offenders, such as women with borderline personality disorder, to be subject to a hospital disposal, as a humane and safe alternative to imprisonment.
101. Although treatment options may be limited at present, this might change in future, and it would be wrong to rule out the possibility of compulsion, should such treatments be developed.
102. If personality disorder were to be excluded from compulsory measures, it might call into question the position of those who are currently detained on that basis.

Arguments against compulsion

103. Although personality disorder is a recognised type of mental disorder, some of our respondents felt that it is not sufficiently well defined to be used as the basis for statutory intervention. It is often not a positive diagnosis, but is in effect a way of saying that a person is exhibiting problematic behaviour without having a definable mental illness.
104. Not only can effective treatment for personality disorder not be forced on an unwilling patient, but to allow detention on the basis of personality disorder might add to pressure on psychiatric services to take responsibility for people who cause problems for society, or commit crimes, even when a clear therapeutic aim cannot be identified.
105. Conversely, if people with personality disorder feel that they may be liable to detention, this might discourage them from seeking or accepting help.

106. Prior to the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, it was not felt necessary to mention personality disorder specifically in the Act, and there is no reason to believe that this created significant difficulties.

Our conclusions

107. In some respects, there are attractions in reverting to the position prior to 1999, when personality disorder was not mentioned in the Act. However, it would not be realistic to ignore the fact that the 1999 Act has given new emphasis to the question of personality disorder.
108. Furthermore, the drafting of the Act, even prior to 1999, was not ideal. Although the term personality disorder was not used, the inclusion of the category of mental disorder 'manifested only by abnormally aggressive or seriously irresponsible conduct' in s17 served to include it by implication. This form of words is a legal test, which does not link well with clinical diagnoses. The equivalent formula in the English Act has been repeatedly criticised, including by the Butler Committee, the Fallon Inquiry into Ashworth Hospital, and the Reed working party on psychopathic disorder²¹.
109. As we say above, we are of the view that people with personality disorder require and deserve appropriate services, and so should be included within the scope of mental disorder so far as mental health legislation in general is concerned.
110. On the question of compulsion, the problem cases in future are not, in practice, likely to be those with a sole diagnosis of anti-social personality disorder, with no associated mental illness or learning disability. Few, if any, Scottish psychiatrists are likely to recommend compulsory measures in such cases. The more difficult cases are those where diagnosis is uncertain, or where a person with an underlying personality disorder experiences a crisis, which could be characterised as an episode of mental illness.
111. If personality disorder is mentioned in other parts of the Act but not in relation to compulsion, this would serve to exclude it, by implication, as a ground for compulsion. This could result in difficult cases turning on whether the patient falls within the distinct legal categories of mental illness or personality disorder, rather than the tests we set out in Chapter 5 of impaired judgement, risk, and benefit from treatment.
112. It is likely that many, indeed most, people with personality disorders will not be liable to detention, because they will not meet these tests: for example because their judgement is not impaired, or because there is no plan of care to be delivered under compulsion which is likely to benefit the patient. In our view, that would be the right way of determining such questions, given the frequent difficulties in reaching a firm diagnosis.
113. In the light of all the above, we have concluded that personality disorder should be included in the Mental Health Act as a form of mental disorder for which compulsory measures may be imposed, where the normal criteria are met.

21 *Committee on Mentally Abnormal Offenders* (Cmnd 6244) 1975; *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*, Vol 1 (Cmnd 4194- 11); *Working Group on Psychopathic Disorder* (Dept of Health/Home Office) 1994

Recommendation 4.12

The definition of mental disorder for the purposes of compulsory measures of care, should include personality disorder.

Exclusions

114. We believe that certain conditions should continue to be excluded from the definition of mental disorder. These are as follows.

Sexual orientation or behaviour

115. The current Act refers to ‘promiscuity’ and ‘immoral conduct’. We believe that these terms are outdated and should be replaced.
116. It was suggested in evidence to us that it may not be necessary specifically to exclude sexual behaviour, since very few psychiatrists would nowadays treat, for example, promiscuity or homosexuality as a mental disorder. Against that, some sexual behaviours such as fetishism and transvestism remain within standard diagnostic classification systems, and there is sometimes pressure to treat other deviant behaviours as justifying detention.
117. We feel it is worthwhile to make clear that, where unaccompanied by some form of mental disorder, particular sexual preferences or behaviours should not be regarded as bringing a person within the scope of mental health law.

Alcohol or substance misuse

118. The current Act excludes ‘dependency on alcohol or drugs’. We agree with this, but prefer the term ‘misuse’, rather than the more narrow term ‘dependency’. The use of drugs, alcohol or other substances should not debar a person from inclusion within the Act if they are a feature of the person’s underlying mental disorder, co-exist with a mental disorder, or have led to the development of a mental disorder. An example of the latter situation would be Korsakoff’s syndrome, which is a form of dementia caused by prolonged alcohol misuse.
119. The basic reason for not including alcohol and substance misuse within the Act is simply that they cannot be considered, on their own, as mental disorders. There are other justifications, including the argument that such behaviour is essentially voluntary in nature, and so the responsibilities set out in law may be different in nature from that pertaining to mental disorder.
120. When visiting community mental health services, we heard some evidence that the distinction between mental health and addiction services was not always helpful, given the very high degree of co-morbidity between substance abuse and mental illness. However, this is an issue which relates to the configuration of health and

social care services. If it requires to be addressed, this can be done without changes to mental health law.

Anti-social behaviour

121. We do not wish mental health legislation to be used for the social control of undesirable or criminal behaviour in the absence of mental disorder.
122. An area in which we wish to urge particular caution is in the management of severe conduct problems in children. Conduct disorders are listed in ICD 10 and DSM IV, and this has provided the rationale for unruly children being held in several States in the USA - a development which we would not wish to see introduced in Scotland. We would expect the procedures in the Children (Scotland) Act 1995 to continue to be the normal mechanism for the small minority of children exhibiting conduct disorder in need of compulsory measures. We discuss the overlap between child care law and mental health law further in Chapter 18.

Imprudent behaviour

123. The Adults with Incapacity (Scotland) Act 2000 contains an additional exclusion from the definition of mental disorder, namely 'acting as no prudent person would act'²². We believe that this would be a helpful addition to the exclusions within the Mental Health Act, to make clear that eccentricity, and even unwise behaviour, cannot by themselves be taken as mental disorder.

Recommendation 4.13

The definition of mental disorder should specifically prevent people being included within the definition by reason only of sexual orientation or behaviour, alcohol or substance misuse, anti-social behaviour, or 'acting as no prudent person would act'.

Changes in category

124. As we have said, it is not uncommon for people with a diagnosis of mental illness subsequently to be diagnosed as having a personality disorder, and vice versa. The same can happen with learning disability and personality disorder, and people with learning disabilities may be diagnosed subsequently as also having a mental illness.
125. At the moment, a change in diagnosis of a detained patient does not require a review of the appropriateness of detention, even where the diagnosis changes from one where the 'treatability' test does not apply, to one where it does: for example a person diagnosed as being mentally ill whose diagnosis changes to anti-social personality disorder.

²² Adults with Incapacity (Scotland) Act 2000, s87

126. We were concerned that this was potentially unfair, and proposed in our second Consultation that, where there is a change in the category of mental disorder which applies to a person subject to compulsion, there should be automatic recourse to the tribunal to test the validity of ongoing detention. Nearly half of those who responded to the consultation expressed a view on this point, and virtually all favoured such an automatic review.
127. To some extent, the issue is less significant under our proposals than under the current Act, because we recommend that the same criteria for compulsory care should apply to all categories of mental disorder. Nevertheless, a revised diagnosis, which results in the category of mental disorder being altered, is a significant change of circumstances and we consider therefore it should result in a review by a mental health tribunal.
128. A review by the tribunal would be triggered where a recommendation for renewal of long term compulsion indicated that the patient's diagnosis had moved from one category to another. In the case of a patient with dual diagnosis (such as learning disability and mental illness), the removal or addition of one element in the dual diagnosis would also trigger a change.
129. The same principle should apply for restricted patients. In line with our recommendations for this group of patients in Chapter 27, a change in diagnosis in the responsible medical officer's annual report should trigger a review of the case by the Restricted Patients' Review Board.

Recommendation 4.14

Where on renewal of long term compulsion the diagnosis of a patient changes from one of the categories of mental illness, learning disability and personality disorder to another, or there is a change in one aspect of a dual diagnosis, there should be an automatic review of the case by a mental health tribunal.

Recommendation 4.15

In the case of a restricted patient, there should be a review by the Restricted Patients' Review Board where a report by the responsible medical officer contains such a change in diagnosis.

Use of the Mental Health Act definition in other legislation

130. Criticism was made, particularly by the Law Society of Scotland, of the indiscriminate use of definitions from the Mental Health (Scotland) Act in other, unrelated, legislation. Examples given included eligibility for jury service and the definition of vulnerable witnesses in the Criminal Procedure (Scotland) Act.

131. There is good reason for having consistent definitions in legislation which serves related purposes. Therefore, we recommend that a new definition of mental disorder be applied to the Adults with Incapacity Act 2000, the Social Work (Scotland) Act 1968 and the Criminal Procedure (Scotland) Act 1995. In relation to other statutes which currently make reference to the 1984 Act, we would not wish the definition simply to be replaced by our proposed new definition. Each case should be considered on its own merits. In appropriate cases, a definition fit for the particular purpose should be introduced.

Recommendation 4.16

The recommended definition of mental disorder should be incorporated into the Adults with Incapacity (Scotland) Act 2000, the Social Work (Scotland) Act 1968, and the Criminal Procedure (Scotland) Act 1995.

Recommendation 4.17

Other legislation which currently makes reference to the definition of mental disorder in the 1984 Act should be reviewed, and new definitions which are appropriate to the intended purpose substituted.

SECTION 2

COMPULSORY TREATMENT

CHAPTER 5

GROUNDS FOR COMPULSION

1. Perhaps the most fundamental issue in mental health law is the justification for imposing compulsory measures on someone without their consent. Such a justification should be ethically appropriate, and also capable of practical application. We believe that the current tests need to be reformed to meet these criteria.

The current law regarding medical consent

2. The specific provisions regarding compulsory treatment for mental disorder should be viewed in the wider context of the legal rights of people to consent or withhold consent to medical treatment.

The general law

3. The general position is that any medical intervention on a competent adult requires the consent of that adult. Treatment given without consent is potentially both a civil wrong, which could result in a claim for damages, and a criminal offence, such as assault. It would also be a breach of professional codes of practice. A competent adult is entitled to refuse treatment, for good or bad reasons, or for no reasons at all.
4. In order for valid consent to treatment to exist, the patient must have been given, and been able to understand, a certain degree of information about the nature, purpose and possible outcomes of the proposed treatment. The caselaw in Scotland and England broadly suggests that, for the purpose of avoiding civil liability for treatment without consent, a doctor must provide such information as would be provided by a responsible body of medical opinion¹.
5. The common law almost certainly allows treatment to be given in an emergency, where it has not been practical to obtain consent: for example where a patient is brought unconscious to an Accident and Emergency department. However, it is doubtful whether the right to treat even in such cases would extend to circumstances where the patient has previously indicated a decision to refuse such treatment and the patient's views are known to those treating him or her (see discussion of Advance Statements in Chapter 15).

Children and adults with incapacity

6. Under the Age of Legal Capacity (Scotland) Act 1991, the same right to give or withhold consent applies to any child who is sufficiently mature to make the treatment decision. If the child is not able to take the decision, the authority to

¹ See *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, and *Hunter v. Hanley*, 1955 S.C. 200

consent or to withhold consent is vested in those with parental rights and responsibilities. If it is felt that the decision by the person with parental rights is not in the best interests of the child, the matter can be resolved by the sheriff court².

7. The position in relation to adults who are not able to consent to medical treatment because of mental disorder has been an area of considerable doubt, but has now been dealt with in the Adults with Incapacity (Scotland) Act 2000. Part 5 of this Act sets out a framework under which medical treatment can be administered to incapable adults. Subject to a range of safeguards, medical practitioners have authority to do what is reasonable in the circumstances to safeguard and promote the physical or mental health of the adult³.
8. The Act defines 'incapable' as meaning incapable of
 - (a) acting; or
 - (b) making decisions; or
 - (c) communicating decisions; or
 - (d) understanding decisions; or
 - (e) retaining the memory of decisions,
 - (f) by reason of mental disorder or of inability to communicate because of physical disability⁴.
9. The authority to treat does not extend to treatment covered by Part X of the 1984 Act (discussed in Chapter 10); nor the use of force or detention; or placing the adult in a hospital for the treatment of mental disorder against his or her will⁵.

Compulsory treatment for mental disorder: current legislation

10. The criteria for interventions under the 1984 Act are set out in section 17. They are based on
 - ♦ the presence of mental disorder,
 - ♦ 'appropriateness',
 - ♦ 'necessity', and, for some kinds of disorder,
 - ♦ 'treatability'.
11. We consider first the tests of appropriateness and necessity.

Appropriateness and necessity

12. Before a patient can be detained, it is necessary for the patient to be 'suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital'⁶. The other test, which applies in all cases, is that 'it is necessary for the health or safety of that person or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained'⁷.

² Children (Scotland) Act 1995, s11

³ Adults with Incapacity (Scotland) Act 2000, s47(2)

⁴ Adults with Incapacity (Scotland) Act 2000, s1(6)

⁵ Adults with Incapacity (Scotland) Act 2000, s47(7) and s48(1)

⁶ 1984 Act, s17(1)(a)

⁷ 1984 Act, s17(1)(b)

13. There is little guidance, in statute, case law, or the Code of Practice, as to how the ‘appropriateness’ test should be interpreted. In relation to the ‘necessity’ test, there has been concern that it militates against doctors detaining people until they are extremely ill, rather than intervening at an earlier stage. However, the Mental Welfare Commission said in their Annual Report for 1994/5:

‘This does not mean that there must be an immediate threat to life or limb, in the sense of either active suicidal intention or immediate threat of violence to others. In the Commission’s view, severity of symptoms or severity of distress may be sufficient to justify admission, especially if the alternative is likely to be the worsening of an already distressing situation, and effective treatment or care is available in hospital.’

14. These criteria are rather circular in nature, in that they may say little more than that part of the test for whether someone should be detained in hospital is *whether a doctor considers that person should be detained in hospital*. The basis on which the doctor should reach that decision is not made explicit. Since the test turns on the need to be in hospital, the detainability of a patient may in practice depend on what community alternatives might or might not be available.
15. The tests do not seem to provide a strong basis from a human rights standpoint to argue in favour of a compulsory intervention. They are discriminatory, in that it would not be lawful to treat a person for a physical illness without consent simply on the basis that to do so is appropriate and considered necessary.
16. The tests are also not compatible with our proposed reforms. These seek to have a flexible range of interventions, tailored to the needs of the individual, and so it would not be possible to base the grounds for compulsion solely on the appropriateness and need for hospitalisation.

Recommendation 5.1

The current criteria in respect of compulsory measures of ‘appropriateness’ and ‘necessity’ tests should be replaced.

The basis for new criteria

17. The criteria for compulsory intervention should reflect the principles we outline in Chapter 3. It follows that such intervention should be used as sparingly as possible, and every effort be made to secure agreement between the service user and care team on a voluntary basis. It is only when such agreement cannot be achieved that the question of compulsion should arise.
18. It is also in accordance with our principles that any care and treatment proposed should be the least restrictive and invasive alternative available, compatible with the delivery of safe and effective care.

19. We believe that replacements for the appropriateness and necessity tests should reflect three underlying justifications for compulsory measures being imposed on a person with mental disorder. These are
- ♦ that, because of the mental disorder, the person's judgement is impaired;
 - ♦ that the person may be at risk or, in some cases, present a risk to others, if compulsory measures are not taken; and
 - ♦ that the patient is likely to benefit as a result of the imposition of compulsory measures.

In our view, all of these factors should be present before compulsion is justified.

20. In our first Consultation, we asked what were the justifications for compulsory intervention. Although there were differences as to the ways in which the criteria were described, and the weight which should be attached to them, these were widely accepted as being key factors.

Impaired judgement

21. There has been much discussion, in Scotland and England, as to whether a 'capacity' test should be introduced into the grounds for compulsion. This would mean that a person could not be subject to compulsory measures under the Act unless it could be shown that he or she lacked the capacity to make a decision in relation to the relevant care and treatment. There could be an exception to this rule where it could be shown that the person presented a risk to others, as a consequence of mental disorder. A serious risk of harm to the patient might also justify imposing treatment on a capable patient, although this is not universally accepted.
22. In our second Consultation, we sought views on the possible introduction of a capacity test. There was an even divide of opinion on this issue. Respondents from the voluntary sector showed more support for a capacity test than did medical professionals.
23. This was one of the most difficult issues we faced as a Committee. There was strong support for the introduction of a capacity test, and there are powerful arguments in its favour. However there was also considerable concern from a number of key interests as to the practical implications of such a test.

Arguments for a capacity test

24. Perhaps the strongest justification for a capacity test is that it provides a specific and ethically justifiable reason for over-ruling a person's autonomy, in that the person's ability to exercise autonomy has already been usurped as a consequence of the mental disorder.
25. This approach would also be consistent with the law regarding other medical treatment, and so compatible with our principle of *Non-discrimination*.

26. We have recommended that mental health law and legislation concerning incapable adults should be broadly consistent, and ultimately brought together into one piece of legislation. Having a consistent basis for intervention, namely lack of capacity, might assist in this process.
27. 'Capacity' has more intrinsic meaning than a test such as 'appropriateness', and so is arguably easier for a court to assess on the basis of evidence led. There is already case law in England and Wales which would give guidance as to the meaning of capacity⁸, and this case law is broadly in line with the approach taken in the Adults with Incapacity (Scotland) Act.
28. As we have said, the introduction of a capacity test received strong support. In their response to our first Consultation, the Law Society said 'there must be a compelling reason for the right to treatment to outbalance the right to autonomy and this could only come about where there was a lack of capacity or impaired judgement'. The Scottish Association for Mental Health (SAMH) argued strongly that 'incapacity should be central when determining the criteria for any general protective intervention'. Many responses from health and social work interests also recognised the attractions of a capacity test.

Difficulties with a capacity test

29. Nevertheless, there were strongly held views against making a capacity test the fundamental criterion for intervention. Many of these turned on the practical operation of such a test.
30. In oral evidence to the Committee, representatives of the Royal College of Psychiatrists put forward a number of concerns. It was suggested that such a test might be difficult to apply in a range of situations, including patients with mood disorders, obsessive compulsive disorders and eating disorders. Such patients might retain legal capacity but be at such risk as to justify intervention. It was not accepted that the definition of incapacity in the Adults with Incapacity (Scotland) Act was suitable for decisions about compulsion related to the Mental Health Act.
31. In relation to forensic patients, it was suggested that the real issue was not capacity, but whether the patient was more appropriately placed in a health care setting rather than a penal setting. There were fears that offenders with mild learning disabilities, in particular, might find themselves going to prison instead of a health setting because not deemed 'incapable'.
32. Individual psychiatrists also commented to the Committee that incapacity was a concept which they would find difficult to measure and apply. The British Medical Association (BMA) suggested that a capacity test would make it harder for GPs and doctors in, for example, Accident and Emergency Departments to come to a decision, and might lead to a reluctance to use the Act. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), while in favour of making the justification for non-consensual interventions more explicit, suggested that professionals were not equipped to apply sophisticated tests of capacity fairly.

⁸ *Re T (adult refused of medical treatment)*, [1992] 4 All ER 649, *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673

33. It was suggested that people experiencing acute mental distress often present to psychiatrists in an ambiguous state of mind: ostensibly resisting treatment but perhaps doing so in the hope that someone will intervene. Capacity in these circumstances would be very difficult to determine.
34. There are particular concerns about defining the threshold at which the patient becomes incapable. While some patients would have fairly clear understanding of the implications of accepting or refusing medical treatment, and others with very severe disorders would clearly not be capable of making a decision, the issue is most likely to arise in practice with patients whose mental disorder has affected their judgement to some degree, but who nevertheless have some decision making ability.
35. Counter arguments were put forward, however, to the suggestion that capacity was not something which doctors could measure. It was pointed out that doctors will be required to assess capacity under the Adults with Incapacity (Scotland) Act for the purposes of that Act. It is also something about which psychiatrists are already required to take a view, in deciding whether a patient is capable of giving consent to certain treatments under Part X of the 1984 Act⁹.
36. However, there are differences between the typical situation which may arise under the Adults with Incapacity Act, and the use of mental health law. It may be easier to determine that a person with a long-standing condition such as learning disability or dementia does not have capacity, than in the case of someone with an acute mental illness, which may fluctuate above and below the capacity 'threshold'. Even if incapacity can be established at a particular time, it would seem impractical for an order for compulsory treatment to stop and start if capacity fluctuates perhaps on a daily basis or even more frequently.
37. For a capacity test to operate, it would be necessary to identify exactly what decision a person must be judged incapable of making. This may be possible where the question is, for example, whether a patient should have a surgical procedure. However, the decision in relation to mental health law may concern a long-term detention in order to allow a range of treatment interventions. It is more difficult in such a case to identify precisely what it is the person must be incapable of deciding.
38. Finally, some people had significant anxieties about the practical outcome of the introduction of a capacity test. It was felt that this might discourage early intervention, where a person with a history of mental disorder is beginning to deteriorate, but still retained some capacity until a crisis situation had been reached. Many of our respondents also felt it to be wrong that a person with a mental disorder should be allowed to bring severe harm to himself or herself, perhaps including death, on the basis of a judgement that the person had the capacity to make such a decision.
39. One possible way round the problem of risk to the person, which seeks to respect the principle of Non-discrimination, is to ask whether the relevant decision is one

⁹ 1984 Act, s98(3)(a)

the patient would have taken, had he or she not been suffering from mental disorder. This was an approach favoured by the Richardson Committee in England¹⁰. However, it is intrinsically extremely difficult to know what the patient's 'true choice' might have been, had the mental disorder not been present.

Our proposals regarding impaired judgement

40. In responding to these dilemmas, we have sought to identify proposals which can be applied in practice, and which recognise that it should not be the function of mental health law to impose treatment on those who are clearly able to make decisions for themselves.
41. We propose that it should not be possible for a compulsory intervention to be made under mental health law unless there is evidence that the person's judgement is significantly impaired, as a result of mental disorder, so as to justify the intervention. This expresses a broadly similar concept to incapacity, but is felt to be a less legalistic formulation, and one which may be easier to apply in practice. It may also be a term which is easier for service users to accept than the term 'incapable'.
42. An alternative formulation to incapacity, which is often used in psychiatric settings, is 'lack of insight'. This term includes situations where a patient may have an ability to take in and act upon information in general terms, and may indeed be very lucid, but does not accept that he or she is ill. In some situations, this may be what is expressed by impaired judgement. However, we have not used lack of insight as a proposed criterion. We understand there is considerable debate in the psychiatric literature about whether this term has a clear and agreed meaning.
43. Impaired judgement should not be taken to be synonymous with mental disorder. It would be necessary to show a connection between the disorder and the impairment to decision-making ability. Nor should it be taken as equivalent to disagreeing with the opinions of professionals.
44. Although the impairment of judgement (as we describe it in the preceding paragraph) must be present in every case, there need not be a precise threshold of impairment beyond which intervention was permissible. The nature and degree of impaired judgement would be judged alongside the nature and degree of risk, and the likely benefits of treatment, in order to determine whether compulsion is justified.
45. It would not be necessary to establish impairment of judgement before making an emergency detention, or while assessing the person's possible need for compulsory treatment under a short term (28 day) order. It would be necessary however to judge that there is a reasonable likelihood that impaired judgement is present. If a responsible medical officer is satisfied that it is not present, compulsory measures should be brought to an end.

10 *Review of the Mental Health Act 1983: Report of the Expert Committee* (Department of Health, 1999) para.7.5

Recommendation 5.2

It should only be possible to impose compulsory measures when it has been established that the necessary care and treatment cannot be provided by agreement with the patient.

Recommendation 5.3

It should only be possible for a person to be subject to long term compulsion where it can be shown that, as a consequence of the person's mental disorder, the person's judgement is impaired to a nature or degree which would justify compulsory measures.

Recommendation 5.4

In relation to emergency or short term measures, it would only be necessary to show a reasonable likelihood that the person's judgement is impaired.

Recommendation 5.5

The care and treatment proposed under compulsory measures should be the least restrictive and invasive alternative available, compatible with the delivery of safe and effective care.

Benefit from treatment

46. One of the principles we outline in Chapter 3 is *Benefit*: that any compulsory intervention should be likely to produce for the patient a benefit which cannot reasonably be achieved otherwise. A primary aim of taking compulsory measures under mental health law should be to do what is possible to alleviate or prevent deterioration in the person's mental disorder.
47. In some respects, this test reflects the fact that a compulsory intervention may in fact enhance the patient's autonomy, by restoring the patient to a situation where he or she can take more control over his or her life. However, the potential benefit from treatment should, in our view, be more closely defined.
48. We believe, therefore, that it should be a necessary criterion for compulsory measures that the patient requires compulsion in order to receive treatment which cannot be provided other than by compulsion, and that the treatment proposed to be administered under the plan of care for the patient is likely to alleviate or

prevent deterioration in the patient's mental disorder, or associated symptoms of that disorder. This requirement should apply to all forms of mental disorder. The 'treatment' which would be covered by this criterion would also be broadly defined, encompassing medical, nursing, psychotherapeutic and other interventions. Furthermore, treatment may be seen as a process of care and management, not a single intervention which succeeds or fails.

49. The requirement that the intended benefit relates to the disorder and associated symptoms might, in some cases, justify treatment of aggressive or dangerous behaviour. It could not justify detention solely for the purpose of preventing the patient from causing harm, with no therapeutic intervention.

Recommendation 5.6

It should only be possible for a person to be subject to long term compulsory measures where the treatment proposed to be administered under the plan of care for the patient is likely to provide a benefit for the patient, by alleviating or preventing deterioration in the patient's mental disorder, or associated symptoms of that disorder.

Recommendation 5.7

In relation to emergency and short term measures, it should be shown either, that compulsion is necessary to receive treatment for the above purpose, or that compulsion is necessary to assess the possible need for such treatment.

Recommendation 5.8

'Treatment' should be defined broadly, to include medical, nursing, psychotherapeutic and other interventions.

Risk

50. We found general support for the inclusion of a risk criterion as one of the tests for compulsory measures. The problems are how to define what nature and degree of risk justifies intervention; how that risk should be measured; and how risk interacts with the other necessary criteria.
51. As we have said, it will be necessary for impairment of judgement to be present before compulsion will be justified. It will also be necessary for there to be a likelihood of benefit from treatment, and it must be shown that it would be unlikely that the benefit could be achieved without the use of compulsion.

52. In that context, we feel that the level of risk, should compulsion not be used, be expressed as a significant risk of harm to the health or safety or welfare of the person, or a significant risk of harm to other persons.

Recommendation 5.9

It should be a requirement of compulsory measures that there should be either:

- ♦ *a significant risk of harm to the health or safety or welfare of the person for whom compulsion is sought, or*
- ♦ *a significant risk of harm to other persons.*

53. This is likely to be broadly similar in its effect to the current provisions. The tests of health, safety and welfare are expressed as alternatives, and it would only be necessary for one to be met for this particular criterion to be satisfied. Health and safety are both mentioned in the current provisions. We have added welfare to accommodate some risks which could flow from a mental disorder, and which we believe might justify compulsory measures, but which might not readily fall into the categories of health or safety. One which was drawn to our attention was the situation of someone with a hypomanic illness, who may put his or her financial affairs at risk from unbridled spending, or reputation at risk from disinhibited sexual activity. In some cases, it might address a point highlighted in the Green Paper regarding the English Mental Health Act: the possible necessity to protect a person from serious exploitation¹¹.

Assessment of risk

54. We heard evidence that the measurement of risk was often subjective, and the evidence base to justify the way risk assessments are typically carried out in mental health cases is poor. However, we do not believe that this difficulty is something which can be resolved by the definitions of risk in the legislation. It is clear that the field is a developing one, and it would not be desirable to specify too closely in legislation how risk should be measured.
55. The MacLean Committee on Serious Violent and Sexual Offenders made a number of detailed recommendations regarding improving risk assessment in relation to serious offending behaviour. These recommendations are of direct relevance to the small number of mentally disordered people involved in serious offending behaviour, rather than the wider group of people who present a risk, particularly of self harm. Nevertheless it is possible that an increased general emphasis on more carefully structured risk assessments will have broader application, including to risk of self harm, as well as risk to others.
56. We note also that the Mental Health Reference Group issued guidance to clinicians and carers on risk management¹², including a recommendation that any organisation providing mental health care should establish a Risk Management

¹¹ *Reform of the Mental Health Act 1983: Proposals for Consultation* (Department of Health, 1999) pp32-33

¹² Issued under cover of circular NHS/HDL(2000)16

Committee. The report does not directly address risk assessment for the purposes of legal hearings, but may nevertheless be of relevance.

57. One particular improvement, which was widely endorsed in our consultations, would be a more multi-disciplinary approach to risk assessment in relation to mental health decisions. Social workers may have much to contribute to a risk assessment, as may nurses, psychologists and other professionals. We would therefore expect the tribunal to consider where necessary evidence from a range of sources as to the level and nature of risk presented in a particular case. As the MacLean Committee report notes, much work requires to be done to develop common understanding between professionals of the techniques and aims of risk assessment.

Treatability

58. For people whose mental disorder is classified as mental impairment¹³, or a persistent disorder 'manifested only by abnormally aggressive or seriously irresponsible conduct'¹⁴, there is an additional test in the current Act: that treatment is likely to alleviate or prevent a deterioration of the patient's condition. In s125, 'medical treatment' is defined as including nursing, and also care and training under medical supervision. This is sometimes known as the 'treatability' test.
59. In relation to mental impairment, the Percy Commission, which reviewed the law in the 1950s, drew a distinction between those who were then categorised as 'feeble minded', and those who were more seriously disabled. The more seriously disabled group were those who may not be able to live an independent existence. It was felt that it might be necessary sometimes to institutionalise people in this group against their will, so that they could be looked after, even if their condition was not likely to improve as a result of the treatment. This was not felt to apply to the less severely impaired group, who would be able to live an independent existence outside hospital.
60. The group of people whose disorder is 'manifested only by abnormally aggressive or seriously irresponsible conduct' are essentially those now commonly described as having a severe antisocial personality disorder and classed in the English Mental Health Act as having a 'psychopathic disorder'. Although the Scottish Act, prior to the passing of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, did not specify personality disorder as a separate category, this group are brought into the 1984 Act by section 17.
61. At the time of the Percy Commission, there was considerable controversy over the extent to which people with psychopathic or personality disorders could or should be successfully treated. As is the case now, many psychiatrists took the view that treatment on a compulsory basis was unlikely to alleviate the disorder. Others however felt that such treatment could be beneficial in some cases.
62. Originally, the 1960 Act drew a distinction for both groups on the basis of age; it being thought that treatment was more likely to be successful with younger

13 Defined in s1 of the 1984 Act as 'a state of arrested or incomplete development of mind not amounting to severe mental impairment which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'

14 1984 Act s17(1)(a)(i)

people. When the Act was revised in the early 1980s, this was changed to the current treatability test. This was intended to allow some discretion to psychiatrists and courts to detain people with personality disorder or less severe mental impairment for treatment, if there was some expectation that treatment might be beneficial.

63. There is no formal treatability test for people with mental illness. It is assumed, and is implicit in the Act, that people being detained should always be receiving treatment, in the widest sense. The difference in the Act between mental illness and personality disorder and mental impairment may be based on a view that remaining in hospital may continue to be appropriate for people with mental illnesses, even where an illness proves resistant to treatment. For personality disorder and mental impairment, such detention without treatment could be considered as at best containment, and at worst equivalent to imprisonment.
64. The treatability test has in recent years been subject to considerable judicial scrutiny. The leading authority on it is the decision of the House of Lords in the case of *Reid*¹⁵. It was pointed out in that case that ‘medical treatment’ is given a very wide meaning by s125 of the Act, including nursing and care and training under medical supervision. Therefore, provided any treatment in this broad sense would be likely to alleviate or prevent deterioration in the patient’s condition, the test would be satisfied. This would apply to alleviation of the symptoms of the disorder, as well as the disorder itself.
65. This means that, for example, a patient whose anger management improves when in a structured setting and supervised environment, such as the State Hospital, may pass the treatability test, so justifying continuing detention.
66. However, the judgement in the case of *Ruddle*¹⁶ established that there were limits to the breadth of the treatability test. The fact that a person may benefit from being denied access to drugs and alcohol as a result of the physical security of the State Hospital reflected an aspect of containment, not treatment. Unless it could be shown that the structured environment of the hospital was likely to improve or prevent deterioration in the patient’s condition, the effect of detention would be no different from that which would result from placing the person in prison. This would not be sufficient to meet the test.
67. We believe that there a number of problems with the current treatability test. The justification for applying it to some groups and not others is difficult to defend in principle, and the wide definition of ‘treatment’ in the current Act or as we have recommended earlier in this chapter may make this distinction meaningless in practice. The interpretation of the judicial statements is complex, and it has been suggested that restricted patients could (at least prior to the passing of the Mental Health (Public Safety and Appeals) (Scotland) Act) secure discharge by not co-operating with treatment, which seems perverse.
68. We therefore believe that the present provision relating only to the groups mentioned in paragraph 58 above should be repealed. However, the underlying

15 *R v Secretary of State for Scotland*, 1999 SLT 279

16 *Ruddle v Secretary of State for Scotland*, Lanark Sheriff Court, 2 August 1999

aim of the test, to avoid the Act being a vehicle for preventive detention, is an important one. We have addressed this in our proposals relating to benefit for treatment.

Recommendation 5.10

The specific provision for a treatability test relating to those whose mental disorder is classified as mental impairment or a persistent disorder “manifested only by abnormally aggressive or seriously irresponsible conduct” should be repealed.

Conclusion

69. It may be convenient to summarise here the conditions, all of which we propose must be met, before long term compulsion can be imposed:
- ♦ The presence of mental disorder.
 - ♦ It has been established that the necessary care and treatment cannot be provided by agreement with the patient.
 - ♦ It can be shown that, as a consequence of the person’s mental disorder, the person’s judgement is impaired to a nature or degree which would justify compulsory measures.
 - ♦ The treatment proposed to be administered under the plan of care for the patient is likely to provide a benefit for the patient by alleviating or preventing deterioration in the patient’s mental disorder, or associated symptoms of that disorder.
 - ♦ The care and treatment proposed is the least restrictive and invasive alternative available compatible with the delivery of safe and effective care.
 - ♦ There is a significant risk of harm to the health or safety or welfare of the patient or a significant risk of harm to other persons if such treatment is not administered.
70. We believe that these factors are, in practice, taken into consideration by psychiatrists and mental health officers at the moment, in deciding whether to seek detention. Expressing them more clearly should help to clarify the issues to be considered by these professionals and by the tribunal. As techniques improve for assessing factors such as risk, these can be brought into play. The Code of Practice could assist in ensuring the most appropriate use of such developing techniques.

CHAPTER 6

COMPULSORY INTERVENTIONS

Current provisions regarding detention

1. The provisions regarding compulsion in the current Mental Health Act, and the associated safeguards, focus largely on the admission of a patient to hospital, rather than a more specific consideration of what kind of compulsion may be necessary and appropriate in a particular case. This to some extent reflects the historical development of mental health law. The Mental Health (Scotland) Act 1960 replaced provisions concerning the ‘certification’ of mentally disordered people receiving institutional care. It is notable that while there were relatively sophisticated procedures introduced in that Act to ensure that people were not compulsorily admitted without due cause, virtually nothing was said about what treatment the person could receive once so admitted.
2. There were some developments when the law was reformed in 1983. Provisions were introduced, (now in Part X of the 1984 Act) to provide safeguards for particular kinds of treatment. We discuss these in Chapter 10. However, these provisions only apply once a patient has been detained. There are no specific provisions relating to treatment at the time a patient is admitted to hospital under compulsion, even when long-term detention in hospital is being considered for approval by the sheriff.
3. The 1984 Act also maintained the link between admission to hospital and compulsory treatment. It only authorised such compulsory treatment where the person remained liable to detention in hospital. However, this link was sometimes more apparent than real, in that it was possible for a patient to be discharged on leave of absence, sometimes for very long periods. During that time, the patient was liable to detention, and so could be compulsorily treated, notwithstanding that he or she was living outside hospital¹⁷. This provision remains but, since 1995, the duration of leave of absence may not exceed 12 months.
4. As with compulsory treatment, the sheriff has no direct oversight of the leave of absence provisions. A sheriff cannot require leave of absence to be given, or review the conditions under which it is given, or a decision to recall the patient to hospital. (This contrasts with the situation of restricted patients, where the sheriff can order a conditional discharge.)
5. In short, then, a patient who is detained under the 1984 Act can be required to accept any form of medical treatment which would fall within the broad definition in the Act¹⁸, subject to the controls on certain forms of treatment set out in Part X.

¹⁷ 1984 Act, s27

¹⁸ 1984 Act, s125-’ ‘medical treatment’ includes nursing, and also includes care and training under medical supervision.

Issues arising regarding the current legislation

6. We believe that the current provisions do not adequately reflect developments in mental health care, and are not wholly compatible with the principles which we advocate for mental health legislation.
7. Firstly, there is no longer the sharp division between hospital and the community which is implied by the current detention provisions. Increasingly, community services are dealing with people with severe and enduring mental illnesses, who may require a complex range of interventions, while hospitals are in many cases moving away from large institutional settings.
8. The blurring has become particularly marked in learning disability services. Where old learning disability hospitals have closed or been reduced in size, some people who are detained under the 1984 Act have been accommodated in 'health care houses'. These are small units, which are domestic in style. They are in many respects indistinguishable from other establishments accommodating non-detained service users, except that they are run by the NHS rather than the local authority or voluntary sector.
9. The requirement that a person who requires compulsory care must be placed in hospital to receive it would not seem to be compatible with the principle of *least restrictive alternative*: that service users should be provided with any necessary care, treatment and support in the least restrictive manner and environment compatible with the delivery of safe and effective care.
10. Secondly, the focus on the admission to hospital, rather than the treatment which the patient will receive, was perhaps understandable where the treatment options were more limited. With the wider range of drug treatments and other interventions now available, and with the issue of medical consent now being given greater emphasis, there is a case for the scope of approved intervention in a particular case to be defined more closely.

Recommendation 6.1

The exclusive linking together of admission to hospital and compulsory treatment should be changed, to allow some patients subject to compulsory care and treatment to remain in the community.

Recommendation 6.2

The authorisation of compulsory measures should require consideration of the treatment proposed.

Treatment and plans of care

Plans of care and compulsion

11. The essence of our recommendations in this area is that compulsory intervention should be tailored to the needs of the individual patient, in a way which reflects the underlying principles of the Act.
12. The framework for such interventions should, in our view, be a plan of care, which is submitted to, and approved by a tribunal. This plan would set out what interventions were likely to be appropriate, and which it may not be possible to provide except on a compulsory basis. It would also set out the other proposed input from health, social work and other agencies, on the basis of a multi-disciplinary assessment.
13. Although the current provisions for detention do not contain reference to plans of care, there are other precedents on which this approach would build. Community care orders require information to be given about the particular conditions which are relevant for the patient, and about the general arrangements for the patient's care. The Care Programme Approach also contains reference to care planning¹⁹, and local authorities have, since 1993, been required to undertake individual care planning for recipients of community care.
14. We note also that the draft clinical standards for schizophrenia, being developed by the Clinical Standards Board for Scotland, state that:

‘A plan of care must be developed with each person at the time of the initial diagnosis, which must detail the care that they and their carer will receive... The plan of care must be documented’²⁰.
15. In relation to the application for compulsion, the general format of the plan of care would be specified in the Code of Practice. We would envisage a single document, setting out what treatments and care are proposed by the range of agencies, and identifying which of these require compulsion, on the basis that they are necessary for the safe delivery of adequate care, and that there is reasonable cause to believe they could not be administered without compulsory powers.

Recommendation 6.3

The basis of long term compulsory interventions should be a plan of care, which should be submitted to and approved by the tribunal.

¹⁹ Community Care: Care Programme Approach for people with severe and enduring mental illnesses including dementia; SWSC Circular 16/96

²⁰ Clinical Standards Board for Scotland Draft Clinical Standards for Schizophrenia - June 2000

Recommendation 6.4

The plan of care should specify:

- ♦ *the interventions which require authority to be administered on a compulsory basis, and*
- ♦ *the proposed plan of medical treatment, care and support from health, social work and other agencies.*

Compulsory measures in the community

16. The idea that people might be required to accept care and treatment outwith a hospital setting is not a new one. The current Act contains two ways in which this might occur: leave of absence (see paragraphs 67-73) and community care orders. The Adults with Incapacity (Scotland) Act 2000 also contains provisions which allow treatment to be provided without consent in a range of settings, both in the community and in hospital.

Community care orders

17. Community care orders were introduced by the Mental Health (Patients in the Community) Act 1995²¹. The orders are generally intended for the small number of people suffering from a serious mental illness who, after discharge from hospital, fail to continue to take their medication or to co-operate with their plan of care, often resulting in the need for a subsequent readmission to hospital.
18. The procedures for obtaining a community care order and the duration of the order are broadly similar to those for detention under s18. Significant differences include
 - ♦ the provisions in Part X of the Act regarding medical treatment do not apply
 - ♦ the order is individualised, setting out a particular set of conditions approved by the sheriff, with procedures for these to be varied
 - ♦ there are extensive requirements for consultation with a range of people at various stages
 - ♦ the sheriff can defer making the order until satisfied that appropriate arrangements have been made for the provision of medical services and after care.
19. There are fairly complex arrangements for readmission to hospital. The 'special medical officer' (whose role is similar to the responsible medical officer in detention) must consider that the patient's mental state has deteriorated and gives grounds for serious concern. There must then be two medical examinations to allow admission to hospital for reassessment, followed by two further medical

21 See sections 35A to 35K of 1984 Act.

examinations, which may lead to return to the community, or an application for detention under s18 of the Act²².

20. Community care orders have not proved popular, with only 13 orders having been made in the period from 1 April 1999 to 31 March 2000²³. Research into community care orders²⁴, and responses to our consultations, suggest that the orders are widely disliked by psychiatrists for two reasons. Firstly, the procedures are seen as unnecessarily cumbersome. Secondly, the order is felt by many to be 'toothless', in that there is no sanction for a breach of the conditions of the order. It is not clear whether the order can specify that the patient accept medication, which many psychiatrists see as being fundamental to maintaining the patient safely in the community. Even if such a condition is made and not observed, the patient cannot be recalled unless and until there is a clear deterioration in his or her mental state.

Consultation on community treatment orders

21. The implication of breaking the necessary link between compulsion and hospitalisation is that some form of compulsory treatment could be imposed on people who are not hospital in-patients. There has been considerable controversy, over a number of years, over suggestions of a 'community treatment order'. Our consultations showed that this is still a controversial idea. However, the oral evidence we heard, and the responses to our second Consultation, suggested that it may be possible to accommodate many of the different viewpoints within a new framework.
22. In our first Consultation, we asked in what ways it should be possible to intervene without consent, and what compulsion, if any, should be possible where a person is not detained in hospital. Around one third of those responding on this point considered that compulsory treatment in the community should be an option, while around one fifth were opposed to this possibility.
23. Support for community treatment orders was particularly strong from psychiatric opinion, with both the Royal College of Psychiatrists and individual psychiatrists in favour. The Mental Welfare Commission also supported such an order, as they have done consistently for a number of years.
24. There were some bodies who voiced strong opposition, including The Scottish Association for Mental Health (SAMH), the Mental Health Foundation, and the Royal College of Nursing. Objections were both philosophical and practical. Respondents questioned how such an order could be enforced in the community, and some felt that a person who was ill enough to require compulsion should always be in hospital. There was also concern that the existence of such orders might discourage people from seeking access to services.
25. Although there was a difference of emphasis between the views of doctors, and those of service users, it was not a clear division. The National Schizophrenia Fellowship (Scotland) reported that a majority of respondents to their

22 1984 Act, S35G

23 Mental Welfare Commission Annual Report 1999-2000

24 Atkinson, J.M, Gilmour, W.H, Dyer, J.T. Hutcheson, F. and Patterson, L., (1997) Consultants' views of leave of absence and Community Care orders in Scotland, *Psychiatric Bulletin* 21 pp 91-94

questionnaire (sent to users and carers) supported the idea of compulsory treatment in the community, and some members surveyed by the Richmond Fellowship were also in support.

26. The Highland Users Group (HUG) also consulted widely with its members. They pointed out that, for many people, the point at which they may be 'sectioned' is often the point at which they have lost much of their ability to function safely in the community. In that situation, most people want a place of safety and asylum, and hospital is seen by many as being able to provide this. There was concern that a community treatment order could be more a means of control than assistance.
27. Others involved with HUG had different experiences, and saw a community based order as providing a degree of security, and, for some, being a way in which a cycle of repeated admission to hospital could be broken. One service user said:-

'Being in [hospital] under a section can be terrifying. It can wreck your life and make you lose confidence in everything. Although being sectioned [in the community] would also be unpleasant, at least you are in your environment, around those that you trust and are still doing ordinary things.'
28. It was also notable that the current provisions for leave of absence, which amount in practice to a kind of community treatment order, appeared less controversial than a hypothetical new order. Most respondents appeared to believe that the system worked reasonably well, although some people wished to revert to the position before 1995, when there was no time limit.
29. Responses to our consultation leaflet for users and carers also demonstrated a range of views. A majority both of users and of carers who responded supported the general idea that compulsory treatment could in some cases be given in the community, although there were many who expressed concerns about the practical implications. Our consultation leaflet directed at people with learning disabilities elicited a similar diversity of opinion.

Concerns regarding compulsory treatment in the community

30. Three particular concerns were identified. The first was about the imposition of treatment on a forcible basis in community settings, particularly in a person's own home. This was felt to be an affront to the individual's right to privacy, and could be dangerous.
31. The second major concern was that community treatment orders would not be an alternative to detention in hospital, but an additional control imposed on people who would otherwise have been dealt with on an informal basis. In the context of the pressures on hospital beds, there were fears that psychiatrists might find it convenient to place significant numbers of people on community treatment orders, to ensure that they took medication, but without the commitment of resources which a hospital admission would involve.

32. The third major concern was that, once on such an order, it might be hard for a patient ever to be discharged. The patient would be maintained on medication, and could not prove that he or she was now able to take responsibility for his or her care. The fact that significant numbers of people maintained on long term leave of absence were neither readmitted to hospital, or placed under community care orders, could suggest a risk of people being allowed to drift on long term community based orders, if there were not arrangements for regular independent review.

Our proposals for a community order

33. We gave careful consideration to all these arguments, and developed a series of proposals, which are set out below. In essence, these sought to reflect the desirable aim of a flexible and individually tailored order, while containing adequate safeguards to meet some of the concerns raised by the possibility of compulsory treatment in the community. We explored ideas with key agencies during oral evidence, and set out our proposals in outline in our second Consultation.
34. The responses to our second Consultation appeared to demonstrate a considerably greater degree of support for these particular proposals, with a considerable majority of the respondents who replied on the point agreeing to the need for some measure of this type. Thirteen responses from user and carer groups supported the proposal, while four disagreed (although amongst these four were some important bodies, such as SAMH and The Scottish Users Network. Most respondents who considered the matter in detail supported the proposals put forward in the consultation paper.

Our proposals

35. We propose that there should be two kinds of long term compulsory orders: hospital based orders, which would be similar to detention under section 18 of the 1984 Act, and community orders. There would be a single route of admission to these orders, via an application to the tribunal, and procedures to move from one order to another as appropriate. The duration of the two types of orders would be the same, and the formal procedures for obtaining, appealing against, and reviewing these orders would be identical.

Who would a community order apply to?

36. The kind of patients for whom such an order would be particularly relevant might include those:
- ♦ for whom it would be an alternative to compulsory hospitalisation;
 - ♦ who have relapsed whilst off medication in the community in the past, presenting a risk to themselves or others;
 - ♦ who have a history of refusing to take their medication once there is no legal compulsion to do so; and

- ♦ for whom all other means of trying to negotiate with them and maintain them in the community without compulsion have been tried and failed.
37. We have considered whether it should be necessary to have a prior period of hospitalisation before being placed on a community order. In practice, we think it unlikely that a person would be considered suitable for such an order unless that person had a prior history which involved admission to hospital. However, we do not propose that, as is the case with community care orders, such orders could only be imposed on discharge from hospital. The order would be free-standing, and based on the needs of the individual service user.
 38. It is impossible for us to forecast the precise numbers of people who might be subject to such an order. However, we note that, in 1994, before leave of absence was restricted to 12 months, there were 129 people on leave of absence for more than a year. It is likely that the people most suitable for an order for treatment in the community might be those who in the past would have been on long term leave of absence, and so this may give a very approximate idea of the limited numbers for whom such an order might be considered.

The requirement to accept treatment

39. Our proposals draw a distinction between compulsory treatment and forcible treatment. There would be no forcible treatment in someone's own home. Any necessary enforcement of treatment would take place only in a clinic or hospital.
40. The evidence concerning the use of leave of absence is that many patients may not wish treatment, or agree that it is necessary, but they are prepared to accept it if required to do so. If the alternative is detention in hospital, a compulsory order relating only to treatment will be a less restrictive alternative, allowing the service user to continue with life in the community.
41. However, there are certain treatments which we believe should only ever be administered in a hospital setting. Compulsory ECT should not be carried out on an out-patient basis. The Royal College of Physicians commented to the Committee that high dosage anti-psychotic drugs should not be given for the first time without supervision, and that this may also be necessary for complex anti-depressant regimes. These issues could be spelled out in more detail in the Code of Practice.

Link to plan of care

42. As we explain above (paragraphs 11-15), the order would be linked to a plan of care, which would detail the services that the person would receive. The compulsory element of the plan of care would require to be kept to a minimum. If the patient had concerns about particular kinds of treatment, these concerns could be taken into account by the tribunal, before deciding whether to approve the plan of care. We set out in Chapter 15 how an advance statement regarding such concerns might be considered by the tribunal.

43. The Code of Practice would identify the general standards for care which the tribunal would expect to see, before approving a community order. These would be derived from current standards of mental health care, such as those set out in relation to the Care Programme Approach and, in due course, clinical standards established by the Clinical Standards Board for Scotland. Key points in the current Care Programme Approach standards, which we would expect to see incorporated, would include a named keyworker, 24 hour emergency contact, and access to advocacy.

Grounds for discharge from the order

44. As with all long term compulsory orders, community orders would be subject to regular reviews and rights of appeal (see Chapter 8). The tribunal or the Mental Welfare Commission would be entitled to discharge the order if satisfied that the grounds for compulsion no longer apply, for example because
- ♦ the patient would accept treatment on a voluntary basis
 - ♦ the level of risk, should the patient refuse treatment, no longer justified compulsion
 - ♦ the patient was no longer suffering from a degree of impaired judgement which would justify compulsion.

Recommendation 6.5

A community order should be introduced, and should be available where:-

- ♦ *a patient meets the criteria for compulsory measures; and*
- ♦ *such an order would be more appropriate than a hospital based order, having regard to the principle of least restrictive intervention.*

Recommendation 6.6

It should not be possible to administer treatment forcibly anywhere other than a clinic or hospital.

Recommendation 6.7

The Code of Practice should identify treatments which should normally only be administered in hospital.

Recommendation 6.8

The Code of Practice should identify general standards of care which should be observed for persons subject to compulsory treatment in the community.

Role of the tribunal in compulsory interventions**Consideration of the plan of care**

45. In any application to the tribunal for approval of compulsory measures, whether for detention in hospital, or for treatment in the community, there would, as we have indicated, be an accompanying plan of care.
46. The range of possible compulsory interventions need not be set out in detail in the Act. However, we think it would be desirable for regulations to specify what interventions, coming within the general scope of treatment and care, could be imposed by a community order. Certain interventions would have additional safeguards, set out in Chapter 10.
47. In relation to a community order, the compulsory measures might include
 - ♦ that the person accept medication
 - ♦ that the person reside in a particular place
 - ♦ that the person attend particular therapeutic services
 - ♦ that the person allow access to certain persons for the delivery of care and support.

Recommendation 6.9

Regulations should specify the range of compulsory measures which could be imposed in a community order.

Matters to be taken into account by the tribunal

48. The tribunal would consider whether the provisions of the plan of care were appropriate and provided for an adequate level of services.
49. It would not be the role of the tribunal to determine the optimum level of services to be provided for a particular individual. Its responsibility would be to be satisfied that adequate services for the needs of the individual are in place, which would ensure the safe delivery of the compulsory measures which are being sought. This role would be particularly relevant where compulsory treatment in the community is proposed, since it could be assumed that a minimum level of safe care would

be in place for those detained in hospital. For example, it would be important to be satisfied that an appropriate place of residence was available for a community order to operate successfully.

50. The tribunal would consider the compulsory measures sought, in the context of the plan of care. They would be entitled to approve all or some of the measures sought, if satisfied that
 - ♦ the person is mentally disordered in terms of the Act
 - ♦ the grounds for compulsory intervention are met
 - ♦ the powers sought are appropriate, in the context of the overall plan of care, and
 - ♦ to grant the powers sought would be consistent with the principles of the Act.
51. In considering whether the proposals for an individual were appropriate and adequate, the tribunal would be expected to have due regard to the general availability of services in the area.
52. If the tribunal was not satisfied that the plan of care provided for an adequate and appropriate level of services, consistent with the compulsory measures sought, it could require that the plan of care be resubmitted before approval of compulsion. It would have the power to make a short term order, lasting up to four weeks, to allow the plan to be resubmitted.

Recommendation 6.10

Before authorising compulsory interventions, the tribunal should require to be satisfied that the plan of care contained provision for an adequate and appropriate level of services, consistent with the compulsory measures sought.

Recommendation 6.11

If not so satisfied, the tribunal should be entitled either:

- ♦ *to refuse to make an order, or*
- ♦ *to make a temporary order lasting no more than 28 days authorising such interventions as it sees fit, pending submission of a revised plan of care.*

Monitoring implementation of the order

53. At any subsequent review or appeal, the tribunal would wish to be satisfied that the plan of care had in fact been delivered, and that this would continue to be the case, before authorising any continued compulsory measures.

54. It would also be possible for the Mental Welfare Commission to remit a patient's case to the tribunal if it was concerned that essential elements of the plan of care were not being delivered.

Recommendation 6.12

The Mental Welfare Commission should be entitled to remit the case of a patient under compulsion to the tribunal on the basis that there is evidence that essential elements of the plan of care are not being delivered.

Moving between hospital based orders and community orders

55. Since there would be a single procedure under which both orders involving admission to hospital, and orders imposing treatment in the community would be obtained, it would be necessary to have appropriate and flexible provision to move from one type of order to another, where the patient's circumstances and needs warranted that.
56. For example, if an order allowing admission to hospital was sought, but the tribunal was satisfied that the person would prefer to remain in the community, and that to do so was appropriate and feasible, it could substitute a community order. Equally, a patient could request that he or she should be admitted to hospital to receive treatment rather than be placed under compulsion in the community, and the tribunal could consider whether this was appropriate.
57. Where a patient was detained under a hospital based order, but it was felt that discharge to the community could succeed, provided a requirement to accept treatment was maintained, this could be done by requesting the tribunal to substitute a community order for the hospital order. In some cases, leave of absence could act as a temporary bridge to such a change. It would allow the patient to be discharged to the community without undue formality, in order to assess whether a community order might succeed, or indeed whether compulsion could be brought to an end.
58. Where one type of order was substituted by another, the time limits for renewal of, and appeals against, an order would be based on those relating to the original order.

Recommendation 6.13

It should be possible for a mental health tribunal to transfer a person subject to a hospital based order to a community order, and vice-versa. Where such a transfer between different types of order takes place, time limits for renewals of, and appeals against, the new order should be those which were applicable to the original order.

Failure to comply with community order

59. If a patient refused to comply with the compulsory aspects of the treatment plan, after reasonable steps had been taken by community mental health services to implement the plan, and the multi-disciplinary team agreed that there was a significant risk of deterioration in the condition of the patient, the RMO could cause the patient to be informed in writing that, in the event of further breaches, the patient could be taken to a clinic or hospital and treated there.
60. In the event of further non-compliance, the patient could be given a further written notice by the RMO that he or she must go with a member of the community mental health team to the hospital or clinic for treatment. If treatment were still not accepted, detention in hospital could follow.
61. Should this period of admission to hospital last more than two months, it would be necessary to approach the tribunal to request that the order be changed to a hospital based order.
62. It would be possible for a person subject to a community order to be admitted to hospital on an urgent basis, should his or her condition deteriorate suddenly. This admission would be on the authority of the RMO, with the consent of the mental health officer (MHO). Should the hospital admission extend beyond 28 days, it would be necessary to make an application to the tribunal for a variation of the community order.
63. In situations where the patient enters hospital on a voluntary basis, it should be possible for a community order to lie 'dormant', and be revived on discharge to the community.

Recommendation 6.14

Where a patient subject to a community order fails to comply with a compulsory aspect of the plan of care, and there is a significant risk of deterioration in the patient's health, the responsible medical officer should notify the patient that the consequence of further breaches may be admission to a clinic or hospital for treatment.

Recommendation 6.15

Should the patient still fail to comply, the responsible medical officer should be able to require the person to be compulsorily admitted to a hospital or clinic for treatment.

Recommendation 6.16

This admission should be for a maximum period of two months after which it would be necessary to refer to the tribunal. The tribunal would be entitled to transfer the order to a hospital based order.

Recommendation 6.17

It should be possible for patients subject to a community order to be able to be admitted to hospital on an urgent basis, where there is an immediate risk of harm to the patient or others. The admission would be authorised by the responsible medical officer, with the consent of the mental health officer.

Recommendation 6.18

An emergency admission should be authority to detain the patient for up to 28 days.

Leaving place of residence while subject to a community order

64. Patients detained under the Mental Health (Scotland) Act who abscond may be taken into custody and returned to Scotland from any other part of the United Kingdom²⁵. We believe that this should be extended to cover patients on community orders.
65. Some people subject to community orders will have a place of residence specified in that order. Moving from that place without approval would be in direct breach of the order. In other cases a person leaving his or her place of residence would not be in direct breach of the order but would be in breach if the effect of moving from the normal residence was that he or she could not receive such treatment or care as was specified in the terms of the order.
66. The Act should therefore provide that any person in breach of the order by reason of having left his or her place of residence may be returned to the area where he or she was receiving services, whether he or she is in Scotland or elsewhere in the UK. We recognise that this may not always be practicable, but recommend that the legislation should provide a power for use in appropriate cases.

Recommendation 6.19

The Act should provide that any person in breach of a community order by reason of removing from his or her place of residence may be returned to the area where he or she was receiving services, whether he or she is in Scotland or elsewhere in the UK.

25 1984 Act, s.84

Leave of absence

67. The leave of absence arrangements appear to work reasonably well at the moment. Although we propose a new community order, there is still a strong argument for retaining a relatively straightforward process by which a patient liable to hospital detention can return to the community when his or her condition improves, or spend short periods in the community without breaking the period of liability to detention. We therefore believe that the power of the RMO to grant leave of absence should remain.
68. The Notes to the Act recommend that the RMO should consult with the patient's GP and with the social work department prior to granting leave of absence. We believe that this requirement to consult should be spelled out in the Act, for any leave of absence intended to last more than a brief period.
69. Given that we propose a new community order, we believe it would be reasonable to reduce the maximum period of leave of absence from the current 12 months to six months. This would allow an adequate period to assess progress, and to consider whether ongoing compulsion in the community is appropriate.
70. We anticipate that there would be three options on the discharge of a detained patient from hospital:
 - ♦ compulsory measures would end
 - ♦ application would be made to the tribunal to amend the hospital based order to a community order
 - ♦ the patient would be granted leave of absence.
71. If a patient was on leave of absence, a decision would be made within the six month period as to whether the patient required readmission, could be wholly discharged, or application should be made for a community order.
72. There is a possible gap in the provisions of the current Act. It is possible for a patient to spend several months on leave of absence, be recalled for a brief period (perhaps only for a few days) and then be given a further period of leave of absence. The maximum duration begins again with each new period of leave of absence. The effect is that a patient could spend long periods of time on leave of absence, punctuated only by short periods in hospital.
73. Although we have no evidence to suggest abuse of the current arrangements, we would not wish the potential for abuse to remain, particularly when an alternative approach is available by means of a community order.

Recommendation 6.20

It should continue to be possible to grant leave of absence for a patient subject to a hospital based order.

Recommendation 6.21

A continuous period of leave of absence should last no longer than six months.

Recommendation 6.22

Before granting a period of leave of absence lasting more than 28 days, the responsible medical officer should be required to inform the patient's GP and mental health officer.

Recommendation 6.23

The total periods of leave of absence in any 12 month period should not exceed nine months.

Community care orders

74. Should our proposals be implemented, we believe that community care orders would no longer have any role to play.

Recommendation 6.24

Community care orders should be abolished.

CHAPTER 7

INITIATING AND APPROVING COMPULSION

1. A number of different people, including relatives, General Practitioners, psychiatrists and mental health officers (MHOs), have a role in the 1984 Act relating to the initiation of detention procedures. We have considered whether these roles continue to be appropriate.

Role of relatives

Consent to emergency and short term detention

2. At present, the law requires that 'where practicable', the consent of a relative (not necessarily a 'nearest relative') or MHO is obtained to an emergency detention²⁶. If it is not practicable to obtain consent from either the relative or MHO, the detention can proceed, but reasons why consent was not obtained must be given to the Mental Welfare Commission.
3. Consent must be obtained by the nearest relative or MHO, where practicable, to short term detention²⁷ (28 days).
4. On our visits and in the responses to our consultations, we heard that many carers and users find these requests add to the distress of families, rather than provide a safeguard for the user, as was presumably intended.
5. We were told by both groups that consents to detention by relatives can have a very damaging effect on a carer's relationship with the service user. During the difficult period when a detention is being considered, the involvement of a service user's family in consenting to the detention itself is counterproductive, in the view of very many of our consultees. It can exacerbate any feelings of negativity about his or her family being experienced by the service user.
6. One service users' group told us:

'Most people [in the group] felt that relatives should not be involved in sections... Often they do not know anything about you. Sometimes they are persuaded by doctors that you are experiencing more problems than you feel you are... Maybe it should always be the MHO instead of relatives.'
7. Some carers to whom we spoke had not been made aware that, irrespective of their views about the detention, they were under no obligation to give their consent to the detention, and could ask that the MHO be approached for consent instead. These carers had found being asked to give consent to be particularly difficult.

26 1984 Act, s.24
27 1984 Act, s.26

8. Several service providers to whom we spoke said that they attempt to avoid requesting consent from relatives, for the reasons that are given above. Instead, they attempt to get a consent from the MHO whenever possible.
9. We discuss below (paragraph 60) the need to consider how the availability of MHOs might be improved. However, even if an MHO is not involved, we believe that there is no substantial benefit to retaining the relative's right to consent, either to an emergency or short term detention.
10. We recommend, therefore, that relatives should no longer have the right under the Mental Health Act to consent to emergency or short term detention.
11. Our recommendations are intended to remove this burden from relatives. They are not intended in any way to lessen the involvement of relatives and carers in the treatment and care of service users. In Chapter 16 we go on to detail the ways in which the rights of carers should be strengthened.

Application for long-term detention

12. Nearest relatives also have a right under s.19 of the Act to apply for detention of a service user, provided they have the appropriate medical recommendations required by s.20.
13. The right for a nearest relative to apply for detention is not in keeping with our proposal that nearest relatives should no longer be asked to give consent to detention. Even more than the consent issue, a request for detention of a service user by a nearest relative may damage family relationships. It would bypass the MHO, whose role we believe is very important. So far as we are aware, the power is rarely used. We therefore recommend that the right should be removed.
14. Section 19(3) gives nearest relatives the right to request an MHO, via the local authority, to assess whether an application for detention should be made. We believe that this right should be retained in a modified form. We deal with this in Chapter 13.

Recommendation 7.1

Relatives/nearest relatives should no longer have the right to consent to emergency or short term detention under the Mental Health Act.

Recommendation 7.2

The right of nearest relatives to make an application for long term detention should be abolished.

Role of general practitioners

Training in mental health issues

15. General practitioners have a vital role in the care and support of people with mental disorders in the community. GPs also provide the primary means of access to specialist psychiatric services.
16. Many carers and service users to whom we spoke were very appreciative of the work undertaken by GPs. However, there were some criticisms, for example, of a lack of responsiveness by some GPs to requests for assessments by carers (see Chapter 13). We were concerned by these criticisms, although it is difficult for the Committee to know with confidence how far such criticisms reflect a general problem, or difficulties in relationships between individual GPs and their patients.
17. We did, however, hear evidence from a number of sources, including from GPs themselves, that GPs may have only limited training in mental health. In view of the importance of mental health to the work of GPs, we feel it is essential that training in mental health issues should be a routine expectation for GPs in training, and that the continuing professional development of GPs should include elements relating to mental health.

Legal role in detention

18. Under the 1984 Act, general practitioners have two pivotal roles relating to detention:
 - ♦ Any 'medical practitioner', including a GP, may initiate an emergency detention, provided they have personally examined the mentally disordered person on the day on which they make the recommendation. An attempt must be made to obtain consent to this detention either from a relative or a MHO²⁸.
 - ♦ The GP can act as the second medical recommendation to a long term detention²⁹.
19. We start from the premise that being made subject to compulsion under mental health law is a serious matter, with major implications for civil liberties. It is important therefore that those who have the authority to initiate such measures have the appropriate skills and knowledge.
20. As we have already said, we perceive a need for training in mental health generally amongst general practitioners to be improved. However, there is a more specific problem in relation to the Mental Health Act, where it is necessary to understand and apply not only medical knowledge, but also complex legislation. The evidence we received indicated that not all GPs feel confident in implementing their responsibilities under the Act.

28 1984 Act, s24
29 1984 Act, s18

Emergency detention

21. We asked in our second Consultation whether GPs initiating emergency detentions should be required to have undertaken specialist training in the use of the Mental Health Act. The majority of those who offered comment supported such a requirement. There was support for this from the British Medical Association (BMA), and strong support from social work and voluntary sector respondents.
22. However, practical concerns were raised by several respondents, for example:
 - ♦ The Royal College of General Practitioners (RCGP) was concerned that such a requirement would serve as a disincentive for GPs to work with mentally disordered people, and could further marginalise mental illness.
 - ♦ The RCGP also expressed serious concern about the potential cost of undertaking such training.
 - ♦ Grampian Primary Care NHS Trust were broadly in favour of training for GPs, but were concerned whether, in practice, an appropriately trained GP would be available at all times.
23. We note these concerns. We would certainly not wish to make any recommendation that would act as a disincentive to GPs to work with mental health service users.
24. This could well be the case if a model of 'specialist' GPs were developed, who were given specific authorisation to deal with emergency detention. Any requirement that GPs with specialisms in mental health be the only ones who could undertake detentions would also cause serious difficulties in rural areas, where there may only be one GP within reasonable travelling distance. There would also be problems for out of hours services, where many emergencies are likely to arise. In an emergency it is unlikely that an on-call GP will have the time to contact and wait for approval from a colleague who is accredited to undertake detentions.
25. The alternative model is that all GPs should be obliged to be trained in the use of the Act. The difficulty with this approach is that initiating Mental Health Act procedures is a rare event in the practice of most GPs, and there would be difficulties in keeping such knowledge up to date. However, we do not believe that training required to ensure a basic knowledge of the emergency provisions of the Act need be particularly extensive, and we feel this is preferable to requiring the development of a cadre of specialist GPs for this purpose.

Short term detention

26. GPs do not currently have any role in short term (28 day) detentions. The proposals we make in Chapter 8 envisage the possibility of short term detention being initiated from the community, but they would involve a practitioner with expertise in treatment of mental disorders, i.e. a psychiatrist rather than a GP.

Long term compulsion

27. GPs are expected to provide the second medical recommendation for a long term detention³⁰. However, there remains the problem, similar to that surrounding emergency detentions, of GPs who are untrained in the use of the Act in recommending long term detentions.
28. In evidence a GP expressed reservations about this responsibility. We were advised that many GPs feel very unhappy at having to defend an application for detention in court. Furthermore, they often do not feel they can add significantly to the evidence of a consultant psychiatrist – particularly when the patient may have been in the care of the psychiatrist for several weeks by the time of the hearing.
29. Two main justifications have been put forward for the involvement of GPs in long term detentions.
30. Firstly, there is the argument that the GP provides an independent medical opinion, and we agree that there is significant value in having a doctor who is independent from the hospital system giving consideration to whether a long term detention is appropriate.
31. Secondly, it has been argued that the GP's recommendation is valuable since he or she will have personal knowledge about the service user and his or her background, which a s20 approved psychiatrist may not have. Indeed, this appears to be the main purpose at the moment of the second recommendation, since s20 states that the recommendation should be given, if not by the patient's own GP, by 'another medical practitioner who has previous acquaintance with him'. However, the evidence we received suggested that the way in which primary care services have developed over the past few years may make it less likely that a service user will have a long-term relationship with a single GP.
32. Taken at its worst, then, one could have a situation where the long term detention of a patient depends, in part, on the evidence of a doctor who may not have any real knowledge of the patient, and who professes no particular expertise in mental health or mental health law.
33. We considered a number of ways in which this could be addressed. There is no wholly satisfactory solution. The options appear to be
 - ♦ Require all GPs to have training in mental health
 - ♦ Restrict the second recommendation to doctors who have received specialist training
 - ♦ Change the category of people authorised to give the second recommendation
 - ♦ Remove the need for a second medical recommendation.

³⁰ 1984 Act, s20(1)(b)

34. We do not believe that the second recommendation should be removed. Although it has limitations, we believe it is also a source of potentially important information for the tribunal and protection for the patient. If, as we recommend, the decision of the tribunal is broadened from the simple question of whether the grounds for detention are met, and there is also the potential for compulsory treatment in the community, the evidence of a health professional working in primary care will become even more significant.
35. We discuss at paragraphs 69 - 76 the role of the community psychiatric nurse (CPN), and conclude that the CPN should not undertake the role of providing the second recommendation. Given that there is already social work input from the MHO, we have not identified any other group of people from the community and primary care services who could provide the second recommendation.
36. It appears therefore that it would be appropriate for GPs to continue to make recommendations in relation to long term compulsory measures. However, in these cases there are not the time pressures that affect emergency or even short term detentions. There is a case therefore for requiring recommendations for long term detentions to be made only by GPs with specialist understanding of the use of the Act, and we considered such a proposal.
37. However, on balance, we do not support this approach. It would change the role of the GP from someone with a direct responsibility for the primary care of the patient to someone acting as a second specialist. While knowledge of the Act is desirable, it is not essential that the GP be an expert in the workings of the Act. It is important that he or she understands enough about mental health care to be able to state a view of the patient's condition, based on their knowledge of the patient, and to advise the tribunal as to what appropriate support can be provided to the patient by primary care services. The decision is of course then a matter for the tribunal.
38. Our general conclusion, then, is that GPs should continue to perform similar roles in relation to compulsory measures as at present.
39. Since any GP however may be called upon to undertake emergency detention or to become involved in long term detention, the training and professional updating they receive in relation to mental health should include basic information regarding the use of the Act.
40. It may be that the development of Local Health Care Co-operatives could provide an opportunity for more structured arrangements, and the possibility of the development of specialisms in mental health by interested GPs. However, we have concluded that this need not affect the legislative provision.
41. Our recommendations relating to an improved and more detailed Code of Practice (see Chapter 36) should improve knowledge and understanding of the Act amongst all groups who use the Act, including GPs.

42. The Mental Welfare Commission, which has taken steps recently to develop its links with GPs, would also be an important source of advice and support.

Recommendation 7.3

Greater training in mental health issues should be a routine expectation for GPs in training, and the continuing professional development of GPs should include elements relating to mental health, including the use of the Mental Health Act.

Recommendation 7.4

Any doctor should be able to undertake an emergency detention, as at present.

Recommendation 7.5

The second medical recommendation for long term compulsory orders should continue to be provided by the patient's GP, where possible.

Role of psychiatrists

'Section 20' Doctors

43. We propose that one of the medical recommendations for long term compulsion, and the medical recommendation for short term detention, should continue to be by a doctor with special experience in the treatment of mental disorder. The current provision in s20 of the Act requires that such practitioners be approved by a health board as having such experience. However, there is no specific requirement that approved doctors have undergone specific training, and no formal criteria set which should be applied by boards. We believe that these provisions should be strengthened to set out the appropriate level of experience for approved doctors, and requirements to have attended relevant accredited training courses.

Recommendation 7.6

The first recommendation for long term compulsion, and the recommendation for short term detention, should be by a doctor approved by a health board as having special experience in the treatment of mental disorder.

Recommendation 7.7

Regulations should specify the criteria to be applied by health boards in approving such doctors.

Substitution of responsible medical officers

44. The RMO has an important statutory role, and we believe it is important that a senior doctor is identified as the responsible medical officer throughout a period of compulsory care. This will require NHS bodies to have appropriate arrangements for temporary substitution, where the patient's normal RMO is absent, whether on leave or because of illness.
45. In particular, it should be the norm that a patient's usual RMO is available to give evidence at any tribunal hearing. Should this not be possible, internal arrangements should be made for substitution by a colleague who is also approved as having special experience in the treatment of mental disorder.

Recommendation 7.8

NHS trusts should ensure that a patient subject to compulsion has an available responsible medical officer at all times to fulfil the relevant statutory responsibilities, including giving evidence to a mental health tribunal.

Psychiatrists in junior grades

46. The 1984 Act states that any second medical recommendation required for long term detention should not be given by a person in a junior grade working directly to the consultant giving the first medical recommendation³¹. This is presumably designed to ensure that there is no bar to the independence of the second medical recommendation.
47. We support this provision, and recommend that the Act should contain a broader statement that no second medical recommendation should be made by a person working directly to the person giving the first medical recommendation.
48. Ideally, the second recommendation would be wholly independent. We considered whether the Act should specify that the second doctor not be employed in the same hospital, or even NHS Trust, but concluded that this requirement might in some cases be impractical, particularly in rural areas. It is a matter which is best dealt with in the Code of Practice.

³¹ 1984 Act, s20(2)(c)

Recommendation 7.9

The Act should require that no second medical recommendation, for long term compulsory measures, should be made by a person working directly to the person giving the first medical recommendation.

Recommendation 7.10

The Code of Practice should provide guidance on means to ensure that the second medical recommendation for long term compulsion should be given by a doctor independent from the doctor giving the first recommendation, as far as possible.

Role of mental health officers**Professional background of mental health officers**

49. The MHO has an important role in the detention and ongoing care of a service user. We have given considerable thought to the issue of whether professions other than social work could undertake the role of an MHO.
50. The 1984 Act states that an MHO is 'an officer of a local authority appointed to act as a MHO for the purposes of this Act'³². The local authority must be satisfied that MHOs have competence in dealing with persons who are suffering from mental disorder, and Scottish Ministers may issue directions regarding their qualifications, experience and competence.³³ Current directions require that MHOs should have a professional qualification in social work and have completed an approved training course³⁴.
51. We asked in our first and second Consultations about this issue. The response was divided, but the number of respondents in favour of keeping MHO status exclusively available to social workers was greater than the number of those against, in both consultations.
52. In our second Consultation, about three quarters of those that responded were in favour of retaining the restriction of MHO status to qualified social workers. Social work respondents were almost unanimous in this view. However, one in three medical and nursing bodies (including the Royal College of Nursing and the Royal College of Psychiatrists) were of the opinion that other professional groups such as nurses and occupational therapists, if suitably trained, should be able to act as MHOs. ENABLE suggested that, subject to suitable training, MHO status could be widened to other professions, such as clinical psychologists and the new area co-ordinators proposed by the Review of Services for People with Learning Disability³⁵.

32 1984 Act, s125(1)

33 1984 Act, s9

34 The current directions are contained in Social Work Services Group Circular SWS19/96

35 *The same as you? A review of services for people with learning disabilities*. Scottish Executive (2000)

53. The College of Occupational Therapists argued that occupational therapy was the one profession that spans health and social care; that its participants were well trained and subject to professional standards, and often undertook similar assessment and case management tasks to social workers. They suggested that there was no rationale behind excluding occupational therapists from the MHO role.
54. Some of the arguments made to us in favour of extension of the role were:
- ◆ Professions other than social work have the requisite care skills and knowledge and understanding of individual mental health needs.
 - ◆ Much of MHO training as it currently operates could be accessible to other professions, thus making work within the statutory framework and other 'social work' skills more accessible to them.
 - ◆ There are sometimes problems, in rural and other areas, with gaining access to MHOs, which could be alleviated if the numbers of MHOs were increased, by allowing other professions to undertake the role.
 - ◆ Staff rotas mean that MHOs sometimes have had little previous involvement with an individual client.
 - ◆ MHOs could maintain their separateness from the health service but need not be exclusively social workers: it was noted by one respondent that social work departments already employ care managers from fields other than social work.
55. Arguments that were put to us for retaining MHO status exclusively within social work included:
- ◆ Social workers have a unique set of skills and experience which they can bring to the role. These include working with clients subject to compulsion, court work and risk assessment.
 - ◆ These fundamental social work skills are an implicit precondition of the current MHO training.
 - ◆ Social workers are best able to provide a social care perspective and link the service user into community care services and resources.
 - ◆ Social workers are independent from the health service, which both means that they can give a genuinely independent view on compulsory measures, and helps the service user's perception that there is independent oversight of his or her case.
56. The Mental Welfare Commission took the view, in responding to our second Consultation, that social workers are currently the only profession to combine independence from the health service with training and experience of working within a statutory framework. We concur. In our view, it would not be appropriate for the independent role of the MHO to be performed by someone employed within the health service, which rules out both nurses, and the great majority of occupational therapists with mental health expertise. We therefore believe that MHO status should continue to be restricted to specially trained social workers.

57. However, we do not believe that this should be specified in primary legislation, since such a requirement may become outdated if there are changes in the structure of social care provision. The Act should set out the general framework, with the specific requirements to be set out by regulations.

Consent to emergency and short-term detention

58. Where practicable, either an MHO or a relative must currently be asked to consent to an emergency or short term detention. We say above that we do not believe that relatives should continue to undertake this role. This, therefore, makes the role of the MHO even more important. We think it is highly desirable that an MHO is involved in all types of detention procedures.
59. We considered whether, in the case of emergency detentions, the consent of an MHO should be mandatory. However, we appreciate the difficulties of ensuring that an MHO is available in all circumstances. We therefore believe that the consent of an MHO should be obtained 'where practicable', as at present, with reasons given where consent has not been obtained.
60. We note that the Annual Report of the Mental Welfare Commission for 1998-9 draws attention to wide variations in the percentage of detentions obtained without consent by a nearest relative or MHO. These vary by hospital from none to 30%, with the variations not easily explained by the location of hospitals. We recommend that all local authorities and health boards give consideration to how the availability of an MHO to respond to emergency detentions may better be ensured.
61. However, it appears to us that, in the case of short term detentions, there should be no difficulty in ensuring that an MHO is available. (They are currently obtained in 99% of cases, according to Mental Welfare Commission statistics.) The emergency detention, if undertaken first, will allow up to 72 hours within which an MHO opinion might be obtained. A short term detention might also be undertaken directly from the community (as we propose in Chapter 8), but even in these circumstances, we believe that it should be necessary to have obtained consent from an MHO before the detention takes place.
62. We therefore recommend that the new Act require consent from an MHO in all cases where a short term detention is being considered.

Initiation of long term compulsory measures

63. The 1984 Act gives either MHOs or the nearest relative the right to initiate long term detentions³⁶. We have already stated that we do not believe nearest relatives should any longer have this right.
64. There are three ways in which an MHO can currently initiate an application for long term detention:

36 1984 Act, s19

- ◆ Firstly, if it appears to him or her to be appropriate to do so, an MHO can initiate an application for long term detention without being asked to do so.
 - ◆ Secondly, if requested to do so by a nearest relative, an MHO must assess the patient and either make an application for detention or give written reasons why he or she does not think detention is appropriate.
 - ◆ Thirdly, if the MHO has received recommendations for detention from two doctors, and one of them requests that an application for detention be made, the MHO must make the application, irrespective of his or her own views on the matter. In making the application, the MHO must provide a statement of whether he or she thinks detention is appropriate.
65. Other than the right of the nearest relative to request assessment for detention, which we discuss in Chapter 13 (paragraph 19-30), we believe that these provisions are adequate, and do not recommend any change in them.

Renewals of long term compulsory measures

66. At present, although they have a fundamental role in applying for long term detentions, the Act does not require MHOs to be involved in the renewal of a long term detention³⁷.
67. We believe that the independent input of an MHO is as important a safeguard at the renewal stage as it is at the time of initial detention. Ongoing input by social work is also important, since the longer-term care of most service users will be in the community.
68. Therefore, we recommend that MHOs should, in future, be required to prepare a report when a long term compulsory order is being renewed by the RMO. The report should state whether the MHO supports or does not support the renewal, and the reasons for the MHO's view. When the MHO does not support the renewal, the case should be referred to the tribunal for consideration.

Recommendation 7.11

Mental health officers should continue to be appointed by the local authority. Regulations should provide that mental health officers should be specially trained social workers.

Recommendation 7.12

Local authorities and health boards should give consideration to ways in which the availability of mental health officers to respond to emergency detentions may be better ensured.

37 Renewals of detention: 1984 Act, s30

Recommendation 7.13

A mental health officer should continue to be required to give consent to an emergency detention 'where practicable', with reasons being given where consent has not been obtained.

Recommendation 7.14

Consent by a mental health officer should be required for a short term detention in all circumstances.

Recommendation 7.15

A mental health officer should be entitled to apply for long term compulsory measures on his and required to do so her own initiative, and required to do so when requested by a doctor who has made a recommendation for such measures.

Recommendation 7.16

A mental health officer should be required to prepare a report when a decision on renewal of long term detention is being made by the responsible medical officer. Should the report not support renewal, the question should be referred to the tribunal.

Role of Nurses**Community psychiatric nurses**

69. Community psychiatric nurses (CPNs) increasingly play a central role in the treatment and care of service users living in the community. In responses to our consultations, we were told by service users of the importance they place on the support that they receive from CPNs. They are, in addition, a valuable source of specialist knowledge on mental health matters in a primary care setting.
70. CPNs do not currently have any formal role under the Act. Some oral evidence that we received on our visits suggested that CPNs heavily influence many GPs in their considerations of detention procedures. We therefore asked in our second Consultation document whether this should be formalised, to give CPNs the power to initiate emergency detentions and/or act as a second medical recommendation for long term detention.

71. Overall, most respondents thought that CPNs should neither be given the power to initiate emergency detention nor give a recommendation for a long term detention. The Scottish Association for Mental Health (SAMH), ENABLE and the Scottish Users' Network (SUN), as well as other social work, voluntary sector organisations and users and carers were against such powers, on the basis that the power to detain would compromise the CPN's supportive role.
72. There was more support for these proposals from health boards and trusts and nursing and medical bodies. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) supported both proposals. The UKCC noted that other professions are currently required to manage the tension between powers to compel and the development of a therapeutic relationship, and added that nurses may even be better placed to do so than other professionals, since they are skilled in supporting people in periods of distress and enabling them to recognise the necessity of actions taken to pursue recovery. The Community Psychiatric Nurses Association (CPNA) said that CPNs have always resisted becoming the person with a power of detention although they accepted there were some practical arguments in favour of such a power in relation to emergency detention.
73. We are aware of developments currently taking place which are extending the role of nurses into areas previously the preserve of doctors. We also accept the argument that CPNs have specialist knowledge of mental disorder and the fact that GPs, in many cases, already take advice from CPNs about detention.
74. Nonetheless, on balance, we are not persuaded that CPNs should have a formal role in applications for detention, either on their own behalf, or in support or consent to medical recommendation.
75. We have already said that we do not support nurses being given the role of MHOs. Nor do we feel it would be helpful to add a formal requirement for a report by a further professional, particularly in emergency and short term detention.
76. However, we suggest that, instead of giving CPNs a formal role in detentions, the Code of Practice should provide that GPs should, whenever possible, discuss any proposed detention of a mentally disordered person with a CPN. This will formalise a practice that already takes place, will make the best use of a specialist resource available to GPs and, if a CPN is already working with the person, it will make it more likely that a recommendation for detention is based upon personal knowledge of the mentally disordered person.

Recommendation 7.17

The Code of Practice should provide that GPs should wherever possible discuss any proposed detention of a mentally disordered person with a community psychiatric nurse.

Nurses in hospital

77. We are aware that nurses in hospital play an increasingly important role as part of the care team. However, we found little support for the introduction of any new statutory role for nurses in the Mental Health Act so far as it applies to patients in hospital.
78. We discuss the ‘nurse’s holding power’ in Chapter 8. Nursing organisations said in evidence to us that the level of training which nurses receive in their legal responsibilities when operating this power is sometimes inadequate. The Mental Welfare Commission has in the past and again recently commented on variations in the extent to which nurses are aware of other parts of the Act with relevance to their work, such as the implications of the forms completed under Part X, which set out what medication may lawfully be administered without consent. We believe that steps should be taken to ensure that all nurses working with patients subject to compulsion have a basic understanding of the Act, particularly as it relates to their professional responsibilities.
79. Regulations specify the classes of nurse who may exercise the nurse’s holding power³⁸. It was pointed out to us that practical problems may arise if the nurse on the scene at the time a patient seeks to leave has not attained the prescribed status. On the other hand, we would not wish junior nurses to be placed in the invidious position of exercising legal powers of restraint when they are not appropriately trained or experienced. We believe that the appropriate level of qualification for nurses entitled to exercise the holding power should be reviewed.

Recommendation 7.18

NHS Trusts should have a responsibility to ensure that all nurses who have to deal with patients subject to compulsion have a basic understanding of the Mental Health Act.

Recommendation 7.19

The Code of Practice should contain guidance on the responsibilities of nurses under the Mental Health Act.

Recommendation 7.20

The requirements as to the grades of nurses who may exercise the nurse’s holding power should be reviewed.

³⁸ The Mental Health (Class of Nurse) (Scotland) Order 1994 (SI 1675)

CHAPTER 8

DURATION, REVIEWS AND APPEALS

Current legislative position

1. There are three types of detention under the Mental Health (Scotland) Act: emergency, short term and long term.
2. Section 24 of the 1984 Act permits the emergency detention of a mentally disordered person in hospital for a period of up to 72 hours. Section 25 of the Act allows for the same type of emergency detention, applied to a person who is already in hospital (for example, a patient in a psychiatric hospital on a voluntary basis, or a person presenting to Accident and Emergency) who decides to leave the hospital but for whom it is considered that in the interests of his or her health or safety or for the protection of others it is necessary to prevent him or her doing so.
3. Section 26 of the Act allows a short-term detention, of up to 28 days in length. A detention under s.26 may only be undertaken if the person has previously been detained under s.24 or s.25, the entire 72 hours of that detention has elapsed, and the continuing detention is approved by a 's.20-approved' psychiatrist.
4. Section 18 of the Act deals with long term detention, of six months in the first instance, which may be renewed for a further six months, and then on a yearly basis³⁹. An application must be made to the sheriff for approval of initial admission under s18.
5. Section 25(2) of the Act gives a 'holding power' to nurses. A person already in hospital receiving treatment for mental disorder on a voluntary basis may be held there by a nurse, if the patient appears to require detention. The authority to hold the patient lasts for two hours, or until the earlier arrival of a doctor.
6. The Mental Health (Scotland) Act 1984 gives patients and their nearest relatives the ability to challenge their detention and imposes a duty on doctors to review detentions.
7. There is no appeal against an emergency detention, nor is there any judicial oversight of its imposition. The Mental Welfare Commission could discharge a patient detained on an emergency basis, but it is not practicable for them to review such cases within the 72 hour period.
8. A patient may appeal to the sheriff against short term (28 day) detention, or request that the Mental Welfare Commission exercise its power of discharge.

³⁹ 1984 Act, s30.

9. The patient or the nearest relative may oppose an application for long term detention, and it is for the sheriff to determine whether the application should be granted.
10. The patient or nearest relative can appeal to the sheriff against renewal of long term detention.
11. If, during the period of detention, the responsible medical officer (RMO) or the Mental Welfare Commission determine that the patient is no longer detainable, either may discharge the patient. With the consent of the responsible medical officer, an order for discharge may also be made by the nearest relative or the managers of the hospital.

Detention under current provisions

12. The Mental Welfare Commission Annual Report for 1999/2000 shows 4284 episodes of emergency detention. Of the total of 4284, 1784 (41%) patients were either discharged from hospital without further detention or remained on an informal basis (no breakdown is available between these two outcomes).
13. One thousand six hundred and fifty-eight (39%) patients were detained for up to a further 28 days under s26, and then either discharged or remained as informal patients. The remaining 842 (20%) patients were detained under s26 and went on to be detained on a long term basis under s18. In addition, 169 patients were detained under s18 without a prior use of emergency and short term detention.
14. The figures show that many episodes of detention are short, and would suggest that patients are not generally kept under compulsion longer than necessary. Only a relatively small minority (20%) of those detained on an emergency basis proceed to long term detention.
15. The evidence from the research into the operation of the courts and s18 detentions (See Annex 7) also suggests that large numbers of people detained under s18 are discharged well before the expiry of the initial six month duration of the order. The research analysed 936 cases of long term detention that were discharged between April 1998 and August 1999. Of these 264 (28%) were discharged at less than six months and a further 221 (24%) at the end of six months. 173 (18%) were discharged between seven and twelve months and a further 129 (14%) between thirteen and twenty four months. However, of the remaining 149 (16%) cases there were many where the detention had lasted for very long periods, including 35 between five and ten years and 13 longer than 10 years.
16. The analysis of these 936 cases also showed that 531 (57%) of the patients were on leave of absence at the time of discharge and of the other patients 230 (25%) remained in hospital informally. A comparatively small percentage of patients therefore were discharged directly from hospital.

17. In another analysis of 1548 patients whose orders were renewed during the year to 31 March 1999, the research showed that in 422 (27%) of cases detention started before 1996. Of these 105 (7%) started before 1990. In the remaining 317 (20%) cases, detention started between 1990 and 1995. These figures again show the existence of a significant number of patients who have been detained for long periods.
18. The lack of a breakdown of the statistics for patients 'discharged to informal status' between those discharged from hospital and those remaining on an informal basis is a serious gap in the statistics.
19. While the fact that so many patients do not remain subject to compulsion beyond the 72 hour stage may be a positive feature, it might also suggest that in some cases perhaps not enough effort was made to secure the patient's admission on a voluntary basis.

Nurse's holding power

20. Section 25(2) of the Act gives nurses of a prescribed grade the power to prevent a mentally disordered person, who is already receiving treatment on a voluntary basis, from leaving hospital. It must appear to the nurse that the patient requires to be restrained from leaving for his or her health or safety or for the protection of other persons, and there must be no doctor immediately available to undertake emergency detention procedures. The power lasts until such time as a doctor may be obtained to assess the person for an emergency detention, or for two hours, whichever is shorter. We are in favour of the retention of this power.
21. However, the holding power appears to run out as soon as a doctor arrives on the scene⁴⁰. In cases which then proceed to emergency detention, there is some question as to what the patient's legal status is between the moment of the doctor's arrival and the completion of the emergency detention procedure. It may be argued that the patient is not lawfully detained during this period.
22. The ending of the holding power as soon as the doctor arrives also militates against obtaining a mental health officer (MHO) to give approval to an emergency detention, which we view as an important safeguard.
23. We therefore believe that the section should be amended to make it clear that a nurse's holding power continues until such time as the doctor is able to complete his or her assessment and, if appropriate, undertake the detention procedure. This should include time to make all efforts possible to contact and involve a MHO in the detention procedure.
24. The nurse's holding power in England and Wales lasts for a maximum of six, rather than two hours. We considered whether there was a case for extending the duration of the power. However, no evidence was put forward to suggest there

40 1984 Act, s25 (2): 'the patient may be detained in the hospital for a period of 2 hours from the time when he was first so detained or until the earlier arrival at the place where the patient is detained of a medical practitioner'.

were major practical problems with the current time limits other than those we have mentioned above.

25. In oral evidence, nursing bodies opposed any extension of the time period, and we therefore recommend that the current two hour limit be retained subject to modifications to deal with the practical problems that have been identified .

Recommendation 8.1

The nurse's holding power should be retained, to allow the arrival of a doctor and to allow time for the doctor to assess the patient's condition and decide whether emergency or short term detention procedures should be undertaken.

Recommendation 8.2

In the event that no doctor has arrived within the period of two hours, the holding power should cease at the end of the two hours.

Recommendation 8.3

In the event that a doctor is already present or that a doctor arrives within the period of two hours, the holding power should continue for a period of one hour from the time of the arrival of the doctor, or until the end of the period of two hours, whichever is longer, to allow the doctor to assess the patient and decide whether detention procedures should be undertaken, and to contact a mental health officer where appropriate.

Recommendation 8.4

During the period of the holding power all practicable steps should be taken to contact and obtain the approval of a mental health officer in any decision relating to detention.

Emergency detentions

26. Emergency detentions currently last for 72 hours. In order to minimise the period that a person would be subject to an emergency detention, we considered whether this should be reduced, perhaps to 24 hours. However, several consultees pointed to the practical problems that this would pose, particularly in remote areas, or if a person is detained at the weekend when it might be difficult to get hold of a consultant psychiatrist to pursue a short term detention. We

accept, therefore, that a maximum detention of 72 hours is a necessary compromise between the rights of the patient and the need for practicality. As at present, this should not be immediately renewable. However, a person should never be held for the whole 72 hours if this is not necessary.

27. We considered whether the distinction the Act makes between emergency detention of a patient already in hospital (under s25) and detention from the community (under s24) should be maintained. Although the procedure and outcome are the same, we consider there is merit in maintaining the distinction, if only in providing information on the use of the Act for statistical purposes.

Recommendation 8.5

Emergency detention should continue to be for a maximum of 72 hours in duration, and not immediately renewable.

Recommendation 8.6

Emergency detention from the community and from hospital should continue to be separately recorded.

28. There is currently no appeal to the sheriff available against emergency detentions. That would be desirable in principle, but given the practical problems with arranging an appeal within a 72-hour time frame, we believe that the introduction of such an appeal would offer little effective protection for the patient. We have therefore come to the view that there should be no appeal to the tribunal against a 72-hour detention. However, we recommend below a number of measures designed to reduce the reliance on emergency detentions.
29. Some respondents have suggested to us that detention without appeal runs the risk of breaching the European Convention on Human Rights. The Convention does state that an appeal should exist⁴¹, but it is our understanding that ECHR allows some leeway for emergency situations⁴².

Recommendation 8.7

As at present, there should be no appeal against the imposition of an emergency detention.

Short term detention

30. A number of possible amendments to the length of short term detentions were suggested to us. These included replacing the short term detention with a

⁴¹ European Convention on Human Rights Article 5 (4).

⁴² *Winterwerp v Netherlands*, EctHR Series A No.33

seven-day assessment order, or maintaining the order at 28 days but having a review of the detention at seven days.

31. An argument in favour of shortening the order is that a short order would avoid a patient being detained for as long as 28 days if he or she simply required a few days admission for a period of crisis to pass. However, we are not aware of evidence to suggest that detentions of undue length under s.26 are a major problem at present, although we note the lack of statistics on the average length of such detentions.
32. There may also be advantages in, if necessary, detaining a person for a full four weeks in appropriate cases before applying for long term detention. Psychiatric evidence to the Committee has indicated that it may take some weeks for the efficacy of a treatment regime to be evaluated. In these circumstances, if the decision is made to apply for a long term detention order, the proposed plan of care put to the tribunal will be based on better evidence than if the person had only been detained for, say, one or two weeks.
33. The Richardson Committee put forward a proposal for a 'paper review' of the continued need for detention at seven days. We are not convinced, though, that such a review would have any appreciable effect.
34. We therefore take the view that four weeks is an appropriate maximum duration for a short term detention. As at present, this should not be immediately renewable.
35. Section 26A of the 1984 Act is intended to cover situations where it has been expected that a short term detention will be allowed to lapse, but the patient worsens towards the end of the 28-day period, without leaving sufficient time for a s.18 application to be made. It permits a three-day extension of the period of short term detention, during which time it is expected an application for long-term detention will be made. Detention under s.26A is not immediately renewable, nor can a person so detained be further detained except under s.18.
36. Sections 21 (3B) and 21 (3C) permit extensions to detentions under ss.26 or 26 (A) to allow, respectively, the court five working days within which to hold a hearing or approve the application, or to allow for continued detention during a court adjournment.
37. We have not received any evidence that the extensions to detentions permitted by s26 (A) and ss21 (3B) and (3C) are misused to the detriment of patients. We understand there are very few episodes of detention under s26A. We accept that, in some situations, a brief continuation of short term detention might be reasonable, to allow proper consideration of the need for long term compulsory measures. We therefore recommend that these provisions be retained.
38. We are concerned however that the authority under s21 (3C) to detain a patient because of an adjournment of the court hearing is potentially for an indefinite period. Except, perhaps, where the patient has sought an adjournment to obtain

further evidence, we believe that there should be a maximum period for such an adjournment.

Recommendation 8.8

Short term detention should continue to be for a maximum of 28 days in duration, and not be immediately renewable.

Recommendation 8.9

There should be provision for the continuation of short term detention for a brief period, to allow the determination of an application for long term compulsory measures. This should be similar to the provisions in s26A and s21(3A) to (3C) of the 1984 Act. The power to continue to detain where an application for long term compulsory measures has been adjourned should be limited to 28 days. The tribunal should have discretion to extend this period at the request of the patient or patient's representative.

39. Short term detentions (ss26 and 26A) may be appealed to the sheriff, although this currently only happens in a very few cases. We favour the retention of this protection, subject to replacement of the sheriff by our proposed tribunal. We recommend in Chapter 23 that the Mental Welfare Commission should retain the power to review and, where appropriate, discharge patients subject to short term detention.
40. We take the view that any appeal against a short term detention should be made within the first 14 days of such a detention and should be heard by the tribunal within seven working days of the appeal having been initiated.

Recommendation 8.10

An appeal to a mental health tribunal by the patient and the named person (as provided for in Chapter 16) should be available against a short term (28 day) detention.

Recommendation 8.11

Any appeal against a short term detention should be initiated within 14 days of the commencement of detention, and the tribunal should be required to consider the appeal within seven working days of the appeal having been made.

Long term compulsory measures

41. We received little evidence to suggest that the current limits of long term detentions lasting six months in the first instance, then renewable for a further six months and yearly afterwards, are inappropriate. Most respondents appeared to accept these as a reasonable framework for long term compulsory measures. We therefore recommend that the time-limits are not changed, and we have indicated in Chapter 6 that they should apply to community orders as well as to hospital based orders. We regard the approval by an independent judicial body of long term compulsory measures before their imposition as an important safeguard, which should be retained. This should apply both to hospital based and community orders.

Recommendation 8.12

Long term compulsion should be for six months in the first instance, renewable for a further six months and then annually.

Recommendation 8.13

Long term compulsion should require the prior authorisation of a mental health tribunal.

42. Section 30 (6) of the 1984 Act permits the patient an appeal to the sheriff against his or her detention after the first renewal of a long term detention (i.e. after six months have elapsed). We believe this right should be retained though at the moment very few patients take the opportunity to appeal to the sheriff.
43. However, there is no provision in the Act for an appeal to the sheriff during the first six months of detention. Although the issue has, in a legal sense, been determined by the granting of the order, much can change in six months – both in the patient's condition, and the surrounding circumstances. Under our proposals, the tribunal would consider and approve the plan of care, not simply whether the criteria for compulsion have been met. We therefore feel that the patient should have the opportunity, after a reasonable period, to seek a variation in terms of the order.
44. It appears from the Act that there is no limit upon how many times during the period of renewed detention a person might appeal. Whilst we would not wish to see the tribunal's business being occupied by persons persistently appealing compulsory orders where there has been no change of circumstances, we are not aware of any particular difficulties being caused by this. We therefore do not recommend any change.

45. The relevant provisions would of course apply to a community order as well as a hospital based order.

Recommendation 8.14

The patient and the named person should have a right to appeal to a mental health tribunal against renewal of long term compulsion.

Recommendation 8.15

An application to a mental health tribunal for a variation of the order should be available to the patient and the named person after the first three months of a long term compulsory order.

46. There is currently no automatic review of detentions by the sheriff. This differs markedly from the situation in England and Wales, where Mental Health Review Tribunals automatically review detentions every three years, if no appeal has taken place during that time.
47. The effect in Scotland, for some patients, is that they may be continuously detained for long periods without any formal review of their detention. Patients who do not wish or feel able to appeal against compulsory measures, for whatever reason, and who are being held under compulsion for lengthy periods, are a vulnerable group. We believe they are not adequately protected by the law as it stands, and that there should be an automatic review of compulsory measures by the tribunal.
48. We considered whether the review should coincide with the annual renewal of long term compulsion. However, to consider the merits of every case every year would place too great a burden on the tribunal. Furthermore, given the continuous informal review that takes place in a treatment setting, and the oversight of the Mental Welfare Commission, we believe this would be a disproportionate response to the problem.
49. Instead, we believe that there should be a formal review by the tribunal every three years, if there has been no appeal during that time. The necessity of compulsion would be reappraised, and the plan of care would be approved or required to be amended.

Recommendation 8.16

A mental health tribunal should automatically undertake a review of compulsory measures every three years, if the patient or named person has not appealed during that time.

Recommendation 8.17

The patient, named person, legal representative and other interested parties should be given the opportunity to contribute to the review.

50. When a plan of care is before the tribunal, it would be open to the named person as well as the patient to challenge or ask for clarification on one or more elements of the service user's plan of care. Either party might wish to challenge on a number of grounds: for example, whether the proposed care to be given in the community is sufficient or practical, or they might wish to propose that a person detained in hospital be given an opportunity to try living in the community.
51. The tribunal would have to take the views put forward into account in deciding whether or not to approve the plan of care.

Recommendation 8.18

When a plan of care is before a tribunal, the named person as well as the patient should have the right to challenge or ask for clarification on one or more elements of the patient's plan of care.

The Mental Welfare Commission's power of discharge

52. The Mental Welfare Commission is a more frequently used method of seeking discharge than the sheriff court. Although discharges by the MWC are relatively uncommon following reviews, we recommend, in Chapter 23, the retention of the right for the Mental Welfare Commission to discharge non-restricted patients.
53. The Mental Welfare Commission also has a duty to visit patients subject to compulsion. It has a particular duty to visit, at least every two years, any patient subject to long term detention. We make recommendations relating to these powers in Chapter 23, which should of course encompass patients on community orders as well as hospital based orders.

Discharge by the responsible medical officer

54. Under the current law the RMO must discharge a patient from detention if the statutory grounds for detention are no longer applicable⁴³. This provision of the Act should serve to prevent a patient being detained for any longer than necessary.
55. We believe that no person should be detained until the completion of an order if it is possible to discharge him or her prior to that. As we have already indicated, there

do not appear to be any statistics on the actual duration of episodes of short term detentions, but the evidence from the Mental Welfare Commission statistics for long term detentions, which we have quoted in paragraph 15 above, is that many orders for discharge are indeed made by RMOs prior to the completion of the term.

56. Despite this, we believe that there is a need for the Act to be clear in providing that the need for compulsion should be kept under constant review, and that no patient who does not continue to meet the criteria for compulsion should be subject to compulsory measures.
57. The power of the RMO to discharge the patient would apply to both hospital based orders and community orders. Where the consequence of a discharge of an order is likely to be that the person leaves hospital, or that plans of care change in other respects, we believe that the RMO should first consult with the MHO. This will allow any appropriate steps to be taken by community services on discharge.

Recommendation 8.19

The Act should provide that the condition of a patient should be kept under constant review by the responsible medical officer, and, if the patient no longer meets the criteria for compulsion, he or she should be discharged.

Recommendation 8.20

The mental health officer should be consulted by the responsible medical officer prior to the discharge of a patient from compulsion, where it is anticipated that aftercare services may be required.

58. There is a requirement in s22(4) of the Act that in the fourth week of a long term detention, the RMO should undertake a review of the case to see whether detention is still warranted. If the outcome is that the patient continues to be detained, the Mental Welfare Commission, the local authority and the nearest relative must be notified. This appears often to be treated as little more than a formality. We have received no information as to the number of patients who might be discharged as a result of such a review. We believe that the other recommendations we make, including the need to keep compulsion under continuing review, provide a more effective framework for protecting patients and keeping relatives informed, and propose that this requirement be abolished.

Recommendation 8.21

The requirement for a review of detention by the responsible medical officer after four weeks of long term detention should be abolished.

The hospital managers' powers of discharge

59. The Act currently gives hospital managers the right to make an order for discharge⁴⁴, which comes into effect within seven days, unless the RMO makes a report indicating that the grounds for detention continue to apply⁴⁵. The provision differs from the English and Welsh Act in that the managers cannot overrule the RMO, and there is no formal review procedure set down in the Code of Practice⁴⁶. In practice, we assume that hospital managers will normally rely on advice from the RMO, who of course possesses an independent power of discharge. Given the powers of the RMO, the Mental Welfare Commission and the tribunal to discharge patients, the power vested in hospital managers would seem to be unnecessary, and we recommend that it be removed.

Recommendation 8.22

Hospital managers should no longer have the right to make an order for discharge.

The nearest relative's power of discharge

60. The nearest relative has the right to make an order for discharge⁴⁷, but only if he or she gives seven days' notice to the hospital managers⁴⁸. If, during that time, the RMO makes a report stating that the grounds for detention continue to apply to the patient, the patient is not discharged and the nearest relative cannot make another order for discharge for six months. This decision is then appealable to the sheriff by the nearest relative⁴⁹.
61. The nearest relative's power to initiate discharge does not apply in relation to patients detained in the State Hospital or to patients detained by order of a criminal court⁵⁰.
62. Our proposals in respect of the tribunal are intended to encourage the participation of carers and families at the initial hearing for long term compulsory measures. We also make proposals later which are intended to encourage relatives and carers to be involved in decisions about care on an ongoing basis. In particular, we recommend in Chapter 16 that relatives and carers should have the legal right to receive improved information and support from service providers.
63. We have also recommended earlier in this Chapter that the 'named person' should have the same right as the patient to appeal against the imposition of short term detention, or the approval or renewal of long term compulsory measures. In view of the above, we take the view that the current right of the nearest relative to make an order for discharge, which is in effect subject to the approval of the RMO, is not necessary.

44 1984 Act, s33 (5)

45 1984 Act, s33 (6)

46 Mental Health Act 1983, s23 and Mental Health Act 1983 Code of Practice (1998), chapters 22 and 23

47 1984 Act, s33 (5)

48 1984 Act, s34 (1)

49 1984 Act, s34 (2)

50 1984 Act, s34 (3) and s.62(1) s60(2)

Recommendation 8.23

The right of the nearest relative to discharge a patient subject to long term compulsion should be removed.

The relationship between emergency, short term and long term detention

64. We now go on to deal with a number of other issues relating to the detention of patients under the 1984 Act.

The use of emergency detentions

65. One of the understandings upon which the Mental Health (Scotland) Act 1960 was based was that long term detentions would be the normal route into detention for the majority of patients. This same belief underpins the 1984 Act⁵¹.
66. However, figures from the Mental Welfare Commission's Annual Reports in recent years have consistently shown that the vast majority of detentions are emergency detentions in the first instance, under ss.24 and 25. In the year 1999-2000, some 96% (4284 out of 4453) of all detentions were emergency detentions. By contrast, in England and Wales emergency detentions are not widely used. Instead, the 28 day assessment order is the main route into detention.
67. There are a number of reasons why emergency detentions are so frequently used in Scotland. The first is that it is not possible to proceed to the 28 day short term detention without it being preceded by an emergency detention. The only alternative to admission from the community is therefore a long term detention, which requires recommendations from two doctors and a RMO and approval by the sheriff. This takes time and is not practical in a situation of urgency. A delay can also be detrimental to the patient's best interests. It may also seem disproportionate to subject a person to potentially up to six months detention when they may require no more than assessment, or perhaps just a very short period of hospital treatment.
68. Furthermore, research⁵² has shown in samples of trainee psychiatrists and GPs that the majority did not view s.18 as the 'mainstay' of formal detention. It was particularly striking that only 16% of a one in four sample of general practitioners in Edinburgh said that it was. The commonly held view is that Sections 24/25 is the normal entry route into detention and, in practice, that is what it has turned out to be.

Short term detention from the community

69. In many cases a short term (28 day) compulsory order would be an appropriate alternative to an emergency detention or long term order. Most importantly, unlike

51 The Notes on the Act state, at paragraph 32, that a s18 application is 'the normal means of securing the compulsory admission of a patient to a hospital'.

52 Humphreys, M. (1997) Non-consultant psychiatrists knowledge of emergency detention procedures in Scotland. *Psychiatric Bulletin* 21, 631-635; Humphreys, M. (1998) Consultant psychiatrists' knowledge of mental health legislation in Scotland. *Medicine, Science & the Law* 38, 237-241; Humphreys, M. and Ryman A. (1996) Knowledge of emergency compulsory detention procedures among general practitioners in Edinburgh: sample survey. *British Medical Journal* 312, 1462-1463.

in the case of an emergency detention, there would be an appeal available. We therefore recommend that it should be possible for a person to move directly from the community on to a short term detention.

70. We also recommend that it should be necessary to gain approval from both a 's20 approved' doctor and a MHO for a short-term order. We accept that in some situations this may be impracticable, in which case an emergency detention would be a reasonable alternative.
71. We considered whether short term detention should require the approval of two doctors, as well as the MHO. An application for long term detention requires two medical recommendations. However, we concluded that if both a doctor approved as having experience in the treatment of mental disorder and a MHO were required to be involved, the participation of a second doctor is unnecessary.

Recommendation 8.24

It should be possible to move directly from the community on to short term detention, with the approval of both a medical practitioner approved as having special experience in mental disorder, and a mental health officer. This procedure should be used in preference to an emergency detention wherever practicable.

Monitoring the use of emergency detention

72. If short-term detention is available from the community as we propose, the use of emergency detention should lessen. In that case, and given the lack of safeguards surrounding emergency detention, we believe it would be desirable for written reasons for the use of an emergency detention rather than short-term detention to be given to the Mental Welfare Commission by the detaining doctor.

Recommendation 8.25

The Act should require that written reasons for the use of an emergency detention, explaining why alternatives were not available or suitable, should always be given to the Mental Welfare Commission by the detaining doctor.

73. There was a lack of systematic research available to us on the reasons for the preponderant use of emergency detention. The provision of written reasons for the use of emergency detention would enable this to be monitored by the Mental Welfare Commission, and in due course might allow research to be undertaken with a view to issuing any necessary guidance.

Recommendation 8.26

The Mental Welfare Commission should monitor the level of use of emergency detentions. Once the new Act has been in force for a period of time, the Mental Welfare Commission should consider commissioning research into the written reasons given for the use of an emergency detention.

Moving from emergency to short term detention

74. It is not currently possible to move a patient from emergency detention under s.24/s.25 onto short-term detention under s.26 until the 72 hours of the emergency detention have elapsed. If a person has been assessed during that period as requiring treatment, the law currently has the dual effect of keeping him or her detained without the possibility of an appeal, and confusing the position relating to his or her treatment.
75. We can see little value in insisting that the full 72 hours elapse before a person may be given treatment under the provisions of the Act, and be allowed to appeal against detention. We therefore suggest that it would be more appropriate, where a patient detained on an emergency basis needs to be moved onto a short term detention, for this to happen as soon as possible. The Act should therefore provide that the RMO should make every effort to assess the patient as early as possible in an emergency detention. In most cases, this would mean that a patient requiring continuing detention could move on to short term detention before the 72 hours is completed.

Recommendation 8.27

It should be possible to transfer a patient subject to emergency detention onto a short-term detention as soon as the procedural requirements for the short-term detention have been completed.

Recommendation 8.28

The Act should provide that the responsible medical officer should assess the patient as early as possible in an emergency detention, with a view to removing the patient from emergency status.

Treatment during emergency and short term detention

76. Currently, emergency detention confers no power to treat the patient compulsorily. Where treatment of patients is carried out without consent on a patient detained under s24 or 25, this is under common law, rather than the Mental Health Act.

Patients detained under short term (28 day) detention can be treated compulsorily under the provisions of Part X of the 1984 Act.

77. We accept that it is appropriate that patients who are subject to short term detention should be able to be treated under the Act. Were this not the case, it could in some cases be necessary to delay treatment for a considerable period pending approval of long term detention. This could be highly detrimental to the patient's welfare. Our proposals to allow swifter transfer to short term detention should allow treatment to be commenced as quickly as is necessary in nearly all cases.
78. There could still be some situations of great urgency, perhaps where treatment cannot safely await the arrival of a MHO to approve short term detention. In such cases, we feel it is undesirable that an Act which is intended to provide a comprehensive statutory code should be silent, with treatment being carried out under common law. We therefore propose that such treatment should be governed by provisions similar to those in s102 of the 1984 Act, concerning urgent treatment for detained patients, and our recommendations are based on that.

Recommendation 8.29

It should be possible to treat a patient subject to short term detention for his or her mental disorder without consent, subject to the safeguards in relation to special treatments set out in Chapter 10.

Recommendation 8.30

It should only be possible to treat a patient subject to emergency detention for his or her mental disorder on a similar basis to the provision for emergency treatment in s102 of the 1984 Act, namely where such treatment is either –

- ♦ *immediately necessary to save the patient's life, or*
- ♦ *not being irreversible or hazardous, is immediately necessary to prevent a serious deterioration of his or her condition or to alleviate serious suffering by the patient, or*
- ♦ *not being irreversible or hazardous, is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or presenting a serious danger to him or herself, or others.*

Recommendation 8.31

Where a patient is given treatment without consent during an emergency detention, the prescribing doctor should notify the Mental Welfare Commission of the fact, and the reasons why treatment was felt to be necessary.

Moving from emergency detention to long term detention

79. It is currently possible under the 1984 Act for a patient to move directly from an emergency to a long term detention. This is, however, rarely done. According to the Mental Welfare Commission's Annual Reports for the years 1992-99, the average number of such transfers has been two per year, and there were none at all in the year 1998-99 or 1999-00.
80. Despite its rarity, we accept that there may be circumstances where it would be appropriate to transfer a patient directly from an emergency to a long term detention. An example of this might be when an application for long term measures is already in train, but a crisis situation develops prior to the hearing.
81. We therefore recommend that this provision be retained. As at present, no power to extend the length of an emergency detention should exist⁵³: if the application is likely to require longer than the 72 hours to complete, the person should first be detained under short term detention procedures.

Recommendation 8.32

It should continue to be possible for a patient, who has been detained on an emergency basis, to move directly onto a long term detention.

Information and support for the patient

82. When considering an appeal against detention, the service user needs to know his or her rights and how to exercise them. Our principle of *Participation* requires that service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.
83. Section 110 of the 1984 Act already contains provisions relating to information. It requires that "such steps as are practicable" are taken to ensure that a detained patient understands:
 - ♦ which provision of the 1984 Act he or she is detained under, and the implications;
 - ♦ what rights of appeal to the sheriff are available;

⁵³ The sheriff has five working days to approve an application or hold a hearing. In the case of short term detentions, by contrast, s26A and s21 (3B and 3C) of the 1984 Act do allow for limited extensions to the lengths of short term detentions (whilst the mental health officer makes an application for long term detention, and whilst court procedures are in train, respectively).

- ◆ that he or she may make representations or appeal to the Mental Welfare Commission;
- ◆ that an order for discharge may be made by the RMO, the MWC or the sheriff;
- ◆ the meanings of Part X (consent to treatment⁵⁴), sections 115 and 116 (withholding of mail⁵⁵) and section 119 (the Code of Practice⁵⁶).

The Act requires that the information be given both orally and in writing.

84. Section 110 is a key section of the Act. The Mental Welfare Commission investigated the operation of the section during their hospital visiting programme for 1998/9, and reported on their findings in its Annual Report.
85. The Commission was disturbed to find that half of the patients they interviewed did not know under what section of the Act they were detained and could not explain what their detention meant, and also that two informal patients interviewed by mistake were under the impression that they were detained. Even allowing for the fact that patients may not have remembered explanations which were given, the Commission points out that the lack of recording in some hospitals of what steps were taken to inform patients of their rights leaves the hospitals vulnerable to criticism.
86. It is of course the case that some patients experiencing an episode of mental illness may have difficulty in taking in and dealing with information regarding detention, and their rights in relation to this detention.
87. The Code of Practice might therefore specifically refer to the need to repeat information in a clear, comprehensible manner as often as necessary.
88. However, more proactive steps may be required to ensure that patients are fully aware of their legal rights. During interviews for the research into the operation of s.18 detentions most service users said that they had not taken legal advice even when aware of the need for legal representation or their right to challenge orders⁵⁷. Some had felt that to do so would mark them out as 'troublesome' and might increase their chances of continued hospitalisation.
89. We have no evidence to suggest that these views are being encouraged by hospital staff. Nonetheless, the Code of Practice should provide that steps should be taken to ensure that service users feel comfortable and unthreatened in exercising their legal rights.
90. The provision of an advocacy service, as we recommend in Chapter 14, will also assist service users to exercise their rights. An advocate can provide effective information and support to a service user, and, if the service user wishes to appeal, can help to make the appropriate arrangements, including contacting a solicitor.

54 see Chapter 10

55 see Chapter 11

56 see Chapter 36

57 *An Evaluation of section 18 of the Mental Health (Scotland) Act 1984* (Central Research Unit 2001) paragraphs 6-88.

91. Currently, the duty to provide information rests solely with hospital managers. If, as we recommend, community orders are introduced, mental health service managers will need to have arrangements in place to impart information to patients in the community

Recommendation 8.33

Mental health service managers should be under a duty (so far as practicable) to ensure that patients subject to any form of compulsion are aware of the nature and effect of the compulsion, and their rights in relation to this. The fact that this has been done should be recorded.

Recommendation 8.34

During mental health hearings, evidence should be led to the tribunal as to the steps that have been taken to inform the patient of his or her rights.

Recommendation 8.35

The Code of Practice should give guidance on the most effective implementation of these duties, including the need for:

- ♦ *clear and comprehensible information;*
- ♦ *information being given as often as necessary;*
- ♦ *steps to be taken to seek to ensure that service users feel able to exercise their rights, including rights to legal representation and*
- ♦ *the involvement of an advocate if the service user so wishes.*

CHAPTER 9

FORUM FOR COMPULSORY MEASURES

1. Under the 1984 Act, the sheriff court is the principal forum which considers applications for long term detention, and appeals against renewals of detention. This is in contrast to England and Wales, where the primary forum is a specialist mental health review tribunal. We have considered both the way the sheriff court operates, and whether it is the best forum for mental health hearings.

Current statutory provisions

2. The Act and regulations contain relatively few formal requirements as to the operation of hearings in mental health cases. In considering an application for long term detention, the sheriff is entitled to 'make such inquiries and hear such persons (including the patient) as he thinks fit'⁵⁸. Should either the nearest relative or the mental health officer (MHO) oppose the application, they must be afforded an opportunity to be heard. A nearest relative who objects is also entitled to call witnesses, although this right is not formally accorded to the patient. The sheriff cannot reject the application (i.e. refuse to detain the patient) without allowing the applicant (normally the mental health officer (MHO)) the right to be heard and to call witnesses.
3. In any application for admission or appeal, the sheriff must give the patient the opportunity to be heard, either in person or by means of a representative⁵⁹. The representative is normally a solicitor, but this is not a requirement of the Act. Notwithstanding this general right to be heard, the applicant can be excluded from the hearing 'where it is established to the satisfaction of the sheriff that it would be prejudicial to the patient's health or treatment if he were present'. If this is done, a *curator ad litem* (an independent person, usually a lawyer, appointed to represent the patient's interests) may be appointed⁶⁰.
4. If no-one who is entitled to speak wishes to do so, the sheriff is entitled to approve the application without a hearing. This must be done, or a hearing held, within five days of the application being submitted (excluding weekends and court holidays)⁶¹. Once begun, the hearing can be adjourned, and a patient who is already detained under the short term (28 day) provisions can continue to be detained until the hearing is determined⁶².
5. The Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc Rules) 1999, S.I.929, sets out some further requirements. Notice of the hearing is normally given to the patient, but the patient does not receive a copy of the

58 1984 Act, s21

59 1984 Act, s113

60 Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc. Rules) 1999, (SI 929), Rule 3.8.5(2)

61 1984 Act, s21(3A)

62 1984 Act, s21(3C)

medical recommendations⁶³. There is no minimum length of notice which must be given. Where, as is normally the case, the patient is already in hospital, notice is served on the responsible medical officer (RMO), who should in turn deliver the notice to the patient. If there are reasons to believe that giving of the notice would be prejudicial to the health of the patient, the sheriff can dispense with service of the notice. In such a case, a *curator ad litem* must be appointed⁶⁴.

6. A *curator ad litem* may also be appointed in any other case where the sheriff considers it appropriate⁶⁵. This might apply where the person has not been excluded under s113, but the RMO has indicated that it would be prejudicial to the patient's health or treatment if the patient were to be present during the proceedings⁶⁶.
7. Where a person who is the subject of an application indicates to the sheriff that he or she wishes, but does not have, representation, the sheriff may appoint a solicitor to represent the person⁶⁷.
8. Legal Aid is available for mental health hearings, under the Assistance by Way of Representation scheme. Recently, the rules were amended so that this is not means tested, and any person who is subject of an application should now qualify for assistance⁶⁸.
9. Either the patient, the applicant (in most cases, the MHO), or the sheriff, can require that the hearing be held in private⁶⁹. The sheriff may hold the hearing in a hospital or other place, where he or she considers it appropriate⁷⁰.
10. There is judicial authority that the decision by the sheriff in a civil mental health hearing is an exercise of administrative, rather than judicial discretion⁷¹. This means that, apart from the procedural rules outlined above, there are few formal procedures for the conduct of hearings. They are not governed by the normal rules of court.
11. Also, the decision of the sheriff is not subject to appeal, other than by judicial review. There is an exception in relation to appeals by restricted patients. Under the amendments to the Act introduced by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, both the patient and Scottish Ministers can appeal the sheriff's decision in such a case to the Court of Session.

Sheriff court hearings

How the courts operate

12. Our views as to the ways the sheriff courts operate were informed by a number of sources including research, written and oral evidence, the prior experience of

63 Rule 3.8.3(1)

64 Rules 3,4 and 5

65 Rule 5(2)(b)

66 Under Rule 4(2)

67 Rule 6

68 The Advice and Assistance (Assistance by Way of Representation) (Scotland) Amendment Regulations 2000, (S.I.109)

69 1984 Act s21(4)

70 Rule 2(2)

71 *FV Ravenscraig Hospital* 1989 SLT 49

members of the Committee at mental health hearings and other court hearings, and discussions on visits and at consultative events with mental health and legal professionals, service users and carers.

13. Committee members also arranged to be present at a number of s18 hearings in the sheriff court. In addition to observing the proceedings, members of the committee were able to speak to participants about their general experience of such hearings. The visits and experience of Committee members tended to support some of the observations of the research, and the comments of consultees (see below).
14. When we began our work, we were concerned to note that there was virtually no published information regarding the operation of the sheriff courts in mental health hearings; even to the extent of basic information regarding how many applications were refused, and how many people exercised their rights to appeal at the various stages of detention. Following representations by the Committee and the Mental Welfare Commission, the Central Research Unit of the Scottish Executive undertook research into the operation of the sheriff courts in detention cases. This research has been separately published⁷², and a summary of the research findings is contained at Annex 7. We mention here some of the significant findings.

The evidence considered by the court

15. There appears to be a large number of determinations made by sheriffs without evidence being heard from those with significant information or interest in the outcome, or even without such people being present. Oral evidence was heard in 50% of the 522 of cases reviewed in the research. 28% of patients attended court, and 39% were legally represented. In just over half the cases, the patient neither attended court, nor was legally represented. Many patients appear to have felt there was little point in attending, or in opposing the hearing. Patients gave evidence in 18% of cases, as did the psychiatrist making the application. GPs gave evidence in 13% of cases.
16. The frequent absence of the patient in such a hearing is concerning. As a general principle, we feel it is desirable that the patient should participate in a decision of such magnitude. The fact that, as we note later, the attendance of patients at tribunals in England is much more common suggests that the lack of attendance cannot be attributed solely to the state of health of patients. The research also suggests that nearest relatives very rarely play a part in the hearing.
17. We are concerned that the sheriff appears sometimes not to have access to significant information about the patient, and the patient's history. As well as being generally unsatisfactory this could lead to rather laborious taking of evidence from doctors and the patient over matters which are not contentious, even though important.
18. We also noted that in none of the cases we observed did the MHO give evidence, other than to confirm that he or she did not oppose the application for admission.

⁷² *An evaluation of section 18 of the Mental Health (Scotland) Act 1984* (Central Research Unit 2001)

In two of these cases, oral evidence was led. In another case, the patient had withdrawn opposition to the application, which was approved without hearing evidence, although the MHO and the RMO were both present.

19. In cases where evidence was not led, the case will have been considered on the basis of the written applications. These applications were brief in many cases, partly because the medical recommendations are completed on standard forms which allow little room for detailed information.

Variations in practice

20. The research found wide variations in practice, with different sheriffs taking very different approaches to issues such as the appointment of *curators ad litem*, and the hearing of evidence. The practice of MHOs also varied widely, with some much more likely than others to be legally represented.
21. There is considerable variation in the degree of formality employed in the hearings, and different sheriffs take different views on matters such as whether to don a wig and gown. In one particular case we observed a sheriff taking considerable care to reassure the patient as to the nature of the proceedings, and the court's independence from the doctors and social workers. The patient in the case told us his view that this was important, and he welcomed the opportunity to state his case in an independent forum.
22. We were advised that the extent to which sheriffs choose to intervene in the process also varies, with some regarding the matter as an adversarial process, with evidence led by legal representatives, and others operating in a more inquisitorial way: for example, by taking evidence directly from witnesses.

Representation and appeals

23. The presence of an experienced solicitor representing the patient appears to contribute significantly to the airing of important issues of concern. As the research shows, such representation is often absent. In one case we observed, legal representation had come about because of the active intervention of the mental health officer in securing a *curator ad litem*, but this went beyond anything that was required of the MHO in the legislation or the Code of Practice.
24. The number of patients who exercised the right to appeal against an application for detention under s26 (a 28 day order), or against a renewal of long term detention, was very small (there were 30 appeals out of 2005 renewals of detention in a year). This contrasts with the significantly higher number who seek a review of long term detention by the Mental Welfare Commission, and indeed the number of appeals to Mental Health Review Tribunals in England. It was also notable that very few appeals in Scotland were successful.

Organisation of hearings

25. The research confirmed that the sheriff court system does not suffer from the long delays which affect English tribunals in relation to long term detention. This difference can be attributed partly to the pressures on the English system of the large number of appeals against short term (28 day) detention, with strict time limits. Also, because the Scottish Act involves prior approval of long term detention, while the English Act does not, the English system as it currently operates is not under the same organisational imperative to ensure timeous hearings in cases concerning long term detention.
26. However, the fact that, in Scotland, mental health cases are fitted into other court business can lead to a degree of confusion over when cases will start, and in which court. This could clearly be upsetting to some patients and relatives. There is also a potential for patients and relatives to be waiting in court alongside people involved in criminal cases, which could increase the sense of intimidation experienced by some patients and families. A number of family members commented on how upsetting they found this.
27. The court research also highlighted that patients and relatives may receive very short notice of a hearing. Partly, this is because the Act requires the hearing to take place within five working days, but in some cases, the amount of notice given is much shorter than even this limited period. This makes it extremely difficult to prepare for the hearing and to arrange representation.
28. Solicitors with experience of mental health hearings also expressed concern regarding a lack of power by the patient to require witnesses to appear.

Training

29. Some sheriffs agreed that more training for sheriffs on mental health issues could be beneficial, particularly for sheriffs likely to hear such cases frequently.

Conclusion

30. The sheriff court has a number of positive features. It is authoritative and independent. Sheriffs have expertise in the law, and experience of applying the law to a range of situations. Sheriff courts are universally available, and can accommodate hearings at short notice.
31. However, we believe that there are significant shortcomings in the current system, when set against the key features we outline below.
32. Although there is evidence of good practice, it would appear that this is localised, and often depends on the initiative of individual sheriffs, sheriff clerks, and in some cases, doctors or MHOs. There are few standards laid down, and little opportunity for good practice to be disseminated.

33. We do not believe that sheriffs, without expert assistance, would be well placed to assess the detail of care plans, or the feasibility of non-compulsory alternatives. As we explain in Chapter 6, this requirement is a fundamental part of our proposed reforms.

The tribunal system in England and Wales

34. In order to obtain a different perspective on how a forum for mental health hearings might operate, we have considered the English system of Mental Health Review Tribunals (MHRTs). Committee representatives observed five tribunal hearings in different parts of England. The Tribunal Service also helpfully provided us with a range of background information. Further information was obtained from the literature review which we commissioned (see Annex 8), and that conducted for the English Mental Health Act review⁷³.

Powers of the tribunal

35. Like the sheriff, the MHRT can discharge a patient on appeal from a long term or 28 day detention, or from a hospital order with restrictions⁷⁴. There is currently a difference in the legislation, in that long term detention under s18 of the Scottish Act requires the prior approval of the sheriff. This is not required in England and Wales, although it is proposed in the Department of Health Green Paper⁷⁵ that this be a requirement in future. Currently, the patient has the right to appeal after long term admission. If the patient does not do so, a hearing must be held if renewal is sought at the end of the six month period. In addition, a hearing must be held every three years if a detained patient has not appealed during that time.
36. In addition to its powers of discharge, the tribunal can also amend the category of mental disorder under which a patient is detained⁷⁶. In one case we observed, for example, the categorisation of a patient as suffering from mental illness and psychopathic disorder was changed to mental illness alone.
37. The tribunal also has the power to attach recommendations to its decision. In one case we observed, it recommended that a restricted patient be moved from a secure hospital to a lower level of security. These recommendations are not binding but may influence the Home Office (who have responsibility for restricted patients in England) and health and social work agencies. We understand they may also assist a patient's legal representatives in some cases where judicial review of decisions by these bodies is under consideration.

Tribunal membership

38. Each tribunal consists of a legally qualified chair (where the hearing concerns a restricted patient, this is a circuit judge or recorder), together with a medical member and a lay member⁷⁷. The lay member will often have a social work or nursing background or family experience of mental illness, but this is not invariable. All posts are now advertised. There are significant problems in

⁷³ *A systematic review of research relating to the Mental Health Act 1983* (Department of Health 1999)

⁷⁴ See Part V (sections 65-79) and Schedule 2 of the Mental Health Act 1983 for general provisions regarding the powers and operation of MHRTs

⁷⁵ *Reform of the Mental Health Act 1983: Proposals for Consultation* (Dept. of Health 1999)

⁷⁶ Mental Health Act 1983, s72(5)

⁷⁷ Mental Health Act 1983, Schedule 2, para. 4

recruiting medical members. These are attributed partly to a general shortage of senior psychiatrists.

39. All members are trained, although some members expressed to us a view that they would wish more training.

Location of hearings

40. Cases are nearly all held at the relevant hospital, and staff and members appeared surprised at the notion of transporting the patient to a courtroom (as happens in Scotland). In the tribunals we observed, the facilities were adequate for the hearing - basically a room in the administrative department of the hospital with a large table and chairs. Indeed, the environment may have contributed to an atmosphere of informality. However there have been criticisms of the facilities at some hospitals.

Legal representation

41. Participants appear nearly always to be represented by solicitors. Indeed, in one case we witnessed, the solicitor attended and participated, even although she had been unable to obtain instructions from the client. The patient is entitled to choose a solicitor. If the patient does not do so, the tribunal service arranges representation from a panel of solicitors who are approved for legal aid purposes to undertake mental health cases. Legal aid is free and not means tested. The hospital is, we understand, rarely legally represented. This only tends to happen in difficult cases, concerning restricted patients, where the Home Office may instruct representation.

Organising tribunals

42. There are eight regional Mental Health Review Tribunals, and one in Wales. Each is chaired by a lawyer, who carries general responsibility for the exercise of the tribunal's functions. These are served by four English and one Welsh Tribunal offices. These offices provide Tribunal clerks and administrative support, and organise hearings. The Tribunal service is funded by the Department of Health in England, and in Wales by the Welsh Assembly. The costs for the financial year 1998-9 were £8,739,434 in England and £605,700 in Wales. In 1998 there were 18,503 applications and references, and 9,057 hearings (many hearings are cancelled because the patient has been discharged or has withdrawn the appeal).
43. There appears to be some pressure on resources, leading not only to delays, but a significant number of hearings being held without a clerk.
44. The strict time limits for appeals against 28 day detention create considerable organisational pressures. These must be held within seven days. The organisational target for arranging a hearing for long term detention is eight weeks. For restricted patients, it is as long as 20 weeks.

45. There is a considerable amount of concern about delays in hearings, which seem to suggest that these are a longstanding and serious problem. The MHRT Annual Report for 1997-98 stated that the mean average waiting time for non-restricted cases at March 1999 varied between regions from 10.3 to 15.2 weeks and, for restricted patients, from 14.4 to 38.7 weeks.
46. The quality of the tribunals is monitored by the Council on Tribunals, who occasionally observe hearings, and who have recently produced a special report on the operation of MHRTs⁷⁸. The report comments on issues of deficiencies in administrative support, a need for more training and better accommodation for hearings.

Tribunal procedures

47. The tribunals operate according to rules prepared by the Lord Chancellor's Department, although the rules do not go into great detail as to how the tribunal itself should be conducted⁷⁹.
48. Patients can be excluded from hearings, or cases can be adjourned if they become upset or aggressive, although this can create administrative difficulties in reconvening with the same three tribunal members.
49. Hearings (both restricted and unrestricted) are held in private, although the patient can request that the hearing be opened to the public⁸⁰.
50. Research into the operation of tribunals has considered the inquisitorial model under which they operate. This is seen by its advocates as allowing a more open debate, and reflecting the fact that the hearing is not a private dispute between two parties. Critics on the other hand argue that this can mean that the tribunal is more like a case conference than a judicial hearing, and may lead to a paternalistic approach, and less emphasis on civil rights.
51. The tribunal receives a report in advance from the hospital, and a report from the approved social worker (equivalent to the MHO). In addition, the medical member must examine the patient shortly before the hearing. This usually happens either the day before or on the day. The medical member also studies the clinical notes.
52. The general atmosphere of the hearings we observed was informal, but also business-like, with considerable effort made to ensure that the patient was at ease and generally understood what was happening. The format in most cases was similar, although the order varied. The president (the legal chair of the tribunal) introduced the parties. The RMO was invited to speak to his or her report, and was questioned by the tribunal and the patient's solicitor (in one case we observed, the patient's husband was also invited to ask questions). The social worker spoke to his/her report, followed by similar cross questioning. Nurses may also give evidence. The patient's solicitor took evidence from the patient and made a closing submission. The decision was made by the tribunal after the parties had withdrawn, following a private discussion.

78 *Mental Health Review Tribunals: Special Report*, (Council on Tribunals, 2000) Cmnd.4740

79 The Mental Health Review Tribunal Rules 1983 (S.I. 942), as amended by S.I. 1998, No.1189

80 *ibid.* Rule 21

53. The fact that the key participants are altogether round a table, rather than giving evidence in series, seemed to allow for a more natural dialogue between the parties about the issues of the case.
54. Although most appeals are unsuccessful, discharges are not uncommon (see below). We were advised that, in most such cases, the discharge will usually be on the basis that the patient is mentally ill, but not sufficiently ill to meet the criteria within the Act of requiring detention in hospital. The advice of the medical member, or independent reports prepared for the patient, generally plays a significant part in arriving at such a conclusion.
55. Although not statutorily required to consider a care plan, the tribunals do look at issues of the care received, partly because of their power to make recommendations. The tribunals were also conscious of the implications of the patient being discharged to an unplanned situation. The tribunal does have the power to make a deferred discharge, to allow practical arrangements to be put in place, although the deferral should only be for a few days. In one case we witnessed, the tribunal asked the social worker to return in a few months to explain what progress had been made on planning a discharge to supported accommodation.

Outcome of hearings

56. As already noted in paragraph 42 above, many applications for hearings do not reach the hearing stage, either because the patient has withdrawn the application or, more frequently, because the RMO has discharged the patient before the hearing. Of the 9057 hearings held in the year to 31 December 1998, the MHRT Report for 1997-1998 recorded that there were discharges in 1169 cases: that is a discharge rate of 12.9%. The figures in the four English regions ranged from 10.5% to 16.1%. In the case of Wales, where the number of hearings was much smaller than in any of the English regions, the discharge rate was 21.8%.
57. However, it is not clear that these variations reflect inconsistency in decision making by the tribunals themselves. It is possible that it may in some cases reflect differing practice by psychiatrists. We heard anecdotal accounts that some psychiatrists may prefer to allow the tribunal to make a decision, where the need for further detention is equivocal. This could lead to patients coming before tribunals in some areas, who would be discharged in other hospitals before reaching the tribunal. Differing pressures on beds and the range and quality of services available locally may also contribute to inconsistencies in approach.
58. The contrast with Scotland is marked. Scotland has very few cases where applications for detentions are refused, and next to no successful appeals against detention. This may partially be explained by the fact that, in long-term detention, the court decision in Scotland normally takes place on admission, while an English appeal may be some time later. Since the patient's mental condition may well have improved, it would not be surprising that appeals met with more success.

However, this would not explain discrepancies in appeals against short-term detention and renewals of detention.

Conclusions regarding the English system

59. There appear to be a number of attractive points in the tribunal model. These included:
 - ♦ informality;
 - ♦ a procedure which is designed to involve all parties in discussion of the situation rather than setting one side against another
 - ♦ attendance of patients as the norm;
 - ♦ guaranteed and trained legal representation;
 - ♦ training of tribunal members;
 - ♦ a multi-disciplinary approach;
 - ♦ periodic review, even where the patient does not appeal;
 - ♦ a process that does not appear particularly intimidating; and
 - ♦ the considerable advantages in holding hearings in hospital.
60. Against this, organising the tribunals is clearly a considerable administrative effort, and the availability of medical members in particular appears to be a problem. Delays are a real problem as we have already noted.
61. Further possible disadvantages include:
 - ♦ medical reports can be out of date by the time of the hearing in long term detention cases because of delays in holding the hearing;
 - ♦ the basis of the panel's decision may not always be clear;
 - ♦ the medical member has a dual function as a member of the panel and as expert advising the panel before the hearing begins. This has been identified as a potential weakness of the system from the point of view of natural justice (since normally the judge in a case should be wholly independent from sources of evidence) and potentially in terms of ECHR obligations.

Proposed changes to English tribunals

62. The Richardson Committee recommended a number of changes to the tribunal system, as part of its review of English mental health legislation⁸¹.
63. It proposed that the administration of the service be transferred to the Lord Chancellor's Department, to emphasise its independence from the Department of Health. A national structure with a president was recommended, with greater resources, and a statutory responsibility to train tribunal members. There should be scope for an appeal on a point of law to the High Court

81 *Review of the Mental Health Act 1983: Report of the Expert Committee* (Department of Health 1999) 5.59-5.80

64. The Richardson Committee felt there was a need to retain access to medical and legal expertise, and also an independent perspective. The requirements for the lay member should be tightened, to provide that the lay member should have experience of mental health services outside hospital either as a professional, carer or user of services.
65. They had particular difficulties with the role of the medical member in the current framework. As already stated, the medical member both assesses the patient and is involved in making the decision. This was felt by the Committee to be untenable, since it means that the tribunal is making a decision partly on the basis of information which is not disclosed to, and therefore cannot be challenged by, the patient or patient's representative.
66. The option of retaining a medical member but having an independent report prepared by another psychiatrist was felt to be impractical on the grounds of the limited availability of psychiatrists. The Committee decided that allowing the medical member to be cross-examined would be unacceptable to many of these members, and would exacerbate problems in recruitment.
67. Richardson therefore proposed that there should be a tribunal without a psychiatric member, but with access to independent medical advice. This might either be a three person panel (a legal chair and two independent non-psychiatrist members) or a single person 'tribunal' with access to a panel of medical experts and also to a panel of independent experts in the provision of community services or risk assessment.
68. The Department of Health accepts the argument that the tribunal should not involve a medical member who assesses the patient⁸². It suggests that many cases under the new procedures will not be contested, and could often be heard by a single person, without requiring either a hearing or an independent medical opinion. It proposes an alternative model of a single person tribunal, with discretion to bring in additional members and to refer the case to a panel of medical or social care experts.
69. This suggestion has been criticised by the Council on Tribunals, in its special report on MHRTs. The Council believes that single-member tribunals and paper based hearings run contrary to principles of natural justice, and recommend a hearing in all cases before a three person tribunal, consisting ideally of a legally qualified Chairman, a consultant psychiatrist and a member with experience or knowledge of mental health services.
70. Tribunal members to whom we spoke were also concerned about the Department of Health proposals. They felt that the three-member composition helped to ensure a more rounded consideration of the case, and they valued the input of the medical member. Although conscious of the procedural issues concerning the dual role of the medical member, they did not feel that it created difficulties in practice.
71. The Council on Tribunals also expressed concern about the fact that the same body would have responsibility for imposing an order for compulsory treatment

82 *Reform of the Mental Health Act 1983: Proposals for Consultation* (Department of Health 1999), Chapter 4

and later reviewing the order. They agreed with the Richardson Committee that the composition of a tribunal hearing a later appeal should not be the same as that which made the initial order.

Consultation

Initial consultations

72. In our first Consultation, we asked what was the most appropriate forum for considering compulsory measures and hearing appeals in mental health matters.
73. The majority of respondents advocated the introduction of some form of tribunal. Various suggestions were put forward, ranging from an experienced sheriff chairing a tribunal to something similar to the children's hearings system. The most common model, however, was a trained, independent tribunal of experts (including legal and medical expertise, experts in social care, and lay people) that would provide an opportunity for reviews to be heard in a multidisciplinary forum. Amongst the bodies advocating a 'panel' or tribunal were the Law Society, the Royal College of Nursing, British Association of Social Workers (BASW), Association of Directors of Social Work (ADSW), Scottish Association for Mental Health (SAMH) and the Scottish Association of Law Centres.
74. The reasons for wishing a new tribunal included concern about the perceived formal and intimidating nature of mental health hearings, and a view that some sheriffs did not treat patients appropriately. It was stated that these concerns inhibited some people from exercising their legal rights. There was also a view that the sheriff court was linked in the minds of service users and relatives with criminal proceedings.
75. The Law Society and SAMH proposed a body which could play a wider role than the sheriff currently does in detention, taking on some of the responsibilities of the Mental Welfare Commission and hospital managers.
76. Other respondents, including the Royal College of Psychiatrists, supported the sheriff court, as having independence and authority, although several of those who favoured the sheriff nevertheless argued that more could be done in terms of training of sheriffs and making hearings more informal. Some suggested specially trained sheriffs, or giving the sheriff access to an independent assessor.
77. Many respondents to our consultation with users and carers felt that the sheriff court, as a venue, was not the appropriate place to hear appeals or consider detentions. Both service users and carers found it intimidating. Some felt the atmosphere of the court made mentally ill people 'feel like they are criminals'.

Proposals in second consultation

78. It was pointed out to us in oral evidence that the choice of appropriate forum depends, to a large degree, on the task that the forum is being asked to undertake.

As we have outlined in earlier chapters, we anticipate that the role of the forum in mental health hearings should change, from simply considering whether the statutory grounds for detention have been met, to a broader consideration of whether the particular compulsory powers being sought are appropriate, in the context of the principles of the Act and the plan of care put forward for the individual patient. Arguably, this shifts the balance away from a body with expertise mainly in the application of the law, to one with some expertise in issues of mental health care.

79. Our second Consultation again canvassed views on the forum, in the light of the suggestions that it play this broader role. Again, more respondents supported a tribunal than the retention of the sheriff, although health bodies and health professionals tended to be less in favour of tribunals than other respondents.

Responses in favour of a tribunal

80. Those in favour argued that a tribunal system would counter many of the difficulties associated with the sheriff court. The Law Society was of the view that there should be an accessible, independent forum to deal with reviews and appeals and that this could best be achieved through an independent tribunal system, situated in local areas, with membership drawn from legal and medical professions, social services and lay people. This specialist tribunal system would require joint training and involve a small number of chairpersons.
81. BASW added, in support of this model, that tribunals should not only consider the need for compulsory intervention but take a holistic view of the care and treatment plans in each individual case.
82. The Mental Welfare Commission was also a supporter of the tribunal option and proposed a panel of three, chaired by a legally qualified person and with the other two members drawn from relevant mental health professionals and lay persons. Competence to make judgements both about the appropriateness of detention and to scrutinise and approve plans of care would be more important than professional background. The Commission envisaged that it could advise on appointments and act as mentor to tribunal members to ensure competence and consistency of practice.
83. Others in favour of the tribunal included SAMH, The Scottish Users' Network (SUN) and ENABLE, for whom the perceived benefits of this model included: independence from clinical staff; the scope for the individual client / user to be more involved in the decision making process and the prospect of more effective and consistent decision making.

Responses in favour of the sheriff courts

84. A number of respondents supported the sheriff court as the preferred option, but suggested that some changes were required.

85. The Royal College of Psychiatrists (RCP) recommended that the sheriff court be retained but that a less formal hearing would be beneficial. Sheriffs should be able to access independent written and oral reports as required and it would be for the sheriff to determine whose advice to seek dependent on the circumstances of each case. The RCP considered that tribunals could be cumbersome and time consuming.
86. The BMA proposed that the sheriff alone should decide upon the legality of detention but should have expert advice on the care plan.
87. The State Hospitals Board regarded an enhanced sheriff court as the preferred forum and suggested that advisors to the sheriff should comprise a psychiatrist and / or an MHO. Tribunals were considered to be cumbersome and slow and likely to lead to inconsistencies.
88. The British Psychological Society was of the view that the sheriff court afforded independence, impartiality and availability and was therefore preferable to a tribunal. The use of independent expert advisors, with competencies in relevant areas, was regarded as an additional benefit.
89. The Faculty of Advocates put forward arguments to justify remaining with the sheriff as decision-maker. The reasoning was that the sheriff is independent, legally qualified, conversant with issues of natural justice and civil liberties and the sheriff court system complies more satisfactorily with ECHR expectations. In addition, it was argued, an infrastructure is already in place, which could be adapted to make its procedures less formal and more sensitive. Sheriffs have jurisdiction under the Adults with Incapacity Act and it would therefore be in the interests of consistency to retain their role in relation to the revised Mental Health Act.

Key features of an improved system

90. As these different views show, the precise model of forum which should be adopted is a difficult question. However, we are clear that the current system needs to be reformed. There are a number of particular features which we believe are central requirements of a reformed system.
91. The forum should be informal and not intimidating, but should be authoritative, and comply with rules of natural justice, and the European Convention on Human Rights. The body should have expertise in the law, and an understanding of the principles of the Act and of mental health care. Those making the decision should be appropriately trained in all of these matters.
92. The hearing should be governed by clear statutory rules of procedure, drawn up after consultation with service user and professional interests. These should be more comprehensive than the current rules. They should also be supplemented by guidance to the forum and participants on best practice.

93. The patient should normally be present, and should have a genuine opportunity to participate. There will of course be patients who do not wish to attend, or who are too ill to attend. However, we were struck by the fact that the English system regards attendance of patients as the norm, and we believe it is a desirable goal.
94. Carers and relatives who wish it should also have an opportunity to participate. We discuss in Chapter 16 the need for carers and relatives to have access to information regarding compulsory measures.
95. The patient should have automatic access to legal representation. We strongly believe that it is not enough that the patient should, as is currently the case in Scotland, have a right to obtain a lawyer. Most patients will not be in contact with solicitors, and it is expecting a great deal of them to find a solicitor while detained in a hospital. We understand that some hospitals and social work departments maintain lists of interested solicitors, but these are often ad hoc, sometimes out of date, and based on self-referral. We believe there should be, as is the case in England, a formal system for obtaining legal representation for patients from solicitors with accredited competence in mental health law.
96. In cases where the patient is not able to instruct legal representation, we believe a *curator ad litem* should always be appointed to represent the patient's interests.
97. Hearings should be held speedily. Hearings should be held in private, unless the patient objects to this. Translation and interpretation facilities should be available, wherever required (see Chapter 18).
98. Hearings should normally be held in a hospital or community based facility. There were differences in view, both amongst service users and others, about the appropriate venue, with some preferring the hospital as more convenient and less intimidating, while others felt the court setting emphasised the independence of the hearing. In our visits to English tribunals, we did not have the sense that the independence of the hearing appeared to be compromised by being in a hospital, and it appeared to be one factor in the much higher rate of patient attendance. We recognise however that, in some cases, particularly if the patient expresses a preference, it should be possible to hold the hearing in another more neutral venue.
99. There should be monitoring of standards across Scotland, in the arrangements for the hearings, and the procedures during hearings.
100. The forum should, in addition to the powers to approve or refuse applications for compulsory measures, and to consider appeals, have the power to call witnesses before it on issues relating to the care of the patient.
101. There should be a right of appeal by the patient, the MHO or RMO from the forum to the Court of Session on a point of law only. This appeal right, apart from being desirable from the point of view of the rights of the patient, may help in developing a body of case law which will assist in interpretation of the Act.

102. For restricted patients, the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 introduced an appeal right to the Court of Session on issues of both fact and law.
103. We considered whether the appeal rights for non-restricted patients should be the same as for restricted patients. However, we felt that to have appeals on issues of fact to the Court of Session in all cases could undermine the status of the forum, and would be inconsistent with the general approach taken in Scotland in relation to the sheriff court and tribunals. Conversely, given the greater element of public interest in cases concerning restricted patients, and the more limited number of cases, we saw no reason to remove the appeal rights which were created in 1999, and which were generally welcomed. We therefore propose that these should remain.
104. Where a restricted patient obtains a decision of the sheriff in favour of discharge, which is appealed by Scottish Ministers, the Court of Session may order that the patient continue to be detained, pending the determination of the appeal. We do not feel it is appropriate that the same provision should apply in respect of non-restricted patients. Should the forum order their discharge, this should take effect. In a case where a patient, subsequent to discharge, meets the criteria for compulsory measures, a new application can of course be made.

Recommendation 9.1

There should be a requirement that all members of the forum for mental health hearings receive ongoing training in mental health issues.

Recommendation 9.2

There should be statutory rules of procedure, drawn up after consultation with service user, carer and professional interests.

Recommendation 9.3

The rules of procedure and practical arrangements should encourage the attendance of patients.

Recommendation 9.4

There should be a procedure for straightforward access to free legal representation by solicitors accredited in mental health law.

Recommendation 9.5

A curator ad litem should be appointed in every case where the forum is satisfied that the patient is unable to instruct legal representation. The responsible medical officer should have a duty to advise the forum as to the ability of the patient to instruct representation.

Recommendation 9.6

Hearings should be in private, unless the patient or patient's representative requests otherwise, but doctors and other professional staff may be present as appropriate for training purposes.

Recommendation 9.7

Hearings should be in hospital, unless the patient or patient's representative requests otherwise. Health boards should have a statutory duty to provide suitable facilities for the holding of hearings.

Recommendation 9.8

The forum should have the right to compel the attendance of parties concerned with the care and treatment of the patient.

Recommendation 9.9

There should be a right of appeal to the Court of Session on a point of law. For restricted patients, the right of appeal should remain, as now, available on issues of both fact and law.

Proposals for a new tribunal

105. We considered a number of options, and concluded that there are two which are most likely to meet our criteria. One is to create a new specialist tribunal and the other is to retain the role of the sheriff, but with the support of expert assessors.

Mental health tribunal

106. A new mental health tribunal would be a three person body, consisting of a legal chair, together with a medical member and a member with professional and/or personal experience of mental health services. This three person tribunal would sit in all cases.

107. The legal member would be an experienced solicitor or advocate or perhaps an academic lawyer with appropriate expertise. In cases concerning restricted patients, it would be a requirement that a sheriff chair the hearing. (See Chapter 27)
108. The medical member would normally be a consultant psychiatrist or recently retired consultant psychiatrist. For some cases, particularly those involving people with learning disability, it might be desirable to allow for a chartered clinical psychologist to be the 'medical' member.
109. The third member could have a background in nursing or social work, or other relevant professions such as occupational therapy, or have personal experience as a carer or user of mental health services.
110. All members would require appropriate training in mental health and mental health law, which training should be regularly updated.
111. We have mentioned the criticisms of the practice in England and Wales of the medical member examining the patient prior to the hearing as well as being part of the decision making process. However, such an examination does have benefits. It means that the medical member (and, by extension, the tribunal) will have a degree of first hand knowledge of the patient, with which to evaluate the evidence presented. The main disadvantage would appear to be the possible incompatibility with the requirements of natural justice and ECHR of the procedure, at least as it currently operates in England and Wales. However, we believe that this issue could be resolved by arrangements in the procedural rules, perhaps providing that the findings of the medical member should be made available to the hearing, and the medical member could be questioned on these by the patient's representative.
112. Appointments to the pool of tribunal members would be made by the Minister for Justice, following public advertisement. As with other tribunals, the Council on Tribunals would have general oversight of the system.
113. It has not been possible for us to give detailed consideration to the organisational structure of a new tribunal system. We anticipate that the responsibility for establishing and funding the system would lie with the Scottish Executive Justice Department. We note that the Council on Tribunals have recommended that the English and Welsh Tribunal System should have a judicial head to provide leadership and direction, and that this proposal was endorsed by the Richardson Committee. We believe that there would be considerable benefits in having a senior judicial figure identified as the head of a Scottish tribunal system.

Sheriff with assessors

114. Should the sheriff court be retained as the forum, the sheriff would sit with two assessors. One of these would be a psychiatrist, and the other a person with personal or professional expertise in social care, applying the same criteria as for

the two non legal members of the tribunal. These assessors would be able to question witnesses during the hearing and would assist the sheriff in evaluating the care plan and other evidence led.

- 115. The medical assessor would examine the patient in advance of the hearing, and provide a report for the sheriff. This would be available in open court for comment by the patient or patient's representative.
- 116. All three members of the hearing would participate in the decision, with the written reasons for the decision being prepared by the sheriff. We considered an alternative option, that the sheriff take the decision alone, after being advised by the assessors. However, the point was made to us that there could be some difficulty in distinguishing and allocating the functions of the assessors in such a way that the process is demonstrably transparent, fair and impartial. If the responsibility for decision-making is to lie with the sheriff, there could be a perception that his or her decision was open to influence by private and untested advice from the assessors rather than on evidence tested in open hearing. As we have noted, the collegiate approach appears to be a valued part of the English system, including those cases where the president is a judge.
- 117. All three members should be present in all cases.
- 118. Although the assistance of assessors would lessen the need for the sheriff to have expertise in mental health issues, we nevertheless believe that a greater degree of training for sheriffs than is currently the norm would be essential. There would also be more advice and information available to sheriffs on best practice in relation to mental health hearings.

Discussion of options

- 119. The two proposed options are similar in many respects. Each would involve adjudication of hearings by a combination of experts in the law, medicine and social care. Whichever option is adopted, there will be many details to be resolved which the Committee has not had time to consider.
- 120. Should sheriffs be retained as the forum, there may be practical difficulties with our recommendation that hearings normally be held in hospital, although we understand that some sheriffs do already hold hearings in hospital in certain cases.
- 121. In relation to organising legal representation, the existence of the tribunal infrastructure in England and Wales seems to facilitate this. We are not sure whether sheriff clerks would be well placed to undertake this role, although they could no doubt do so, if suitably resourced.
- 122. We understand that it is relatively uncommon for there to be formal arrangements to monitor the consistency of approach of sheriffs in relation to a particular kind of hearing, in the way that could be done with a tribunal system through a central organisational structure, and the oversight of the Council on Tribunals.

123. A provision that sheriffs sit with assessors is unusual, although we understand that it is not totally unprecedented (for example in race relations cases). It remains to be seen whether sheriffs would feel comfortable with their role in leading a three person hearing.
124. Against these points, the creation of a new tribunal system would no doubt be more of an administrative undertaking than developing a system of sheriffs with assessors. In either case however it would take some time to establish the new system of hearings and have it in operation.
125. We are not in a position to provide financial estimates, but it may be that a new tribunal system would be more expensive to operate than retaining the sheriff court, even with the addition of specialist assessors.
126. We were particularly concerned by the delays in the English system. Such delays could not be countenanced where a hearing is required prior to the application of long term compulsory measures as would continue to be the case in Scotland, and as indeed it is now intended for England under the Department of Health proposals. However, it would not seem to be the case that tribunals are inherently liable to delay, but simply that adequate resources must be in place to deal with the workload, including proper administrative support. The practice occurring in England and Wales of tribunals taking place without a clerk would be unacceptable.
127. Based on the English experience, the biggest practical difficulty, in either of the options we have outlined, might be obtaining an adequate pool of psychiatrists to act as tribunal members or assessors. No doubt some use could be made of retired psychiatrists but there is of course a danger that, in time, they may lose touch with current clinical practice. We accept that this may present problems but we would re-emphasise our view that the input of experts, including medical experts, is fundamental to the role of the forum under our general scheme of reform.
128. We recognise that either of our proposed options represents a major change. It will be essential that the change be properly planned, and that arrangements for the new system be robust. Most importantly, the new system must be adequately funded, so that there would be no question of the problems which have occurred in England because of a lack of resources arising here.
129. On balance we favour the establishment of a specialist tribunal system. This seems to us to provide for appropriate expertise and authority, while providing a setting which allows for a full and open discussion of the best options for the patient. Our aims could no doubt be achieved in the Sheriff Court, but to a large degree by the Sheriff Court becoming more like a tribunal than a traditional court hearing. That being so, and given the criteria we have already described for the new forum, the most satisfactory conclusion is to adopt the specialist tribunal option.

Recommendation 9.10

The forum for mental health hearings should be a new mental health tribunal.

Recommendation 9.11

There should be a national structure for mental health tribunals, with a senior member of the judiciary at its head.

Recommendation 9.12

Mental health tribunals should be funded by the Scottish Executive Department of Justice.

Recommendation 9.13

Tribunal members should be appointed by the Minister for Justice.

Recommendation 9.14

Each tribunal should have three members: a legal chair, a medical member, and a member with professional and/or personal experience of mental health services.

Recommendation 9.15

The medical member should examine the patient prior to the hearing. Any findings should be given to the hearing, and the medical member should be able to be questioned by the parties or their representatives.

CHAPTER 10

TREATMENTS AND INTERVENTIONS REQUIRING PARTICULAR SAFEGUARDS

The current position

1. Although any treatment under compulsion is potentially controversial, some treatments create particular concern. The current Mental Health Act specifies additional safeguards in relation to a number of treatments for mental disorder.
2. Section 98 provides that certain forms of treatment can only be given to a detained patient if the patient has consented, or the treatment is approved by a doctor appointed by the Mental Welfare Commission. It states that this applies to the administration of medication for mental disorder to a detained patient, if three months have elapsed since the first period when medication was given while the patient was detained. The provisions also apply to ECT given at any time while the patient is subject to detention⁸³. However, it is possible to administer ECT to a detained patient in an emergency⁸⁴.
3. Section 97 imposes more stringent safeguards for treatments which raise particularly serious issues. It applies to any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue, where this is carried out as a treatment for mental disorder. (Such treatments are commonly referred to as psychosurgery or neurosurgery for mental disorder.) Regulations also apply this section to the surgical implantation of hormones to reduce male sex drive⁸⁵. Both such treatments are extremely rare. In 1998-9, the Mental Welfare Commission assessed seven people for psychosurgery, of whom two were detained. The Commission has no records of hormonal implants being carried out in recent years.
4. The treatments covered by s97 require both the consent of the patient, and the approval of a doctor authorised by the Mental Welfare Commission. In addition, two other people, not being doctors, also authorised by the Commission, must certify consent. In practice, the Commission maintains a pool of medical and non-medical Commissioners who provide the necessary three people for such assessments.
5. Section 47 of the Adults with Incapacity (Scotland) Act 2000 also makes provision for exceptional treatments. The general authority under the Act to treat adult patients who are unable to grant consent will not apply to these treatments, and regulations will set out the safeguards which should apply. We understand that the intention is that neurosurgery for mental disorder, ECT and sterilisation would be amongst the treatments which would be so specified, but that a final decision on the treatments and safeguards has been deferred, pending the report of this Committee.

83 Mental Health (Specified Treatments, Guardianship Duties etc.) (Scotland) Regulations 1984, (SI 1494)

84 1984 Act s102

85 Mental Health (Specified Treatments, Guardianship Duties etc.) (Scotland) Regulations 1984, (SI 1494)

6. There are also special non-statutory arrangements in place for patients who are not detained, in relation to psychosurgery. These followed the report of a working party in 1996⁸⁶. This recommended that the law in Scotland be changed, so that the protection set out in s97 be extended to informal patients, as is the case in England. In the meantime, it has been agreed with the only hospital in Scotland which carries out this procedure that all patients will be assessed by the Mental Welfare Commission under arrangements similar to s97.

What makes treatments 'special'?

7. It is difficult to define precisely what it is about certain treatments that means that they require particular safeguards. Two of the factors most frequently mentioned in evidence to us were treatments that were hazardous or irreversible. These are also the factors mentioned in s102 of the 1984 Act, as matters to be taken into account in weighing up which treatments may be given without consent where it is immediately necessary. We agree that both are important. However, neither is straightforward.
8. The risks of a particular treatment may vary from patient to patient. There are also different kinds of risk, and differences in the degree to which the level of risk is known. An established treatment may have a well-known possible side effect, while the risk in relation to a new treatment may be a less quantifiable risk of unforeseen consequences.
9. So far as irreversibility is concerned, this may relate to the intervention itself, or to potential side effects. The risks that a negative outcome may be irreversible may vary.
10. It is also apparent that these are not the only factors which concern service users. ECT is a treatment which remains controversial, but there is evidence that the risks attached to it are no greater than apply to some other treatments for mental disorder, which do not excite similar controversy.
11. We have concluded that it is impossible to devise a checklist which can be applied mechanistically to determine what treatments should be regarded as special. However, we do not wish simply to set out a list of treatments, without further justification. Such a list risks being arbitrary. It is also likely to become out of date quickly: both because new treatments have been introduced, and because the problems associated with current treatments may change as technology improves or new evidence emerges.
12. We therefore propose that the Act itself should specify certain treatments which are, and are likely to continue to remain, controversial or which raise particularly serious issues. It should also make provision for regulations to add to, or amend, the list of specified treatments. We discuss below ways in which the list might be kept up to date. We believe it would assist in this process if the Act were to set out the general factors which should be borne in mind when considering whether a treatment should attract special safeguards.

86 CRAG Working Group on Mental Illness *Neurosurgery for Mental Disorder* (Scottish Office 1996)

Recommendation 10.1

The Act should specify that the factors to be taken into account when considering whether a treatment for mental disorder should attract special safeguards should include the extent to which the treatment

- ♦ *may be hazardous*
- ♦ *may be irreversible*
- ♦ *is novel*
- ♦ *may involve significant physical distress*
- ♦ *may carry a high risk of serious side effects*
- ♦ *is perceived as controversial by society, or significant sections of society.*

13. Of course, it must be acknowledged that severe mental illness is itself both distressing and can be life threatening, and that many of the currently accepted treatments will have some of these attributes. We do not propose that a treatment should necessarily be treated as special, simply because it has one or more of the above attributes. They are general factors to be taken into account. In general, the safeguards which we propose have sought to balance the need for effective treatment with respect for the rights of patients.

The safeguards for special treatments

14. There are a number of possible safeguards which could be created, ranging from simply mentioning treatment in the Code of Practice, to requiring approval by a Court. In general, we feel that the current provisions of sections 97 and 98 remain broadly appropriate.

Recommendation 10.2

The Act should continue to distinguish broadly between

- ♦ *certain treatments which should require both the patient's consent and approval from an independent doctor and others representing a non medical opinion (the present s97); and*
- ♦ *treatments which should require either the patient's consent or a second medical opinion, (the present s98).*

15. Within that framework, we deal below with a number of particular treatments.

Treatments which should require consent and a second opinion (present s97)

Neurosurgery for mental disorder

16. Neurosurgery for mental disorder attracts concern, despite the rarity of the procedure. To some degree, this concern is caused by the association in the public mind with out of date procedures such as lobotomy. Current procedures are much more limited and carefully targeted. Furthermore, under the current arrangements, they are only carried out on individuals with extremely severe conditions, where all other options have been tried. Such patients are often totally incapacitated by their illness, and the procedure may be the only hope of them regaining some degree of normal functioning.
17. Nevertheless, we agree that any operation to destroy brain tissue, where this is not for treatment of a physical illness, requires stringent safeguards. We believe that the current provisions in s97 are appropriate and should be retained. We also believe that the same safeguards should be extended to informal patients by statute, rather than by the current voluntary arrangement.

Recommendation 10.3

The current procedures in ss 97 for neurosurgery for mental disorder should apply by specific provision in the Mental Health Act to all patients, whether or not subject to compulsion.

18. There is, however, the problem of patients who could not be treated under the s97 procedure because they are not capable of giving consent. We strongly believe that no-one should have psychosurgery imposed on them against their will. However, it is the case that some people may be so affected by their illness that, although not objecting to the treatment, their ability to give a fully valid consent is compromised. Unless some special arrangement is made, such patients could never be treated by this means, even if it were their last hope of recovery.
19. We do not think it would be wise to make provision which could prevent such people from ever receiving this treatment. On the other hand, the concerns which arise in relation to undertaking such a treatment on a patient without consent are such that we believe that additional safeguards are required, for the very rare case which might arise.

Recommendation 10.4

It should only be possible to carry out neurosurgery for mental disorder on a patient who is not capable of consenting to the treatment if

- (a) *the patient does not oppose the treatment being carried out, and*
- (b) *the treatment has been approved by the Court of Session.*

20. We note that the Report of the Working Party on Neurosurgery made a number of recommendations concerning good practice. These include the carrying out of a prospective evaluation of the effectiveness of the procedure, and the establishment of a Standing Advisory Committee. So far as we can ascertain, these have not been fully implemented. This is an undesirable state of affairs.

Recommendation 10.5

The Scottish Executive should implement the outstanding recommendations of the Central Research Audit Group (CRAG) Working Group on neurosurgery for mental disorder. These recommendations should be incorporated in the Code of Practice.

Surgical implantation of hormones to reduce male sex drive

21. Currently, the surgical implantation of hormones to reduce male sex drive is designated as a special treatment under s97 by regulations. However, it would appear that the procedure is now obsolete. Where clinicians believe that reduction of sexual drive is clinically appropriate, they would use oral medication, which we discuss below.
22. On that basis, we feel the surgical procedure should be removed from the regulations governing procedures requiring special additional safeguards.

Recommendation 10.6

The provision in current regulations governing approval of surgical implantation of hormones to reduce male sexual drive should be removed, on the basis that the procedure is obsolete.

23. We do not propose that any new treatments should be added at present to the list of treatments which attract particularly stringent safeguards under s97. We go on to discuss treatments which should attract safeguards currently provided for in s98.

Treatments which should require consent or a second opinion (present s98)

Medication to reduce sex drive

24. As we state above, clinicians do on occasion feel it appropriate to reduce male sexual drive by means of oral medication. The most common drug for this purpose is Cyproterone acetate ('Androcur'). The Mental Welfare Commission considered this treatment in its 1991 Annual Report, and concluded that it was indeed not covered by s97, although in some circumstances the more limited safeguards of s98 might apply.

25. We believe that the safeguards for such medication need not be quite as stringent as were provided for hormonal implantation. The procedure is more easily reversed, and cannot be forcibly imposed on an unwilling patient. However, administering drugs with the specific intention of reducing sexual drive is a step with considerable implications for human rights. We heard anecdotal evidence of its use with people with learning disabilities, and the current position provides few safeguards against misuse. We therefore believe that an independent second opinion should be obtained in all cases where the patient has not given consent, before such treatment is administered.

Recommendation 10.7

The administration of oral medication to reduce sexual drive should be specified as a special treatment by specific provision in the Mental Health Act requiring either consent or a second opinion as in the present s98, and in the case where a second opinion is required, treatment should begin only after that has been obtained.

Electro-convulsive therapy

26. As we have already mentioned, ECT is controversial. Most Scottish psychiatrists regard it as a safe, effective and well-evidenced treatment in appropriate cases, for example severe depression, and much research supports this. Many service users report considerable benefits while others regard it as an almost uniquely invasive and distressing intervention.
27. We are satisfied that the degree of concern felt by many service users regarding ECT is such that it should continue to attract special safeguards when carried out on patients subject to compulsion, by specific provision in the Act.
28. We also considered whether it should ever be possible to give ECT to a patient who, at the time the treatment is offered, is competent to consent to it but refuses consent. A large number of those who responded to our consultations felt that it should not be permitted. In view of this, and despite the evidence we have already noted that the risks attached to ECT are no greater than those applying to some other treatments for mental disorder which do not provoke similarly strong feelings, we feel it is appropriate to provide that any patient who is capable of making a treatment decision at the time the treatment is being offered should be entitled to refuse ECT.

Recommendation 10.8

ECT should be specified as a special treatment by specific provision in the Mental Health Act. This should normally be authorised by consent or a second opinion, as under the present s98, but it should not be lawful to administer ECT to a patient who is refusing the treatment, and who is competent to make such a decision.

Long term medication

29. The evidence we received suggested that there was general support for the current arrangements, that any medication for mental disorder given for over three months to a detained patient should be a special treatment. There was however considerable support for the suggestion that this could be shortened, perhaps to two months. We can see no objection in principle to this, and it would significantly shorten the time during which a person could be receiving treatment on a compulsory basis with no independent oversight. The main practical consideration would be if it would greatly increase the number of cases for consideration by approved second opinion doctors. However, information received from the Mental Welfare Commission suggested that the amount of additional second opinions which would be involved would not be unmanageable.
30. We also feel that the current definition of the time period after which consent or a second opinion should be obtained is unnecessarily complex. It would be simpler if the 'clock' started to run from the date of compulsory measures being imposed, given that treatment will almost always be commenced then or shortly afterwards.

Recommendation 10.9

The administration of medication for mental disorder after the expiry of two months from the date of the imposition of compulsory measures should be specified as a special treatment in the Mental Health Act, requiring consent or a second opinion as in the present s98.

Forcible feeding

31. The issue of forcible feeding of patients with, for example, eating disorders is controversial. There has been some doubt about whether it constituted treatment under the Act at all, since Part X of the Act covers only treatment for mental disorder, not physical treatments. Case law in England⁸⁷ has established that forcible feeding can be considered treatment for a mental disorder, and so can be carried out on patients under mental health law.
32. We accept that this may be appropriate in some situations, although of course there will be difficult judgements as to whether physically forcing a person to accept food is clinically appropriate and likely to be effective. The intrusive nature of the treatment is such that it should attract special safeguards.
33. These safeguards should not apply to steps taken to encourage or persuade a patient to take nourishment, but should apply where a patient is compelled to eat or is given nutrition against his or her will by artificial means. In these latter circumstances, the question of consent cannot of course arise, but there should be a requirement for a second opinion.

⁸⁷ see *South West Hertfordshire Health Authority v KB* [1994] 2 F.C.R.1051 and *B v Croydon Health Authority*, *The Times*, December 1, 1994

Recommendation 10.10

Forcible feeding should be specified as a special treatment in the Mental Health Act, requiring a second opinion, consent not having been obtained.

Medication outwith the normal range

34. There are established dosages for the various types of psychotropic medication. In the great majority of cases, drugs will be administered within this range, but there are occasionally situations where a higher dose is felt to be necessary or where a high dose of a particular class of drug is achieved through the use of more than one individual drug (polypharmacy). This was identified as an issue of concern, including by the Royal College of Psychiatrists. In some cases, drugs may also be used for a purpose other than their normal recommended purpose, as specified in the product licence. We feel that additional protection is appropriate for such cases.

Recommendation 10.11

The administration of dosages of medication for mental disorder should be specified in regulations as a special treatment requiring consent or a second opinion where they

- ♦ *are above the maximum levels specified in the British National Formulary, or*
- ♦ *involve the administration of more than one neuroleptic drug in dosages which, when expressed as percentages of the maximum recommended dose, add up together to more than 100%, or*
- ♦ *are used for a purpose other than the normal recommended purpose.*

Behavioural and other psychotherapeutic interventions

35. We heard evidence of concern about a range of behavioural and other psychotherapeutic treatments. It was suggested that explorative psychotherapy could sometimes be very distressing, particularly if the patient was not clear about the implications of the exchanges with the professional.
36. For people with learning disability in particular, there are a range of behavioural techniques which are used. We were advised that the cruder forms of 'behavioural modification', involving sanctions for non compliance, were no longer widely practised. Nevertheless, we believe that safeguards may well be appropriate for particular approaches and techniques.
37. We do not believe it would be practical to spell these out in the Act itself, since it would be difficult adequately to define the particular interventions, but we feel that

it would be appropriate to review these treatments, to consider whether any should be specified in regulations.

Recommendation 10.12

Consideration should be given as to whether regulations should specify particular types of behavioural and other psychotherapeutic intervention as special treatments requiring consent or a second opinion.

Restraint

38. Some consultees suggested that safeguards were needed in relation to restraint. We agree. However, we feel that restraint falls into a different category, since it is not a treatment, but a response to the behaviour of the patient. We deal with this in Chapter 12.

Adding to the list of special treatments

39. Since the regulations immediately following the 1984 Act were passed, there have been no additions to the list of special treatments. We are concerned to ensure that new treatments which may arise are evaluated in accordance with the criteria which we specify above. We suggest that this responsibility be vested in the Mental Welfare Commission. The Commission would also be well placed to consider whether there are other current procedures, which should be added by regulation to the list of special treatments.

Recommendation 10.13

The Mental Welfare Commission should have a statutory responsibility to consider from time to time whether there are treatments which should be added to the list of special treatments under the Act, and to advise Scottish Ministers accordingly.

The nature of the second opinion

40. The role of the second opinion doctor is to specify whether, having regard to the likelihood of the treatment alleviating or preventing a deterioration in the patient's condition, the treatment should be given⁸⁸. The Act does not specifically require the doctor to consider whether the treatment is the best treatment for the patient, or whether other alternatives might be more acceptable to the patient.
41. It would seem that the term 'second opinion' may be something of a misnomer, to the extent that it implies a doctor coming up with a wholly independent diagnosis and treatment plan. Instead, the second opinion doctor in this context may be

88 1984 Act s98(3)(b)

more concerned to be satisfied that the treatment which is proposed is within the acceptable range of treatment options for the patient. It is also the case that the approval by the second doctor tends to be of a fairly general nature, for example consent to any anti-depressant specified in a particular part of the British National Formulary, within the prescribed therapeutic dose.

42. There is clearly a tension between providing a thorough and independent check, and avoiding the second doctor dictating treatment to the doctor who carries responsibility for the patient. We believe that the role of the second opinion doctor should be more clearly linked to the principles of the Act, such as that of the least restrictive intervention. It would be helpful for the Code of Practice to set out in some detail the responsibilities of the second opinion doctor, and for these to be followed up in training of all approved second opinion doctors.

Recommendation 10.14

The second opinion doctor should be required to consider whether the proposed treatment is appropriate, bearing in mind the principles of the Act, and any possible alternative treatment approaches.

Recommendation 10.15

The Code of Practice should set out the responsibilities of the second opinion doctor, and all approved second opinion doctors should receive training in these.

The duration of the second opinion

43. The 1984 Act does not specify any particular time limit, after which a second opinion must be renewed. In theory, a second opinion could operate to authorise treatment for many years. The Mental Welfare Commission has recommended that, for patients who refuse consent, a second opinion should be renewed every 3 years⁸⁹, although this does not apply to cases where the patient is simply unable to give consent.
44. We believe that such a safeguard should be reviewed regularly and that 2 years would be a more appropriate time limit.

Recommendation 10.16

A second opinion should be renewed at least every two years.

⁸⁹ Mental Welfare Commission Annual Report 1994-5, page 65

Role of the tribunal

45. In approving a plan of care involving special treatments, the tribunal should be entitled to satisfy itself that the necessary safeguards have been or will be followed, but not to add additional safeguards.

Recommendation 10.17

Before approving long term compulsion based on a plan of care involving the use of special treatments, a mental health tribunal should be entitled to be satisfied that the statutory safeguards for such treatments have been or will be followed, but should not impose additional special requirements in relation to such treatments.

Urgent treatment

46. We accept that provision requires to be made for urgent treatment to which the safeguards currently in sections 97 and 98 cannot apply because of time constraints, but which should attract other conditions and safeguards. We propose that the arrangements should remain as set out in s102 of the 1984 Act. We note that the Mental Welfare Commission has expressed concern that the requirement to report to it cases of treatment being given under s102 may not always be implemented.

Recommendation 10.18

Provisions similar to those of s102 should continue to apply to urgent treatments administered to patients subject to compulsion.

Recommendation 10.19

The Code of Practice should highlight the importance of the requirement to notify the Mental Welfare Commission of urgent treatments administered to patients subject to compulsion.

Children and young people

47. Under the terms of the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995, it is possible for a person with parental rights and responsibilities to consent to medical treatment on behalf of a child aged under 16, if the child is not capable of understanding the nature and possible consequences of the treatment. This applies to treatment for mental disorder, as

it does for other treatment, but would not apply where a child is treated compulsorily under mental health law. We recommend in Chapter 18 that the Code of Practice should give guidance on when it would be appropriate to rely on parental consent for treatment of a child for mental disorder, and when the Mental Health Act should be used.

48. In relation to special treatments, the safeguards in the Mental Health Act are not replicated in children's legislation. This means that a parent may be able to consent on behalf of a child to treatment such as ECT or long term anti-psychotic medication, without a second opinion being obtained.
49. We believe that this places parents in a difficult position, and potentially undermines the safeguards of the Mental Health Act in relation to children. We therefore believe that the legislation should provide the same protection in relation to special treatments for children unable to consent to treatment as would apply to children subject to compulsion under the Act.
50. Where a child has the necessary maturity and understanding competently to consent to (and refuse) treatment, we believe that the current position should be maintained, that such a child is legally in the same position as a competent adult. The effect of this is that such a child could not be treated for mental disorder against his or her will without the use of the Mental Health Act, and would be entitled to refuse ECT while legally competent.

Recommendation 10.20

The same safeguards in relation to special treatments should apply to children who are incapable of consenting to treatment on their own behalf as would apply to children subject to compulsion under the Mental Health Act.

51. So far as treatment without consent is concerned we received evidence that further safeguards were desirable for children and young people. This is, of course, an extremely vulnerable group. Also, the issues of diagnosis and treatment are particularly complex. There may be additional risks to certain treatments, associated with the fact that a child's physical and mental development is not complete.
52. We therefore believe that special treatments should only be lawfully administered without consent to this group where they have been approved by two specialists in child and adolescent psychiatry. This is similar to the guidance in the Clinical Resource Audit Group good practice statement on ECT⁹⁰. The two approvals could be by the responsible medical officer (RMO) and the approved second opinion doctor. Where the RMO is not such a specialist, we believe two further opinions should be obtained.
53. In relation to neurosurgery for mental disorder, the CRAG working group on that issue considered that it should never be carried out on a patient aged under 20.

⁹⁰ ECT: A Good Practice Statement, CRAG Working Group on Mental Illness (Scottish Office 1997), chapter 7

We agree that this should almost never be considered, although we do not believe that it would be desirable for the Act to rule it out altogether. It should however be mentioned in the Code of Practice.

Recommendation 10.21

The second opinion for any treatment which is a special treatment in terms of the Act which is to be administered to a person aged 18 or under, should be given by a specialist in child and adolescent psychiatry. Where the responsible medical officer in relation to any such treatment is not a specialist in child and adolescent psychiatry, a further opinion by such a specialist should be obtained.

Recommendation 10.22

The Code of Practice should emphasise that neurosurgery for mental disorder should not normally be considered for patients aged under 20.

CHAPTER 11

OTHER PROVISIONS RELATING TO PATIENTS SUBJECT TO COMPULSION

Introduction

1. We deal in this chapter with a number of other provisions which affect patients subject to compulsion, namely transfer of patients within Scotland, communication, patients absent without leave, searches and sharing information.

Transfer of Patients within Scotland

2. Section 29 of the 1984 Act contains provisions regarding the transfer of detained patients within Scotland. It provides that patients can be transferred by the managers of a hospital to another hospital, provided the managers of the other hospital consent. Transfers must be intimated by the receiving hospital to the Mental Welfare Commission and the nearest relative within seven days of the transfer having taken place.
3. Currently, s29 allows patients to be transferred from detention to the guardianship of a local authority or a person approved by a local authority. However, that provision will be repealed when the relevant provisions of the Adults with Incapacity (Scotland) Act 2000 take effect.
4. The effect of a transfer is that the hospital to which the patient is transferred is treated as the hospital named on the original detention. The duration of the detention, and time limits for appeals, do not change.
5. It is clearly desirable that there be simple and flexible arrangements to allow patients subject to compulsion to move between hospitals. In many cases, the reasons for a transfer are likely to be because the patient wishes to be nearer family or other local connections, or because the services at the receiving hospital are more appropriate for the patient's needs. However, pressures on services can lead to transfers which are not primarily in response to the patient's wishes or clinical need. We therefore feel that safeguards are necessary.
6. As the Act stands, the patient has no appeal against a transfer. There is an exception for transfers to the State Hospital, which we deal with in Chapter 27. Indeed, the Act does not currently require the patient to be given notice of the transfer before it takes place, or to be advised of the implications of the transfer after it happens. So far as the nearest relative is concerned, there is no right to prior consultation. Information is given after the event, by which time any representations the relative wishes to make may have little effect.

7. We believe that patients should have a formal right to be consulted prior to any such transfer. Ideally, such consultation should allow the patient sufficient time to consider the implications of the transfer, seek advice or make representations. However, we recognise that a minimum period of consultation, if rigidly applied, may delay transfers which the patient would strongly wish to happen, and which are very much in his or her interest.
8. We propose that the normal provision for patients subject to long term compulsion should be that the patient should be given at least seven days notice of an impending transfer. The information which is passed to the Mental Welfare Commission should confirm that this has been done, or indicate the reasons why such notice was not given.
9. We have also considered transfers during emergency and short term detention, and we understand that the Mental Welfare Commission is concerned about the detrimental effect such transfers can have on a patient's welfare. We believe that this is an important issue for operational management in providing acceptable standards of care, but it is not a matter for the legislation. However it could well be a matter for monitoring by the Scottish Health Advisory Service.
10. In Chapter 16, we recommend that the 'nearest relative' in the Act be replaced by a 'named person'. The named person should also be entitled, in normal circumstances, to at least seven days prior notice of a transfer, and the information passed to the Mental Welfare Commission should confirm that this was done, or why it was not done.
11. We also propose in Chapter 16 that, in those cases where the named person is not also the primary carer, the primary carer should have a right to certain information, in order to carry out the caring role. A transfer is obviously a significant change in the circumstances of the service user. Provided the user does not object, the primary carer should be entitled to the same notice as the named person of the impending transfer. The Code of Practice should specify circumstances where it may be appropriate to notify the primary carer of the transfer, notwithstanding any objections by the service user.
12. We would expect that in most cases of long term compulsion the mental health officer (MHO) should be involved in discussion covering the transfer. This may also be a matter which could be dealt with in the Code of Practice.
13. We considered whether patients should have a formal right to request a transfer, but concluded that it was not necessary to spell this out in legislation. However, we believe that the Code of Practice should emphasise the need to treat such requests with sensitivity and respect.
14. We are attracted by the idea that there should be a right of appeal against a transfer. We would hope that this would only rarely be used, since most transfers should be in the interests of the patient. However, where this is disputed, the transfer is such a significant change to the plan of care that, in our view, the

tribunal should have an opportunity to consider it. The right of appeal would not apply in cases of short-term detention, since the tribunal would be required to approve any continuation of detention within a reasonably short period in any case. There may also be cases where the transfer is anticipated at the time the tribunal authorises long term compulsory measures, or considers an appeal against them. In such cases, it may be appropriate for the tribunal to approve the subsequent transfer as part of its consideration of the plan of care.

Recommendation 11.1

There should continue to be provisions to allow patients subject to compulsion to be transferred between hospitals, by agreement between the managers of the respective hospitals.

Recommendation 11.2

There should be a requirement to notify a patient subject to long term compulsion and the named person of an impending transfer. Wherever practicable, the notice should be at least seven days in advance.

Recommendation 11.3

Unless the patient objects, the primary carer (if not also the named person) should also be entitled to notice. The Code of Practice should set out circumstances where the primary carer should be given notice, notwithstanding objections by the patient.

Recommendation 11.4

Details of the transfer should be provided to the Mental Welfare Commission within seven days of it taking place. This should include confirmation that at least seven days prior notice had been given to the patient, the named person and, where appropriate, the primary carer; or a note of the reasons why such notice was not practicable.

Recommendation 11.5

Where a patient is subject to long term compulsion, the patient and the named person should have the right to appeal to a mental health tribunal against a transfer. The appeal should be initiated within 28 days. This right should not apply in cases where the transfer has already been considered and approved by a mental health tribunal as part of its consideration of the patient's plan of care.

Recommendation 11.6

The Code of Practice should contain guidance on responding to requests by patients for transfer.

Recommendation 11.7

The Scottish Health Advisory Service should consider monitoring the extent to which patients subject to emergency and short term detention are transferred for non clinical reasons.

Communications With and By Patients**Written communications**

15. Sections 115 and 116 of the 1984 Act contain provisions regarding the correspondence of patients. Mail from any detained patient may be withheld if the person to whom the communication is addressed has so requested it.
16. There is an additional provision in relation to detained patients in the State Hospital. Any postal packet sent by such a patient may be withheld if the managers of the hospital consider that it is likely to cause distress to the person to whom it is addressed or any other person (other than a member of the staff of the Hospital), or to cause danger to any person.
17. Incoming mail to a detained patient can be withheld only in the State Hospital. This can only be done if, in the opinion of the managers of the hospital, it is necessary to do so in the interests of the safety of the patient or for the protection of other persons.
18. There is a list of exceptions to the State Hospital's powers, which preclude interference with correspondence between a detained patient and MPs, the Mental Welfare Commission, various ombudsmen, the judiciary, health boards and trusts, local authorities, legal advisers and the European Court of Human Rights.
19. The State Hospital, we understand, has a policy with regard to incoming and outgoing mail. If the clinical team consider it necessary, a patient's mail is checked and all incoming mail is passed through an X-ray machine. All parcels are opened in the presence of nursing staff. All mail considered inappropriate is dealt with in accordance with s115 of the Act.
20. Any decision by a hospital to withhold a postal packet must be notified, within 7 days, to the Mental Welfare Commission, giving details and the reasons for withholding the packet.

21. Under Section 116, the patient or the sender of a postal packet to the patient may ask the Mental Welfare Commission to review the decision to withhold the postal packet or its contents. The Commission has the power to direct that the postal packet or its contents shall not be withheld. This power does not apply where the intended recipient of the correspondence from the patient has requested that it be withheld.
22. The Mental Welfare Commission made some observations regarding this issue in its Annual Report for 1995/96. The Commission stated that it rarely receives reports from “open” hospitals of mail being withheld, but that it is a reasonably regular occurrence for the State Hospital to notify the Commission of the use of these powers. Some concern was expressed by the Commission that, in circumstances where mail is withheld, the Commission is not given sufficient detail as to the justifications for withholding the correspondence. We understand that the Commission continues to have these concerns.
23. The European Convention on Human Rights contains protection for individual's correspondence. Article 8 states that everyone has a right to respect for his private and family life, his home and his correspondence. It goes on to state that:

“there shall be no interference by a public authority with the exercise of this right, except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”.
24. The Committee is not in a position to give an authoritative interpretation of Article 8, as it affects Sections 115 and 116 of the 1984 Act. This is a matter which the Scottish Executive will need to consider, though it would appear to us that the purposes for which correspondence may be withheld under these Sections are capable of coming within the provisions of Article 8.
25. The Committee was not made aware of any major difficulties with the operation of these Sections. We believe that the list of persons and bodies, correspondence with whom is protected, should be widened to include recognised advocacy groups, and to specifically include Members of the Scottish Parliament and European Parliament. Other than this the main problem with this part of the Act would appear to be that it has not kept pace with the development of other forms of written communication, including fax and E-mail.
26. The issue of access to the internet was a significant feature of the Report of the Committee of Inquiry into the Personality Disorder Unit at Ashworth Special Hospital⁹¹. The Inquiry recommended that patients at that Hospital should not be allowed to have ‘mobile telephones, personal organisers, palmtop computers, hand helds, laptop computers and pagers’ (Recommendation 35). The Report also recommended that patients should only be allowed adapted computers connected to a patients’ server in their rooms (Recommendation 33).

⁹¹ *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*, Volume 1 1999, Cmnd. 4194-II

27. At the State hospital, all patient computers are 'stand alone'. There are no modems in ward areas, and electronic games and discs are screened prior to use by patients.
28. We agree that such restrictions may be appropriate in a secure hospital. In order to regulate the use of these restrictions, they should have a proper legislative base.
29. We also believe that legislation should clarify the extent to which patients in other hospitals should have access to electronic mail and the internet. In our view, the Act should provide that restrictions should only be allowed where it can be demonstrated that it is necessary to restrict access to such media in the interests of the health or safety of the patient or for the protection of other persons from harm or distress.
30. Such a decision to restrict access should, in all cases, be subject to review. We propose that this review should be by the Mental Welfare Commission, which should have the power to direct that a patient be allowed to use such equipment.
31. The same provisions should apply in relation to other forms of written communication, such as faxes, and it should be possible to extend the powers to other forms of electronic communication which may emerge.

Recommendation 11.8

Withholding of the correspondence of patients should continue to be dealt with on a similar basis to that outlined in s115 of the 1984 Act, with the safeguards currently in s116.

Recommendation 11.9

The restrictions on the powers of the State Hospital to withhold correspondence should be extended to correspondence with recognised advocacy groups, MSPs and MEPs.

Recommendation 11.10

Similar provisions should apply to the transmission of written communications by other means, including electronic mail and faxes.

Recommendation 11.11

Legislation should regulate the extent to which detained patients should have a right of access to mobile telephones, the internet, and other forms of electronic communication. It should only be possible to restrict access where it can be demonstrated that this is in the interests of the health or safety of the patient or for the protection of other persons from harm or distress. The patient should have the right to have any such restriction of access reviewed by the Mental Welfare Commission, who should be entitled to require that access be given.

Recommendation 11.12

The State Hospital should have the right to restrict access to mobile telephones, the internet and other forms of electronic communication, in accordance with directions by Ministers. A patient should have a right to appeal to the Mental Welfare Commission.

Telephone calls

32. Although the Act is silent about telephone communication, we understand that restrictions are sometimes imposed on patients, particularly in the State Hospital. We are advised that the State Hospital has a telephone policy, with clear guidelines. There is a dedicated telephone for patient use on each ward, which is controlled and monitored by ward based staff. Patients are only allowed to call telephone numbers on a list which has been approved by the clinical team, and all calls are monitored by nursing staff, except those accepted as appropriate by the clinical team.
33. This is broadly consistent with the recommendations of the Ashworth inquiry. Recommendation 34 stated that

‘Patients’ access to telephones should be limited to telephone numbers on the list of patient’s approved numbers. All telephone calls by patients should be carefully monitored, except privileged calls, such as those to legal advisers, in which cases the number should be dialled by a member of staff who, having done so, should retire out of earshot, but maintain observation to ensure no other number is dialled.’
34. There is provision in relation to high security hospitals in the Regulation of Investigatory Powers Act 2000. Under s4, interception of telecommunications in the State Hospital is lawful if in accordance with directions by Scottish Ministers to the State Hospitals Board. The Act received the Royal Assent on 28 July 2000. We understand that directions have not yet been made.
35. We fully appreciate why it may often be necessary for the State Hospital to monitor telephone calls, and to control access to telephones. However we are concerned

that 'blanket' policies could be unfair to individual patients, and possibly in breach of Article 8 of the European Convention. We believe that the directions by the Executive should ensure that such policies are applied with due regard to individual circumstances, and contain procedures for independent review by the Mental Welfare Commission.

36. Neither the 1984 Act nor the Regulation of Investigatory Powers Act makes reference to interference with telephone calls in other hospitals, including the proposed medium secure units. Although we have heard little evidence on the matter, we can anticipate circumstances where it would be appropriate either to restrict access to a telephone, or monitor calls made, by a patient in a regional secure unit, or even an ordinary psychiatric hospital. We believe that this should be regulated by statute, on a broadly similar basis to written communications.
37. However, on our visits, it was also pointed out that some people had no effective access to telephone communications for much more pragmatic reasons. There may be circumstances where a detained patient has no funds to make calls, for example if detained when without money on his or her person. Even where patients have money, we were told by patients' groups of phones which were regularly out of order, thus denying patients any direct communication with the outside world. In our view, this is unacceptable.

Recommendation 11.13

All detained patients should have a legal right to obtain access to a telephone.

Recommendation 11.14

Directions by Ministers to the State Hospital, under s4(6) of the Regulation of Investigatory Powers Act 2000, should

- ♦ *take account of the recommendations of the Inquiry into Ashworth Special Hospital*
- ♦ *provide that decisions regarding the monitoring of telephone calls or control of access to telephone calls should take account of individual circumstances*
- ♦ *provide for review by the Mental Welfare Commission of decisions to monitor telephone calls or restrict access to a telephone.*

Recommendation 11.15

Hospitals other than the State Hospital should only be entitled to restrict use of a telephone, or monitor calls, of a detained patient where

- ♦ *this is necessary to protect other persons from harm or distress, or*
- ♦ *the recipient of the calls has requested that such calls should be restricted, or*
- ♦ *making the calls would be in breach of a court order, or*
- ♦ *this is necessary to prevent nuisance calls, or*
- ♦ *to do so is necessary in the interests of the health, safety or welfare of the patient*

Any such restriction or monitoring in respect of an individual patient should be reported to the Mental Welfare Commission who should have the power to require that the decision be changed.

Recommendation 11.16

It should not be lawful to restrict or monitor telephone calls to or from the parties to whom correspondence from a detained patient cannot be withheld, except where the recipient has requested that any such calls be monitored or prevented, or such calls are unlawful under any other provision.

Patients who are absent without leave

38. Under s28 of the 1984 Act, patients who are absent without leave can be returned to hospital by a mental health officer (MHO), staff of the hospital and others authorised in writing by the hospital, or a police officer. Patients can also be returned to the place where they are required to stay under leave of absence provisions. The power to take a patient detained under s18 into custody lasts for up to 6 months, or the expiry of the period of detention, whichever is longer. If a patient who has been absent without leave is returned or taken into custody within a week of the end of his or her detention, the detention can be extended for up to a week to allow a decision to be made as to whether detention should be renewed⁹². If a patient is returned after more than 28 days absence, an examination must take place to determine whether the patient still meets the criteria for detention⁹³.
39. Sections 120 and 121 make provision for patients being conveyed to the place of detention to be in legal custody, and for patients who escape from custody to be retaken into custody.
40. In 1995, the period during which a patient who is absent without leave could be taken into custody was extended from 28 days to 6 months. We accept that this

92 1984 Act, s31
93° 1984 Act, s31B

is appropriate for patients detained by order of a criminal court. However, it was pointed out by a users' organisation that this could in some circumstances prove counter productive. The threat of being taken into custody and redetained, lasting for as long a period as 6 months, could discourage a patient absent without leave from re-engaging with services.

41. We received no direct evidence as to how far this was a problem in practice, and we are aware of different views. On balance, we feel that for civil patients there is a case for a compromise between the original period of 28 days and the current provision of 6 months.
42. Section 108 of the Act makes it an offence to induce or knowingly assist a detained person to absent himself without leave or to escape from custody. It is also an offence to knowingly 'harbour' a patient who is absent without leave. It would appear that these provisions are very rarely, if ever, used. We believe they should be retained as they may occasionally provide a useful deterrent against persons whose actions may place a detained patient at risk. However, we recognise that there may well be situations where a friend or relative may take in or help a person who is absent without leave, out of genuine concern for their welfare. Refusal to do so might place the person at greater risk. We would not wish the law to be used to punish people who act in this way.

Recommendation 11.17

The Act should contain provisions regarding patients absent without leave similar to those contained in sections 28, 31, 31A, 31B, 120 and 121 of the 1984 Act.

Recommendation 11.18

For patients detained under civil procedure, the period of absence during which the patient may be taken into custody and returned to hospital should be reduced to three months.

Recommendation 11.19

There should continue to be an offence of assisting or inducing a detained patient to be absent without leave, similar to s108 of the 1984 Act.

Searches

43. It may sometimes be necessary to search a patient's belongings, particularly in forensic settings. This may not only be necessary for physical security, but also to prevent access to illicit drugs. At the moment, the Act contains no specific framework for this.

44. In relation to secure hospitals, the matter was considered in England, in the case of *R v Broadmoor Hospital Authority and others, ex parte S and others*⁹⁴. Three patients objected to a policy of random searching. Mr Justice Potts concluded that since 'detain' means 'keep in confinement' a general power to search patients in order to prevent escape from detention must be implicit. A general power to search patients must necessarily be implied as part of the duty to create and maintain a safe and therapeutic environment. The legal issue was whether the exercise of that power was reasonable, under the general principles of reasonableness applicable in judicial review cases. On appeal, his view that there is a general power of search was upheld.
45. It would seem that this principle could apply to all detained patients, not only those in secure hospitals. However, the reasonableness of such searches will depend on the particular circumstances.
46. If this is also the legal position in Scotland, it may not be necessary for the Act to make specific provision in relation to searches. However, we feel that it is important that the rights of patients are clear in relation to this. It has also been pointed out to us that visitors may require to be searched in some circumstances. We therefore believe that all services which accommodate detained patients, and who would in some circumstances carry out searches, should be required to have a clear policy in relation to this issue. The Code of Practice should set out the general parameters of these policies. The Mental Welfare Commission should monitor the operation of search policies.

Recommendation 11.20

The Code of Practice should contain general guidance on searching of patients and visitors.

Recommendation 11.21

All services which accommodate detained patients, and who on any occasion search patients or visitors should be required to have a policy on searches.

Recommendation 11.22

The Mental Welfare Commission should monitor individual searching policies, and their implementation.

Sharing information regarding patients

47. Another issue which has been raised with the Committee, particularly by people working in forensic settings, is the extent to which patient information can be

⁹⁴ Reported in The Times, November 5, 1997. The case is discussed in the *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Hospital*, volume 1 (1999) Cmnd. 4/94 - II

disclosed to other organisations, such as the police and prisons, as part of intelligence gathering or risk assessment processes. The extent to which the public interest can override the normal requirements of patient confidentiality is not always clear.

48. In 1997, a report was published by the Caldicott Committee on the Review of Patient-Identifiable information in the NHS. The UK government made a commitment to implementation of the report, which recommended that 'Guardians' be appointed in health organisations to oversee issues of information management. The Caldicott Committee's remit did not extend to Scotland, but a number of the Committee's recommendations were taken forward by the Scottish Office, which issued a 'Manual for Caldicott Guardians' in 1999. In summarising guidance on protecting and using patient information, this manual stated:

'Reflecting a lack of legal clarity, complex ethical dimensions and the different viewpoints of different sections of society, the guidance on some issues may reflect the perspective of the issuing body and conflict, at least in part, with guidance issued by other bodies', and

'This whole area is in a state of flux at the moment with the onset of Human Rights legislation and an ever-changing legal position'⁹⁵.

49. So far as we are aware, there is no Scottish legislation specifically concerning this, and few relevant Scottish judicial decisions⁹⁶, although general legislation such as the Data Protection Act 1998 is relevant. There is a Code of Practice on the Confidentiality of Personal Health Information, which is, we understand, being updated. The current Code was issued in 1990⁹⁷, and states that information can be made available where the public interest in passing the information outweighs the duty of confidence to the patient. It would seem to be clear that information may be disclosed where this is necessary to prevent serious harm to others: for example where there is reason to believe that a person may be about to commit a serious crime. What is perhaps less clear is the extent to which information can be shared as part of long term risk assessment and risk management procedures.
50. We considered whether this was a matter which required to be addressed in the Mental Health Act. On balance, we have concluded that this is not appropriate, at least at the moment. The issue of patient confidentiality, and the difficulty of knowing how far it extends, affects all patients. While there may well be a case for general legislation, to provide separate legal rules for some patients with mental disorders risks confusing the position further. Furthermore, we have received little evidence which would assist in articulating what special rules might apply to patients with mental disorders, or in particular to those thought to present a high risk.
51. That said, we agree that practitioners need clearer guidance than is currently available. The general framework should be contained in the revised Code of Practice on Personal Health Information. In relation to patients subject to compulsory orders, this should be supplemented by more specific guidance in the

95 'Protecting and Using Patient Information-A manual for Caldicott Guardians (Scottish Office 1999), page 27

96 The leading English authorities are *W v Egdeell* [1990] All ER 835 and *R v Crozier* (1990) the Guardian 8th May. A paper on Confidentiality and Mental Health was produced for the English Mental Health Act review by Professor J.V. McHale, and is available on its website, at <http://www.doh.gov.uk/menhlth.htm>

97 NHS Circular No 1990 (Gen) 22

Mental Health Act Code of Practice. Finally, we understand that, in the follow up to the Caldicott report, all Scottish NHS Trusts and Boards are required to develop local protocols governing the disclosure of patient information to other organisations⁹⁸. These should take due account of the issues of risk assessment and sharing of intelligence which may be relevant for some patients, but also of the rights of all patients to proper safeguards against inappropriate disclosure of confidential information.

Recommendation 11.23

The Code of Practice on Personal Health Information should be revised as a matter of urgency, and should give general guidance on disclosure for risk assessment purposes.

Recommendation 11.24

The Mental Health Act Code of Practice should contain more detailed guidance on disclosure of information with regard to patients subject to compulsion.

Recommendation 11.25

Local protocols on patient confidentiality should take account of issues of risk assessment and intelligence gathering.

98 NHS MEL (1999) 19

SECTION 3

RIGHTS OF USERS AND CARERS

CHAPTER 12

RIGHTS OF INFORMAL PATIENTS

Background

1. One of the most significant reforms introduced by the Mental Health (Scotland) Act 1960 was the principle that compulsory measures should not be used where it is possible to treat an individual on a voluntary basis. This is currently enshrined in s17(2) of the 1984 Act, and is reflected in our proposed principle of *Informal care* (see Chapter 3).
2. This reform took many people out of the scope of the compulsory provisions of the Act. Nearly 90% of hospital admissions are now on an informal basis.
3. Informal admission means that the patient retains the right to give or refuse consent to treatment. It avoids the added distress for the patient which compulsory detention can involve. It also saves care professionals and the legal system from a considerable amount of additional administration.
4. We are firmly of the view that compulsory measures should remain as something to be used only when absolutely necessary. However, there are reasons to be concerned that this may result in there being a lack of formal protection for people who may not in fact be fully consenting to their care and treatment.
5. The first difficulty concerns the patient who does not object to being in hospital or to treatment, but who is not able to make a fully autonomous decision about the treatment. Many such patients would be described as incapable, as the term is used in the Adults with Incapacity (Scotland) Act 2000.
6. That Act will greatly improve the safeguards for this group although, as we go on to discuss, there may still be some gaps.
7. The second problem concerns people who do not agree with the treatment which they receive, but who are nevertheless being treated as 'informal' patients. This can happen in some cases, because the service user may lack the confidence to object to the treatment being given. We heard, for example, that people from ethnic minorities may find it difficult to challenge decisions made about their care, and that many people with learning disabilities find it hard to be listened to.
8. The other situation about which we received evidence was the 'coerced voluntary patient'. Some service users do not wish to enter or remain in hospital, or to agree to particular types of treatment. However, they are told or believe that, if they do

not accept the treatment on a voluntary basis, they will be detained under the 1984 Act, and receive the treatment compulsorily. Either because of the stigma of detention, or because it is perceived that this will result in further restrictions on the service user's freedom, he or she accepts treatment to avoid detention.

Incapable patients

9. The issue of people who are effectively, but not formally, detained, is sometimes known as the 'Bournewood' problem, after the legal case in England in which the issue was highlighted. In that case¹, a 48 year old man, who was profoundly autistic, had been admitted to hospital, and remained there against the wishes of the couple who cared for him. He was not free to leave, in the sense that any attempt by him to leave would have resulted in his being formally detained. However, since he was so disabled that he could not attempt to leave, or express a wish to leave, it was held that he did not require to be admitted under the English Mental Health Act. The actions of doctors in admitting and treating the patient were held by the House of Lords to be justified under common law principles of the duty of care and necessity.
10. The result of this was that the safeguards of the Mental Health Act, such as the right to a review of detention from time to time, and a compulsory second opinion for certain treatments, did not apply to the patient. Even the judges who made the ruling were uncomfortable with this result, with one describing it as 'an indefensible gap in our mental health law'².
11. In Scotland, the Adults with Incapacity (Scotland) Act will provide some of the safeguards which were felt to be missing in the English law. Section 47 makes provision for medical treatment of people who are incapable of consenting, including medical treatment for mental disorders³. It applies to people being treated both in the community and as hospital in-patients. The Act sets out the procedure that should be followed in deciding on treatment, and also makes provision to resolve disputes about treatment.
12. In a case such as Bournewood, it would be necessary to certify that the patient is legally 'incapable' before carrying out any treatment. The patient, or a relative or other concerned third party, could go to court to challenge decisions about treatment, or to seek powers to have the person removed and cared for elsewhere. The Act could not be used to admit the patient to hospital for treatment for mental disorder against his or her will.
13. There are still however questions to be resolved, for example about the effect of s47(7) of the Adults with Incapacity Act. It states that the authority to treat does not authorise the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances. Different views were expressed by judges in the Bournewood case as to whether or not the patient was in fact 'detained'. Whatever the facts of the individual case, it is clearly envisaged that some people may be 'detained' without being formally detained under mental

1 *R v Bournewood Community and Mental Health NHS Trust, ex parte L*, [1998] 3 All ER 289

2 Per Lord Steyn at p305

3 'medical treatment' is defined in s47 as 'any procedure or treatment designed to safeguard or promote physical or mental health'.

health law. There is a danger that some situations may slip between the two Acts. Patients could be held in ways which are not authorised under either Act, more as a result of uncertainty about the boundary between the two legal frameworks than any bad faith.

14. In the longer term, we would hope that the consolidation of the two Acts, which we recommend in Chapter 2, would help to resolve some of these difficulties. We also believe that the Codes of Practice of the two Acts should offer guidance in clarifying the areas of overlap.

Recommendation 12.1

The Codes of Practice for the new Act and for the Adults with Incapacity (Scotland) Act 2000 should provide guidance on the circumstances when it is appropriate to admit, detain or treat a patient compulsorily under mental health legislation, rather than under the Adults with Incapacity Act.

‘Coercive’ voluntary admissions and treatment

15. As we have indicated in paragraphs 7 and 8 above, many service users commented to us that they have had experience of feeling under pressure to accept admission to hospital, or treatment, with the threat of detention if they did not comply. One service user who responded to our users and carers consultation said that ‘the threat of section... should we object to our treatment is commonplace. And so the legal rights mentioned should be extended to cover all.’ A theme which emerged during the consultation events held with users and carers was a wish ‘to see principles and protocols laid out to prevent being coerced into treatment.’
16. This is a very difficult area. The patient may feel that he or she has no choice but to comply, but is then deprived of the safeguards of the Act. On the other hand, a doctor or nurse may simply be seeking to encourage the patient to accept treatment on a voluntary basis, while explaining that the service user’s condition causes such concern that compulsory measures will be necessary if the service user is not prepared to accept treatment.
17. We do not believe that the answer to this difficulty is to be found primarily within the legislative framework. We would not wish formal steps to be required whenever a patient expresses reluctance to accept treatment, since this would militate against the aim of encouraging the service user and professionals to discuss and agree a treatment package, and would have the undesirable effect of increasing the number of detentions, which would be contrary to what we wish to achieve.
18. Instead, we feel it would be better to look at the problems which may underlie the issue of perceived coercion. There would seem to be two main issues. The first is

the feeling of many service users that they are not able in practice to negotiate treatment with professionals, particularly during a period of crisis. The second is that detention is understandably perceived by most service users and professionals as a greater infringement of the patient's rights, with the accompanying protections seen as of less importance.

19. When we asked about this issue, greater access to advocacy was particularly highlighted as a possible solution. In Chapter 14, we make a number of recommendations designed to increase access to advocacy services. The recommendations we make in Chapter 15 regarding advance statements may also, in some cases, help to clarify when treatment may be administered without compulsory measures when the patient is not currently in a position to give proper consent.
20. We recommend various measures in Chapter 23 to strengthen the powers of the Mental Welfare Commission. It has always been the case that the Commission has had responsibility, not simply for detained patients, but for all people with mental disorders. In their role of promoting the principles of the Act, we recommend that they issue guidance about the issue of 'coercive admissions'.

Recommendation 12.2

The Mental Welfare Commission should issue guidance on best practice in relation to the use of compulsory measures of care and treatment when patients are reluctant to accept treatment on a voluntary basis.

21. We would also hope that the changes which we recommend to the provisions in the Act relating to compulsory measures may make it less likely that people will be so worried about being detained that they accept treatment to which they have not consented in any meaningful way. That said, we are conscious of the stigma which attaches to detention in particular. We deal with stigma generally in Chapter 17.

Restraint

22. A particular issue which causes considerable difficulty is the extent to which it is appropriate to restrain informal patients, or for such patients to be in environments with locked doors. We are satisfied that restraint may be needed occasionally for informal patients. However, there must come a point where such restrictions in effect constitute a form of detention which should be subject to the safeguards of the Mental Health Act.
23. We are aware that the Mental Welfare Commission issued guidance a few years ago about restraint, and that it has recently reviewed the practices of hospitals regarding locked wards. We believe that the best way forward is to ensure that care providers have appropriate policies in relation to issues of locked rooms and restraint, and that practice is subject to regular monitoring and review.

24. The Mental Welfare Commission appears to us to be the body which is best placed to develop general guidance on these issues, which would be applicable to people with mental disorders in a range of settings. This could then be incorporated in the Code of Practice. It would then be for the appropriate registration and inspection bodies, including the Scottish Health Advisory Service (SHAS) and the proposed Scottish Commission for the Regulation of Care, with the assistance of the Commission where appropriate, to ensure that specific policies are produced and implemented by individual care providers.

Recommendation 12.3

The Code of Practice should contain general guidance on restraint, including an expectation that care providers will develop policies on restraint, which will be monitored by the Mental Welfare Commission.

Exceptional treatments

25. In Chapter 10, we have dealt with treatments that require particular safeguards: the so-called 'special' or 'exceptional' treatments. The Adults with Incapacity Act contains provision⁴ for regulations to specify medical treatment in relation to which the general treatment authority does not apply, and to specify the circumstances in which such treatment may be carried out. We understand that regulations are to be introduced shortly.
26. In general, it is our view that the protection for incapable patients in relation to exceptional treatments should be consistent with that for patients subject to compulsion. We therefore recommend that the special treatments, and relevant special procedures, dealt with in Chapter 10, also be incorporated into the regulations for exceptional treatments under the Adults with Incapacity Act.
27. This protection should be extended to incapable patients, whether in hospital or the community, and in principle should apply to long term medication for mental disorder, as well as the other treatments covered in Chapter 10. We have heard evidence of concerns that, for example, some patients with dementia in nursing homes may be receiving high doses of anti-psychotic medication, with limited oversight and review by medical professionals. An article in the British Medical Journal in 1996, for example, suggested that there was cause for concern about the level of prescription of neuroleptic drugs to residents in nursing homes⁵.
28. However, there are practical problems in relation to patients in the community. Although we do not have figures for the numbers of patients who would be classed as incapable, and who are in receipt of long term drug treatment for mental disorder, it would be considerable. Several people with expertise in this area suggested that it would simply be impossible for approved 'second opinion' doctors to review them all. We are persuaded that to make this a requirement in every case is not practical.

4 Adults with Incapacity (Scotland) Act 2000, s48

5 McGrath A and Jackson G, *Survey of neuroleptic prescribing of residents of nursing homes in Glasgow*, BMJ, Volume 312, 9 March 1996, pp611-2

29. We have also considered whether the second opinion might be obtained locally rather than through the Mental Welfare Commission but we recognise that there are also difficulties in that.
30. However, we do wish to see some mechanism by which families and others can be reassured that such treatment is appropriate. We therefore propose that any person with an interest in the welfare of an incapable patient, including relatives, guardians, and advocates, should be entitled to require that a second opinion from a doctor approved for the purpose by the Mental Welfare Commission be obtained for any drug treatment for mental disorder which has been given under the authority of the Adults with Incapacity Act for more than two months. In our view, this would be a limited, but useful, safeguard.
31. We recognise that, in itself, it may not deal with every situation where there may be concerns about medication for elderly patients, including those with dementia. However, we believe that the broader issue of the quality of medical care for this vulnerable group is best addressed through the development of guidance and standards by the appropriate regulatory and professional bodies. The increased powers that we recommend in Chapter 23 for the Mental Welfare Commission in relation to facilities in the community, and the regulatory powers to be vested in the Scottish Commission for the Regulation of Care, should also be helpful.

Recommendation 12.4

The provisions to be made for 'exceptional treatments' under s48 of the Adults with Incapacity (Scotland) Act 2000 should be the same as those which we recommend for special treatments under the Mental Health Act, except in the case of patients in the community, for the provisions relating to drug treatment for mental disorder which lasts for over two months.

Recommendation 12.5

Where a patient in the community receives drug treatment for over two months on the basis of an authority to treat conferred by s48 of the Adults with Incapacity (Scotland) Act 2000, the nearest relative, or primary carer, or any other person with an interest in the welfare of the patient should be able to require that a second opinion be obtained by a medical practitioner appointed for the purpose by the Mental Welfare Commission.

CHAPTER 13

SERVICE USERS' RIGHTS TO ASSESSMENT AND SERVICES

1. This Chapter considers the rights of service users to assessment and services. The question of the rights of informal carers is considered in Chapter 16.

Rights to assessment

2. Assessment of needs, medical and social, is fundamental to the care and treatment of people with mental disorders. Assessments are constantly undertaken on an informal basis in medical and social work services. However, the law provides that social work assessments of need for people with mental disorders should be mandatory in certain circumstances⁶. There is no parallel formal legal requirement on health services. We have therefore given consideration to whether the new Mental Health Act should introduce such a requirement.

Current legislative position

Community Care Assessments

3. Section 12A of the Social Work (Scotland) Act 1968 provides for community care assessments by social work services, for people (including people with mental disorder) who need or may need local authority services, so that they can consider the provision of such services.
4. The assessment is mandatory, if need or possible need comes to the attention of the local authority. The assessment does not need to be requested by the client and, indeed, may be required even if the client does not wish to have such an assessment.
5. Social work services are also required, under subsection (3) of Section 12A, to liaise with health boards and housing authorities regarding needs identified in the assessment which may require action by these authorities.
6. The assessments are intended to be needs-led rather than services-led. The needs assessed will not necessarily always match the available services. However, there is an expectation that the needs identified by the assessment will be met by appropriate services when available. The social work department must take account of the person's assessed needs in making their decision about what services to provide.

6 Since the enactment of the NHS and Community Care Act 1990, amending the Social Work (Scotland) Act 1968.

Disabled person's assessment

7. Where a local authority is making a community care assessment and it appears that the person being assessed is a disabled person, they are obliged to assess what services the person is eligible for under the Disabled Persons (Services, Consultation and Representation) Act 1986 and inform the person of his or her rights under the Act⁷. The definition of disabled person includes a person with a mental disorder, as defined in the 1984 Act.
8. This provision is of importance, as it can lead to a legal right to certain services under s2 of the Chronically Sick and Disabled Persons Act 1970. A person or their carer may also directly request the social work department to consider whether the person may be eligible for services under the 1970 Act, and an assessment must be carried out.

Consultation

9. Respondents from all sectors to our consultation documents agreed that assessments were an important part of care. The great majority of respondents expressed support for the right to an assessment and plan of care by mental health services. The majority of respondents believed that this right should be extended to both detained and non-detained patients (social work services tended to this view more strongly than health boards and trusts).
10. Most of the problems identified with such an assessment were practical ones, and in the main respondents were concerned about the link between an assessment and the actual provision of services. This is dealt with further below.
11. Some problems and potential problems were identified with inter-agency working. One council told us assessments developed by local authorities are 'largely ignored' by health professionals. A user told us of his personal experience of delays in the assessment procedure caused by a breakdown in inter-agency working. We believe that it is important that inter-agency working is the norm, that people are made aware of their rights to an assessment, and that social work services assessments are considered as an integral part of a person's overall assessment of needs. The Royal College of Psychiatrists pointed out that it would be important to provide guidance on which agency had control of which part of an assessment and the provision of services. We concur with this view.
12. Users and carers told us that it is often difficult to obtain assessments of the user's need at times when it might be advantageous. There were circumstances when users and their carers had not been able to receive formal assessments at times of difficulty.

Care planning

13. We are in favour of the formulation of a plan of care for people subject to compulsion, whether detained in hospital or subject to compulsion in the

⁷ Social Work (Scotland) Act 1968, s12A(3C)

community. Such a plan of care would detail the compulsion to which a person is subject, as well as non-compulsory elements, and the services that they can expect. The model of a plan of care has been described in Chapter 6 for people subject to compulsory treatment.

Assessment of patients subject to compulsion

14. Fundamental to this concept of care planning is a thorough assessment of needs and preferences. We are therefore in favour of a right under the Mental Health Act to a formal assessment of needs for people subject to compulsion.
15. Close working between health and social work is necessary to assess fully the needs of persons with mental disorder. Plans of care for service users, whether in hospital, living in the community, or moving between hospital and the community, may contain a mixture of elements provided by psychiatric and social work services. We therefore recommend that, for patients subject to compulsion, both agencies should, in future, be involved in an assessment of needs. Assessments done by social work and health agencies should be brought together and made the basis of a single plan of care which would be approved by the tribunal.
16. Some of our respondents made the point that there should not be too many processes of assessment and care planning, since this will lead to confusion and duplication of effort. In addition to the statutory assessments carried out by social work departments, the Care Programme Approach⁸ sets out expectations for care planning and joint working in respect of some people with severe and enduring mental illnesses. Many of these people might also be liable to compulsory measures from time to time.
17. We do not, therefore, propose a detailed new set of procedures for assessment and care planning in relation to people subject to compulsion. The procedures should reflect current legislation and guidance.
18. In order to facilitate this, we recommend the right to assessment under the Mental Health Act should be framed in such a way as to be complementary to the pre-existing right to a social work assessment.

Recommendation 13.1

There should be a duty on health and social work services to participate in an assessment of needs for patients subject to compulsion under the terms of the Mental Health Act.

Recommendation 13.2

In these circumstances, this assessment should form the basis of a plan of care.

⁸ Community Care: Care Programme Approach for people with severe and enduring mental illness including dementia, SWSG Circular 16/96.

Recommendation 13.3

The right to assessment for people subject to compulsion should be framed in a manner to make it compatible with the relevant provisions of the Social Work (Scotland) Act 1968.

Assessment with a view to compulsion and/or other services

19. Carers currently have a right to request a social work assessment of whether a person requires detention under the Mental Health (Scotland) Act. There is a provision (Section 19(3) of the 1984 Act) which gives the 'nearest relative'⁹ the right to require a local authority to direct a mental health officer (MHO) to consider whether a person requires to be admitted to hospital under the Act. If the MHO decides not to proceed with an application for admission, the nearest relative must be informed in writing of the reasons for this.
20. There is not currently any similar right to request an assessment from psychiatric services and have the request considered, although, of course, such requests for assessment are currently made on a regular basis.
21. Nevertheless, we have heard evidence from carers and users that the lack of any formal right to assessment in the community may be a bar to people with mental disorders receiving appropriate services. Some carers have told us of years of attempting to access services for the person for whom they care.
22. There are different situations when a person living in the community may require to be assessed. Sometimes, a person may have had no prior contact with psychiatric services, but be behaving in a way which causes concern to those who know him or her. In other cases, a person may have had one or more prior episodes of mental illness and appear to those nearest to him or her to be in the process of suffering a relapse.
23. The common factors are that assessment may not be requested by the service user him or herself and that it may potentially lead to compulsion as well as other types of service provision. We have considered whether it is possible to improve the balance between ensuring that the rights of the patient are protected and ensuring that services are made available if necessary.
24. The primary responsibility for assessing the needs of a person with no prior contact with psychiatric services and referral of them, if necessary, to secondary psychiatric services, should continue to lie with primary care. Although we appreciate the concerns of those who have told us of their difficulties in accessing services via primary care providers, we believe it would be inappropriate to give direct access to secondary psychiatric services, even if only for assessment, to any person on demand. This seems to run contrary to the general health service principle of primary care as the 'gateway' to secondary services.

⁹ We discuss definitions of 'carers', 'nearest relatives' etc in Chapter 16

25. However, there are ways in which the responsiveness of primary care could perhaps be improved. It is always a difficult decision for a carer to decide to approach a GP with concerns about a person in their family: we would expect GPs to respond sympathetically to these approaches.
26. In addition, community psychiatric nurses (CPNs) might undertake a more direct role in these cases, by being more available to talk through the user's and carer's concerns with them and make their own assessments of whether a referral would be appropriate.
27. We have also heard evidence that GPs are reluctant to visit adults who are not themselves concerned about their mental health. We believe that the fact that a person may not wish to be assessed need not necessarily be a bar to an assessment of the person's needs, although it would, of course, be a factor in the GP's consideration of the case. In general, we expect that the GP should consider the evidence presented by the carer and, if possible, attempt to visit (or have the CPN visit) and talk with the person about their mental state. If it is not possible to gain access to the person, then it might eventually prove necessary to invoke the powers discussed in Chapter 19 on Vulnerable Adults.
28. The arrangements for people who have previously received treatment for mental disorder, whether as detained patients or voluntary patients, and who may be experiencing a relapse or deterioration of their condition, are more complex. In some cases, it will be appropriate for primary care services to continue to take the lead role, while in others, rapid access to specialist mental health services will be appropriate. In either case, the evidence of service users and informal carers was that a rapid response at times of crisis is vital.
29. We believe that, in these cases, there should be a right to request a medical assessment of a person's mental health needs be carried out by psychiatric services. As with the existing right to request an assessment by the MHO for detention, the right would not be absolute. Not all requests for an assessment of mental health will be justified. However, there would be an obligation on psychiatric services to consider the request, and give reasons in writing if they choose to reject it.
30. The right to request an assessment by the MHO should be linked to this right to request a medical assessment. However, we believe that the right to request an assessment should no longer be directly linked to detention. We recommend in Chapter 7 removing the nearest relative's right to consent to detention. For similar reasons, we do not believe that relatives should have the right in law directly to request consideration of detention. Instead, they should have a general right to request an assessment, which might include social work and/or health elements, and might, in some situations, lead to compulsion of some sort.

Recommendation 13.4

The Code of Practice should give guidance on how the responsiveness of primary care service providers may be improved with respect to requests for assessment by service users and carers during the service user's first period of suspected mental illness.

Recommendation 13.5

Service users and carers should have a right to request an assessment of needs for a user who has previously had contact with mental health services. Mental health services would not be bound to undertake such an assessment, but would be required to give reasons for a refusal to do so.

Rights to services

31. We heard a good deal of evidence on the subject of service provision. In our users and carers consultations in particular most people suggested that service users should have the right in law to good medical treatment, follow-up services and social provision.
32. We believe the difficulties faced by some users and carers in gaining access to the services they need are caused by a number of factors, of which the law is only one. However, the interaction between the law and services cannot be ignored. For example, there are several sections of the 1984 Act which place specific duties on local authorities to provide certain services. More generally, the proper operation of the whole Act is clearly predicated on the provision of effective and responsive mental health services. We have therefore considered whether people with mental disorders should have a right in law to obtain services.

Reciprocity and patients subject to compulsion

33. In our consultation papers we asked whether, if a person was subject to compulsion, there should be a reciprocal duty on service providers to provide appropriate services. The response was strongly in favour of such a duty.
34. The main reservation expressed was that to provide services as a matter of right to patients subject to compulsion might differentiate them in an unhelpful way from voluntary patients. At its worst, this might have the unwanted effects of discriminating against those not subject to compulsion and, potentially, acting as a perverse incentive to bring people under the compulsion of the Mental Health Act.
35. However, we have concluded that it is a matter of natural justice that people who are given treatment against their will or otherwise made subject to compulsion be

given access to an adequate level of service. That is why *Reciprocity* is one of the key principles that we propose.

36. We believe that the way in which this 'adequate level of service' is defined should be based upon the plan of care. As we have already indicated (paragraphs 15-18), this would be developed after a full assessment of needs by health and social work services. The plan of care would give details of the services that a person subject to long term compulsion might expect.
37. We have dealt in Chapter 6 with the consideration by the tribunal of the plan of care and the factors they should take into account in deciding whether or not they will approve the plan of care.

Recommendation 13.6

There should be a duty on health boards and local authorities to provide appropriate services to those subject to compulsion under the provisions of the Mental Health Act, as assessed and detailed in their plan of care.

38. This duty would be in addition to the duties to service users in general, already provided for in the Mental Health (Scotland) Act and elsewhere, which we now go on to deal with.

General rights to services

Current legislative position - other legislation

Chronically Sick and Disabled Persons Act

39. Under s2 of the Chronically Sick and Disabled Persons Act 1970, if it is established by means of an assessment that a disabled person needs certain specified services, the local authority must provide the services, irrespective of the financial implications. There is however caselaw to the effect that the local authority can have regard to its level of resources in determining whether a need exists¹⁰.
40. The services include elements such as help at home, holidays, transport, and recreation.

Social Work (Scotland) Act

41. The Social Work (Scotland) Act 1968 has a wide variety of provisions including, at s12, the fundamental duty on the local authority to promote social welfare. This is a duty, not a power, but is so widely expressed that it is difficult to enforce on an individual basis.

National Health Service (Scotland) Act

42. Under the terms of the National Health Service (Scotland) Act 1978, Scottish Ministers have a legal duty to ensure a comprehensive and integrated health

10 *R v Gloucester County Council, ex parte Barry* [1997] 2 All England Reports, 1.

service for the whole of Scotland. In addition, they must make arrangements for the prevention of illness, the care of persons suffering from illness or the after care of such persons. There have been a few cases where people have taken legal action in an attempt to secure particular assistance from the health service. These actions have generally been unsuccessful, since courts are highly conscious of the problems of resourcing health care.

Other legal provisions

43. It remains to be seen whether developments such as the Disability Discrimination Act 1995, and the incorporation of the European Convention of Human Rights into domestic law, will lead to new legal challenges to failures to provide adequate services to individuals or particular groups.

Current legislative position: the Mental Health (Scotland) Act

Duty to provide or arrange care and support

44. Section 7 of the 1984 Act gives local authorities a discretionary power to provide residential care, ancillary or supplementary services and supervision to people suffering from mental disorders. This power runs alongside the duties in the Social Work (Scotland) Act to provide services to 'persons in need', including people with mental disorders.
45. From the evidence we have received, this section does not appear to be much used, as it is largely subsumed by the broader duties imposed on local authorities
46. Section 8 of the 1984 Act imposes a duty on local authorities to provide 'after-care services' to persons who are or have been suffering from a mental illness, or have a learning disability, whether or not they have been in hospital.
47. It is unclear precisely what 'after-care' means, or how long such care is expected to last. Both the Association of Directors of Social Work (ADSW) and the British Association of Social Workers (BASW) made the point to us that this section appears to view mental illness as a progression from hospital to the community (where 'after-care' is then provided). However, in reality it is a more common pattern for the course of a mental illness to be cyclical. This makes it even more unclear where the boundaries of after-care may lie, as the patient's care oscillates between hospital and the wider community.
48. However, the section does, taken at the minimum, indicate that mentally disordered people are entitled to help from social work services.
49. In view of the concerns expressed to us about the lack of services at present, we see no case for weakening the statutory duties of local authorities in respect of mental health care. We do however believe that they should be expressed in a way which is meaningful, both to local authorities and service users.

Duty to provide training and occupation

50. Section 11 of the 1984 Act relates to 'training and occupation' for people with learning disabilities living in the community. It states:

"it shall be the duty of the local authority to provide or secure the provision of suitable training and occupation for persons suffering from mental handicap who are over school age"¹¹.

51. It is for the local authority to determine what is 'suitable'. In practice, this tends to take the form of day centres and the like, either local authority-run or run by voluntary organisations with funding from the local authority. The local authority cannot charge for these services.
52. The term 'training and occupation' is arguably rather outdated. The Scottish Executive's review of services for people with learning disabilities¹² sets out the need for 'training and occupation' to be mainstreamed, to include, where possible, the transformation of day centres into drop-in resource centres, and the provision of real jobs and lifelong learning. However, it acknowledges that those with complex needs may continue to require the greater structure of day-care. This more flexible approach may not fit well with the more limited statutory terms of 'training and occupation'.
53. We received strong representations from learning disability organisations, such as ENABLE, that the duty in s11 should remain. Although services for people with learning disabilities can be provided under the general duty to 'promote social welfare' in s12 of the Social Work (Scotland) Act 1968, it is felt that this specific duty provides a helpful focus on the needs of people with learning disabilities.
54. We agree with these arguments in favour of a continuing duty directed at the developmental and social needs of people with learning disabilities, rather than their care needs. Such needs will not always be best met by social work departments directly. Other bodies such as further education colleges, training agencies, and employers, all have a part to play. However, these agencies may not have a primary focus on the needs of people with learning disabilities, and the local authority can play a vital role in co-ordinating services and funding voluntary sector groups to provide innovative and flexible services.
55. However, it is important that further consideration be given to the implications of the learning disability services review, and whether there should be a more coherent legal framework in place for people with learning disabilities. The issue of learning disability and its relationship with mental health law is complex. We have recommended in Chapter 4 that a review of the law relating to people with learning disabilities be undertaken, with a view to possibly creating a new legal framework for learning disabilities. One of the tasks of this review should be to consider this specific issue of how developmental services should be provided for in legislation in the future.

11 Mental Health (Scotland) Act 1984, s11(1)

12 *The same as you? – A review of services for people with learning disabilities*, (Scottish Executive 2000) Chapter 5

56. People with other mental disorders may also require such developmental assistance. We are therefore in favour of extending the provisions to people with mental disorders who have been assessed as needing assistance with training or personal development. Many people with mental illnesses find it difficult, without support, to maintain working life or lifelong learning. The range of activities (supported working, training etc) should be based upon a person's current state of mental health and take into account the fact that their illness may be recurrent in nature.
57. The duties relating to people with learning disabilities and people with other mental disorders should be separate and differently worded, to reflect the fact that people with learning disabilities often have ongoing developmental requirements, whilst those with mental illness may need assistance on a permanent, periodic, or one-off basis, depending on their circumstances.
58. The requirements of s11 include that transport is provided to places of 'training and occupation'. We believe that this duty should remain. However, neither the duty to provide training, nor the duty to provide transport apply in the case of a person in hospital. We believe that this anomaly should be removed.

Recommendation 13.7

There should continue to be a duty on local authorities to provide or arrange care and support services to persons who are, or have been, suffering from a mental disorder.

Recommendation 13.8

There should be a duty on local authorities to ensure the provision of or arrange day activities for people with mental disorders.

Recommendation 13.9

These 'day activities' should include support for employment, training and education, and social activities. This duty should include a duty to arrange transport, where appropriate, including where patients are in hospital.

Rights to services of voluntary patients

59. It could be argued that all mental health service users should be afforded the same rights to the formulation and implementation of a plan of care, as we have recommended for patients subject to compulsion. We have already recommended (paragraphs 19 - 30) that there should be provision for an assessment of needs for all service users.

60. The question is whether the law should move beyond this and give all service users a statutory right to services. This could run contrary to the principle of *Non-discrimination*, which states that people with mental disorders should, wherever possible, be treated in the same way as people suffering from other disorders, who do not have such a right. With other illness, people however rightly expect the best treatment available, and this should be no different for people with mental disorders.
61. In our first Consultation we asked whether there should be a duty to provide a particular level or range of services to all patients whether subject to compulsion or not. Most local authorities and voluntary organisations thought there should be, as did the Law Society. Those in favour talked of a joint responsibility on health and social work services. However, concerns were raised by several other bodies that the law would not lend itself to setting standards. Many were concerned that such a duty would be difficult to enforce.
62. As we say in our Introduction, we have considerable concern about the evidence we received about the inadequacy of many mental health services. Nevertheless, we are not convinced that mental health law by itself is the most appropriate instrument to employ to secure adequate services for all people with mental disorders, most of whom will not be subject to compulsory measures of care. There are a range of other mechanisms in place, including procedures for clinical governance; complaints procedures; the setting and monitoring of standards by the Clinical Standards Board for Scotland; and the monitoring and inspection functions of agencies including the Mental Welfare Commission, the Scottish Health Advisory Service, professional bodies and the proposed Scottish Commission for the Regulation of Care.
63. Therefore, apart from updating the existing duties as elaborated above in sections 7, 8 and 11 of the 1984 Act, we do not propose that the Mental Health Act should impose further requirements to provide particular services, or any particular level of services, for patients who are not subject to compulsory measures.

Inter-agency working

64. We asked in our first and second Consultations whether there should be a requirement on agencies to co-operate. The desirability of co-operation was agreed by all respondents. However, many respondents to both consultations were uncertain that this should be a matter for primary legislation. Several observed that the Clinical Standards Board and the Commission for the Regulation of Care will have responsibility for setting and monitoring standards, including co-operation, and that the Mental Welfare Commission also has an oversight role in individual cases.
65. We believe that it is essential for the provision of good mental healthcare that agencies co-operate in its provision. We have heard from users and carers, during our consultation process, of the problems that can ensue for individuals when they do not. There already exists such a general duty in primary legislation¹³ although

13 National Health Service (Scotland) Act 1978, s13 (amended by NHS & Community Care Act 1990, Sched 9, para 19(4))

we received evidence that it is not always fully implemented. We therefore believe that there should be statutory backing to the principle of inter-agency working in the mental health field. Beyond that, we propose that the Code of Practice should give guidance to service providers on the most appropriate ways to encourage inter-agency working in relation to the operation of the Mental Health Act.

Recommendation 13.10

There should be a provision in the Act which requires agencies to co-operate in the provision of care to people with mental disorders. The Code of Practice should give guidance to service providers on the most appropriate means by which this may be achieved.

Charging for services

66. Section 87(1) of the Social Work (Scotland) Act 1968 provides that social work departments may charge for the services they provide. Health services cannot so charge. Furthermore, the power to charge does not extend to services provided under the duties set out in section 11 of the 1984 Act.
67. People with mental disorders tend to use both health and social work services, to various degrees dependent on circumstances. The differences in charging policies can thus seem rather arbitrary, and can cause difficulties as a person moves to different parts of the care system.
68. Aspects of this are beyond our terms of reference. The issue of charging for residential care is one which is under consideration by government in the light of the report of the Royal Commission on Long Term Care¹⁴.
69. In relation to home care services, the recent report of the Joint Future Group¹⁵ makes various recommendations, including that the Convention of Scottish Local Authorities should develop guidance on charging policies to reduce the inconsistencies in home care charging. Similarly, the Health and Community Care Committee of the Scottish Parliament recommended, in the report of its recent enquiry into the delivery of community care, that steps should be taken to ensure uniformity throughout Scotland where charges are made for the provision of support services¹⁶.
70. This is then, a general problem for community care services which is currently under active consideration elsewhere. In light of this, we make no firm recommendations.
71. There are two matters of particular relevance to the Mental Health Act, which should be borne in mind in these wider reviews. These are charging for services provided under the Act, and charging patients for services delivered to them under compulsion.

14 *With Respect to Old Age* Royal Commission on Long Term Care (1999),

15 Report of the Joint Future Group (Scottish Executive, November 2000)

16 Health and Community Care Committee, *Enquiry into the Delivery of Community Care in Scotland*, 16th report, 2000

72. On the first point, our consultations did not reveal support for changing the current position that services delivered under s11 of the 1984 Act (training and occupation of people with mental handicaps) should not be subject to charging. Voluntary organisations such as ENABLE strongly opposed the introduction of charges for these services, whose purpose is primarily developmental, rather than the provision of care.
73. In relation to people subject to compulsion, we felt that, in general, it was wrong that a person should be made to pay for a service which he or she may not want, but is required by law to accept. This might apply, for example, to prescription charges or charges for services delivered by a local authority to a person subject to a community order. We feel that there is an important point of principle involved here, which should be borne in mind in consideration of the wider issue of charging for care services.

CHAPTER 14

INDIVIDUAL AND COLLECTIVE ADVOCACY

Rights to individual advocacy

1. Currently, not all mental health service users have access to an advocate at times when they may wish one. We have considered whether rights to obtain access to advocacy should be strengthened.
2. Our consultation process indicated a wide consensus in favour of the principle of advocacy. Many consultees told us in detail of the importance to service users of independent advocacy. In our consultation with users and carers the need for advocacy was a recurring theme.
3. In the context of the NHS, advocacy means:

 “enabling people, so far as possible to make informed choices about, and to remain in control of, their own health care”¹⁷.
4. Its objectives can be seen as
 - ♦ To promote respect for the rights, freedoms and dignity of vulnerable people, both individually and collectively.
 - ♦ To ensure people receive the care or services to which they are entitled, and which they wish to receive.
 - ♦ To enhance people’s autonomy.
 - ♦ To assist people to live as independently as possible and in the least restrictive environment.
 - ♦ To help protect disadvantaged people from abuse and exploitation.

Who can benefit from advocacy?

5. Any person can benefit from advocacy if, for whatever reason, they find it difficult to put their own case to service providers or do not feel in a strong position to exercise or defend their rights. It is particularly helpful for people who are at risk of being mistreated or ignored, or who wish to negotiate a change in their care, or are facing a period of crisis.

¹⁷ *Advocacy - A Guide to Good Practice*: Scottish Health Advisory Service

6. Advocacy can be used by people with physical or mental disorders, or by people who simply feel overwhelmed and confused by institutions and care, or by carers of such people. It can be difficult, for a number of reasons, for service users to speak up for themselves. Advocacy gives them a route by which this may be achieved.
7. The Accounts Commission for Scotland, in its recent report on mental health services¹⁸ highlighted the need for agencies to support both individual and collective advocacy. Similarly, the Royal Commission on Long Term Care has emphasised the importance of advocacy for older people¹⁹.

Types of advocacy

8. At present, there are several types of individual advocacy, all of which are used in different parts of Scotland. They are complementary in nature, and each of them may be appropriate at different times. Advocacy is still developing, and the list below is not a comprehensive view of all the ways in which it may operate. However, it aims to provide an overview of some of the ways that advocacy can work.

Citizen advocacy

9. Citizen advocacy normally takes the form of a long term involvement with a person by a trained volunteer attached to an advocacy project. The citizen advocate develops a relationship with the person, and works to promote their interests. This type of advocacy will be appropriate in many different circumstances, but crucial to the success of citizen advocacy is an understanding by the volunteer advocate of when specialist expertise is required, and the development of relationships by the advocate with people who may be able to provide it. For example, it may be appropriate to seek legal advice at times, or advice from specialists on benefits entitlement.

Crisis advocacy

10. Crisis advocacy is one-off involvement with a service user centred on a specific situation. In the case of mental health service users, for example, it might be used at times when detention procedures are being considered, or when a person is due to be discharged from hospital. We have heard evidence that the help of a well-informed, neutral third party to help a person express their views at such times can help to make the experience less difficult.

Peer advocacy

11. Peer advocacy is when a person advocates for another person experiencing similar difficulties. This has the advantage that the advocate will have first-hand knowledge of the service user's situation, but is not personally affected by it.

Advocacy on behalf of people unable to express their views

12. Advocacy on behalf of a person who is not able to make his or her views known, in order to safeguard their best interests, is a different process from other forms of

18 *A Shared Approach: Developing Adult Mental Health Services* Accounts Commission for Scotland (1999)

19 *With Respect to Old Age* Royal Commission on Long Term Care (1999)

advocacy, where a person's views can be ascertained and put forward by an advocate. Advocates acting in this role must attempt to ascertain the person's views, preferences and value base as far as this is possible, by reference to any current or previously-expressed wishes and information provided, for example, by carers.

The legal position of advocacy

13. At present there is no legal right to an advocate for people with mental disorders. In 1986, the Disabled Persons (Services, Consultation and Representation) Act was passed. Sections 1 and 2 of this Act would give disabled people (including people with mental disorders) the right to a 'representative' who would have the right to accompany the disabled person to meetings, receive information about the disabled person and act for them in dealings with the local authority. However, these sections have not yet been brought into force.
14. However, there are some ways in which the access to an advocate has been facilitated. For example, the Patient's Charter in Scotland stated in 1991 that all users of health services have a right to advocacy, and a patient can insist on having a 'patient's supporter' with them when in discussion about their NHS care and treatment.
15. Recently, policy guidance has consistently emphasised the importance of independent advocacy²⁰.
16. The Adults with Incapacity (Scotland) Act 2000 does not make specific reference to advocacy, but one of its key principles is that:

"In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of –

(a) the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult²¹".
17. This is intended to include the services of an advocate, and we understand that the Codes of Practice for the Adults with Incapacity Act are likely to include specific references to advocacy.

Existing advocacy services

18. Advocacy has existed in Scotland for a number of years. It has mainly been aimed at the most vulnerable groups, including people with mental disorders. However, it has developed in an ad-hoc manner, encouraged to various degrees by health boards, NHS trusts and local authorities.
19. Advocacy services come in a variety of forms. Generic services offer assistance to people with a variety of physical and mental problems, and those who may

20 See, for example, the policy documents *Designed to Care* (1997); *Modernising Community Care: An Action Plan* (1998) and *Modernising Social Work Services in Scotland* (1999).

21 Adults with Incapacity (Scotland) Act 2000, s1(4)

require advocacy or advice for other reasons. Other services are solely aimed at one client group, for example, people with mental health problems, or persons being discharged from a learning disability hospital. Members of the Committee visited a generic advocacy service in the north-east of Scotland, and we took evidence from advocacy service providers working within other models.

20. Differences in the ways services are set up and delivered are not necessarily a disadvantage. One of the key advantages of local schemes as opposed to centrally imposed advocacy services is that they are flexible enough to address local needs.

Advocacy 2000

21. One service from which we took oral evidence is Advocacy 2000. It was set up in 1999 by a consortium of 11 different voluntary sector organisations involved with and committed to safeguarding independent advocacy in Scotland. We see its introduction as a significant development in ensuring that advocacy develops throughout Scotland.

Scottish Executive policy towards advocacy

22. The Scottish Executive is supportive of the development of advocacy services.
23. In 1997, the Scottish Office Health Department published 'Advocacy: A Guide to Good Practice', aimed at health boards and other service providers. We understand the guidance for commissioners on the development of local independent advocacy services is likely to be issued soon by the Executive.
24. In a speech on 18 February 2000, the then Deputy Minister for Community Care announced that funding was to be made available to appoint an Advocacy Development Officer to work with local health and social work services to develop an integrated advocacy service for every health board area in Scotland.
25. We welcome these developments, but believe that stronger measures are required.

Problems faced by advocates

26. We received evidence from advocacy workers that some advocates have to spend a good deal of time justifying their role to professional staff. While it appears from the evidence available to us that advocacy is becoming increasingly accepted by staff, there is still room for improvement in this regard.
27. We are also aware that conflict can occur between carers and advocates regarding the latter's involvement with the service user. We believe that the two have complementary roles, and it might be that better provision of information to the carer about the role of an advocate would reduce this type of difficulty.

A legal right to access to advocacy

28. We have considered whether there should be:
- ♦ a right to advocacy for all service users; or
 - ♦ a right to advocacy only for those service users subject to compulsion; or
 - ♦ whether it would be adequate merely to encourage the development of advocacy, perhaps by way of the Code of Practice.
29. Our consultation indicated a high level of support for a legal right to advocacy. In our first Consultation most local authorities and health agencies and all voluntary sector organisations were in favour of such a right. In our second Consultation we found the same pattern. Nearly all of our many respondents on this point were in favour of a right to advocacy for mental health service users, irrespective of legal status.
30. We believe that access to advocacy should be a right for all mental health service users. One of the fundamental principles of the new Act that we propose is that of *Participation*. This principle indicates the importance of ensuring that, as far as possible, a service user is able to indicate his or her preferences and have them taken into account. Advocacy is a powerful tool for ensuring that this happens.
31. We did, however, give consideration to the question of whether only patients subject to compulsion should have a right to access an advocate, and have concluded that this would not be appropriate. Some particularly vulnerable people are not subject to any compulsion, and may require the protection of advocacy. More generally, though, many other service users may feel, for whatever reason, that they cannot make their voice heard. We therefore believe that this right in the Mental Health Act should extend to all mental health service users.

Recommendation 14.1

The Mental Health Act should give a right to all mental health service users to obtain access to an advocate.

How the right would work in practice

The right of access to an advocate

32. The right to access would mean that service users would have to be informed, in an appropriate fashion, that advocacy services exist in their local area, and of what they are and what they can do. They would also need to be advised that they are legally entitled to make use of their services, and of the steps a user should take to contact them.

33. If the user expresses an interest in using an advocacy service, all necessary steps should be taken by health or social work to contact the advocacy service and make advocacy available to the user.
34. However, this right to access advocacy would not place any obligation on the service user. A service user who did not wish to make use of an advocate, or who had been using an advocate and wished no longer to do so, could decline to use the service.

Recommendation 14.2

There should be an obligation on service providers to inform service users about the availability of advocacy services, and to take steps to ensure that the user has an advocate if the user so wishes.

Duty to provide advocacy

35. The right in law for all mental health service users to access an advocate will place an obligation on service providers to ensure the provision of advocacy. However, it is important to establish onto which service provider(s) the duty to provide advocacy would fall. Consultation responses were mixed on this question. Some strongly favoured the introduction of a new national body to provide advocacy. This would have certain advantages in terms of independence from existing service providers, and consistency of service provision. However, there are also problems with such a model. Primarily, there is a danger that the imposition of advocacy from a central body could stifle local innovations in advocacy provision. Such a body might also prove to be costly to operate.
36. We considered whether the responsibility should fall on health boards alone. Most people with mental health problems or learning disabilities are in contact with health services. However, we concluded that the responsibility should be a joint one between health boards and local authorities. People who use mental health services will in most cases have contact with both hospital and community services. It is important, therefore, that their access to advocacy is not based upon their place of residence at any one time.
37. We therefore favour responsibility for ensuring that advocacy is in place lying jointly with health boards and local authorities, who should be obliged to provide a joint plan for the provision of advocacy. This does not mean that health or social work staff would have any direct involvement in the provision of advocacy services. As at present, these services would be commissioned from services which would remain operationally independent from the purchaser, but we envisage health boards and local authorities working to ensure that responsive local schemes are set up and developed in their area.

Recommendation 14.3

There should be a joint duty on health boards and local authorities to ensure that advocacy services are available.

Duty to ensure advocacy is of a satisfactory standard

38. Concerns were expressed from time to time about the quality of advocacy. In particular, we heard concerns about the level of training that advocates have, and linked to that, problems with ensuring that the views being presented are the views of the service user and not his or her advocate.
39. If advocacy is to be made more widely available, the question arises of how at least a minimum level of quality may be ensured. We heard evidence that there is a diversity of view amongst those working in advocacy about whether national standards for advocacy are desirable. There is concern that advocates should retain a primary responsibility to the service user, and their role should develop from the relationship between them. This is particularly relevant for citizen advocacy, where it is felt to be important that the advocate does not become another professional worker.
40. Our view is that advocates should not be unduly 'professionalised' but that they should be trained and competent, and prepared to refer the service user on when they are unable to meet their requirements. Any standards that may be set for advocacy should not be overly rigid. The responsiveness of small-scale advocacy projects to local needs is one of their key strengths.
41. The primary responsibility for ensuring the quality of advocacy should rightly lie with the advocacy services themselves. However, health boards and local authorities, which would have the statutory obligation to ensure that advocacy services are available, should also have the ultimate responsibility for ensuring that they are of a reasonable quality. This would mean that health boards and local authorities would have to monitor standards in the local projects that they support, and compare them against national best practice. Service commissioners would have discretion, if it can be shown to be justified, to require improvements or remove their support from local advocacy projects.
42. This responsibility to monitor quality should not serve as a means to exert control over advocacy organisations, in a way which would restrict their ability to challenge service providers, in the interest of their clients.
43. There may be a case for some form of oversight at a national level, but we take the view that this is a matter which should be considered by the Scottish Executive in relation to advocacy generally, not only advocacy for mental health service users.

Recommendation 14.4

The duty to ensure that advocacy is of a satisfactory standard should fall on the commissioning services.

Resources

44. Some consultees raised concerns about what the practical implications of the right to access to advocacy would be. Clearly, there would be resource implications. Many advocacy projects struggle to find funds to continue their support of service users. We believe that advocacy is too important to continue on such an insecure basis year on year.
45. We would hope that the Executive's stated commitment to advocacy, and the new right to advocacy under the Mental Health Act which we are proposing, would lead to the provision of appropriate levels of resourcing.
46. Furthermore, if done well, advocacy is a cost-effective way of improving the responsiveness of services. In the context of mental health, it may help to engender genuine sharing of responsibility between patients and professionals, which may lessen the need for compulsory measures.

Advocacy for carers

47. We discuss the rights of carers further in Chapter 16, but one issue which has been raised with us is the question of whether advocacy should be developed specifically for carers.
48. We have heard that carers are often bewildered by the experiences they face, and feel that their voice is not being heard. Advocacy for carers is one way in which these difficulties could be ameliorated.
49. We are aware that this is an area which is developing at present. There are a small number of dedicated carer advocacy services in Scotland at present. We welcome the development of these services, and recommend that the Scottish Executive give consideration of what steps it should take to further promoting carer advocacy in Scotland.

Recommendation 14.5

The Scottish Executive should give consideration of what steps it should take to promote advocacy for carers.

Rights to collective advocacy

50. Collective advocacy may be defined as a group of service users, working together to promote their joint views with service providers and others. User empowerment is a growing force, not only in mental health services, but throughout the NHS and elsewhere. There was wide support in our consultations for the concept of collective advocacy, which we also endorse.
51. As with individual advocacy, collective advocacy comes in a variety of forms. Patients' Councils are a form of collective advocacy, which work in hospitals to present the views of patients to management. There are also an increasing number of collective advocacy groups which have been set up and are run by users themselves.
52. We heard evidence from the groups themselves and from service providers of the impact the existence of such a group can have. The users themselves feel empowered, and service providers are made more aware of their views and wishes. Collective advocacy can also permit users collectively to bring pressure to bear on the Scottish Executive, health boards and local authorities. This works well where such collective bodies are encouraged and supported.
53. There are, unfortunately, still areas of Scotland where service users have indicated to us that they feel their voice is not being heard, and that they do not perceive any desire on the part of the statutory authorities to facilitate this.
54. We gave consideration therefore to whether collective advocacy should be put in place by statutory services. However, we concluded, after listening to the views of users, that much of the value of collective advocacy is in its user-run nature and independence of the statutory services. We do not believe, therefore, that there should be a statutory obligation on service providers to develop collective advocacy in their area.
55. However, that is not the same as allowing service providers to deny a hearing to users' groups, by discouraging collective advocacy deliberately or by omission. If collective advocacy is to work properly, it has to be encouraged and financially supported by service providers, and facilitated by organised support staff even although the overall management of the collective advocacy project should be undertaken by users supported by professionals.
56. In this context, one problem which has been raised with us is that some collective advocacy groups, usually user-led community groups, are not being accorded recognition by statutory bodies. We asked in our second Consultation whether there should be a statutory obligation on service providers to recognise collective advocacy groups as a legitimate voice of users in their area. The great majority of respondents were of the view that there should be such an obligation.
57. There is obviously a need for enquiry to be made as to how representative any particular organisation may be. Where they are so representative, we recommend

that there should be a statutory obligation on service providers to provide support services to collective advocacy groups as required, to recognise these groups as a legitimate voice of service users and involve them in decisions on service development and policy.

Recommendation 14.6

There should be a statutory obligation on service providers to provide support services to collective advocacy groups as required.

Recommendation 14.7

There should be a statutory obligation on service providers to recognise collective advocacy groups, whether in hospital or elsewhere, as a legitimate voice of service users and involve them in decisions on service development and policy.

CHAPTER 15

ADVANCE STATEMENTS

What are advance statements?

1. In their most general form, advance statements (also sometimes described as 'advance directives') are a method by which a person can plan for their future treatment. They are a statement by a person, who understands the implications of his or her choices, of the types of treatment and care he or she wishes to receive, should he or she lose decision-making capacity in the future.
2. Advance statements may deal with a variety of issues regarding treatment. The broad issues were discussed by the Scottish Law Commission (SLC) in their report, *Incapable Adults*. This recommended that 'subject to certain exceptions... a valid refusal made by a competent patient to treatment that may be offered in the future when he or she is not mentally capable should have the effect that doctors have no authority to give the treatment in question'²². However, under the Law Commission's proposals, an advance statement would not apply in relation to a detained patient to the extent that it refused treatment for mental disorder which could be given under Part X of the 1984 Act without the consent of the patient.
3. The SLC recommendations were not included in the provisions of the *Adults with Incapacity (Scotland) Act 2000*. In their policy statement, 'Making the Right Moves', the Scottish Executive said 'Although such proposals have the sincere support of particular interest groups, we do not consider that they command general support. Attempts to legislate in this area will not adequately cover all situations which might arise, and could produce unintended and undesirable results in individual cases'²³.
4. The *Adults with Incapacity (Scotland) Act* does however make provisions in relation to 'welfare powers of attorney'. These allow an individual to authorise another person to make personal decisions, including medical decisions, concerning the granter, should the granter become incapable.
5. Under Part II of that Act, such a power must be in written form and signed by the granter, and a solicitor or other authorised person must certify that he or she is satisfied that the granter understood the nature and extent of the power, and is not acting under undue influence.
6. There are procedures under which decisions made by a welfare attorney can be challenged. Also the welfare attorney has no power to place the granter in hospital

²² Scottish Law Commission, *Report on Incapable Adults* (Scot Law Com No 151), recommendation 68

²³ *Making the right moves* (Scottish Executive 1999) 6-14

for treatment of mental disorder against his or her will, and cannot consent to treatment of a detained patient which would be covered by Part X of the 1984 Act²⁴.

7. As we go on to explain, we do not make recommendations regarding advance statements in general. We are concerned only with advance statements concerning treatment for mental disorder, especially when the person may be subject to compulsory measures.
8. In mental health care, advance statements would permit a person, during a period of mental well-being, to plan for the types of interventions he or she would wish or be prepared to receive in the event of a relapse into mental illness. Should the person then relapse and his or her judgement become seriously impaired as a result of illness, there is a record of his or her wishes whilst he or she had decision-making capacity.
9. Such advance statements might have one or more of several different functions, and need not be restricted to medical issues. For example, they could:
 - ♦ give details of the circumstances under which the patient agrees that treatment would be appropriate (for example, a statement might detail the types of behaviour that are indicative of the early stages of a relapse)
 - ♦ give details of treatment and the care package that a patient would prefer to receive, if he or she became ill in the future;
 - ♦ give details of treatments that the patient has made an informed choice not to receive in the future;
 - ♦ give details of to what extent the patient wishes a named carer or nominated person to be kept informed of the progress of the illness and treatment; or
 - ♦ be a statement of the general beliefs and value-system of the patient.
10. In Chapter 16, we propose that service users should have a right when able to do so to nominate someone to act as their 'named person', and this nomination would be, in effect, a kind of advance statement.

Advantages of advance statements

11. We perceive several advantages to advance statements. They can promote service user autonomy, and help to redress the power imbalance many service users have told us that they feel between themselves and mental health professionals. In our consultation, service users frequently made the point that they need to understand and influence what is happening in their care and to feel that their views are listened to, respected and acted upon. Advance statements are one way to promote these aims.
12. Advance statements can reduce the uncertainty about the future felt by many service users, by clarifying the steps that would be taken if the service user became unwell.

24 Adults with Incapacity (Scotland) Act 2000, s16(6)

13. Doctors are expected to consider a patient's preferences when deciding on treatment, and an advance statement can be an important part of this consideration.
14. They represent a formalised way of negotiating treatment options. They can promote collaborative working between mental health professionals and service users, and may reduce the need for compulsion by achieving agreement from both professionals and service users of the situations in which interventions might be needed, and what those interventions should be.
15. They are a way of assuring people that their personal beliefs and wishes will be respected as far as possible. We have heard concerns that a person's individuality of beliefs or plans for the future may sometimes be misinterpreted as the effects of a mental illness. An advance statement can help to show whether or not a person's wishes have been affected by a deterioration in mental state.
16. Generally speaking, there was agreement amongst our respondents that advance statements are a good way to improve the care of service users.

Concerns about advance statements

17. We are aware however that there are genuine concerns about the use of advance statements, particularly in relation to the possibility that advance statements could be used to request that lifesaving treatment be withheld. The recommendations that we make later in this chapter address these and other concerns.

Current legal effect of advance statements

18. There is no explicit statement in current legislation that the provisions of advance statements must be adhered to. However, there are certain considerations which must be taken into account.²⁵
19. Firstly, there is a general duty on medical staff to consider a patient's wishes when making decisions on treatment. Therefore, as far as advance *requests* for certain kinds of treatments are concerned, an advance statement might be one means by which a patient's wishes might be expressed, and should therefore always be taken into account. This could be particularly useful in helping the doctor to choose from a range of treatment options. However, clear statements of preferences of this sort are not legally binding. Indeed, no patient has a right to insist that a particular type of treatment is provided under the NHS.
20. In the case of advance statements which *refuse* treatments, the situation is different. The BMA states the following:

"Competent, informed adults have an established legal right to refuse medical procedures in advance. An unambiguous and informed advance refusal is as valid as a contemporaneous decision. Health professionals are bound to comply when the refusal specifically addresses the situation which has arisen."²⁶

25 For a fuller discussion of this matter, see *Incapable Adults*, paras 5.41 to 5.46 and British Medical Association, *Advance Statements About Medical Treatment* 1996. This was written in response to a report by the House of Lords Select Committee on Medical Ethics, which called for a Code of Practice on advance statements.

26 *Advance Statements About Medical Treatment*, 1996, British Medical Association.

21. This statement appears to reflect the law in England and Wales. It is difficult to know what the law is in Scotland, since there have been few reported cases. We understand that many legal commentators would expect the legal position to be broadly similar.
22. Be that as it may, the position is different for mental health service users subject to detention. Generally speaking, if an advance statement conflicts with other legal provisions, advance statements are superseded by existing statute. That means, in mental health, that an advance statement can currently be overruled by compulsion under the Mental Health Act²⁷.

Future legal force of advance statements

23. We gave consideration to the future legal effect of advance statements. There are a variety of ways in which the legal effect could change, ranging from giving advance statements no formal legal effect to making them legally binding in all circumstances.

Consultation

24. Whilst, as we have said, there was general support for the use of advance statements amongst our consultees, there was more disagreement about what force they should have in law. The issue elicited considerable comment.
25. In our first Consultation we asked about advance refusals of treatment, in the context of the (then forthcoming) Adults with Incapacity legislation. There was a majority, including many medical respondents, who were in favour of respecting advance refusals of treatment but not giving them legally binding force. However, there were also a number of respondents who were very strongly opposed to their use.
26. In our second Consultation we asked about advance statements in more general terms, setting out the arguments, as we have done above, in favour of their use in a *psychiatric* setting. There was a considerable amount of support for making advance statements legally binding, albeit with qualifications and safeguards. However, responses from health bodies, including health boards, NHS Trusts, and medical and nursing bodies, were less enthusiastic about this suggestion.
27. Amongst those in favour of making advance statements legally binding were the Law Society, Scottish Association for Mental Health, ENABLE and the National Schizophrenia Fellowship (Scotland) (NSF (Scotland)). All accepted however that there would be circumstances where the level of risk involved might justify overruling the advance statement.
28. Others considered that it would be premature to include advance statements in legislation, as they were relatively untested in practice. The Mental Welfare Commission recognised the potential value of advance statements, but considered that, as yet, experience of making and interpreting such statements is

27 Although only if the advance statement related to something that came within the scope of the Act itself. An advance statement on another matter would not be affected.

too limited to incorporate them into legislation. The Commission suggested that the Code of Practice could emphasise users' rights to record their wishes regarding care and treatment and for these wishes to be recorded and carefully considered. The British Association of Social Workers shared the view that advance statements were untested and that good practice had not yet developed sufficiently.

29. We received a helpful submission from an academic who is undertaking research into the nature and acceptability of advance statements. This suggested that, at present, to make advance statements legally binding is likely to cause more problems than it solves. The literature appears to suggest that many health care professionals do not support advance statements being legally binding, and that few people, from whatever quarter, support their being binding in all circumstances. There are considerable concerns about how competence to make an advance statement should be assessed, and when the advance statement should be invoked. In relation to treatments such as electro-convulsive therapy (ECT), there are difficulties about whether any right to refuse such treatment in advance should be restricted to those who have had experience of the treatment. There are also resource implications if patients who refuse effective treatment require longer periods of hospitalisation as a result (although this argument would apply to any refusal of treatment, and does not prevent patients in general from refusing treatment when competent).
30. Against that, the submission stated that one of the advantages of advance statements from both the users' and health care professionals' perspective is that it opens up discussion and negotiation about future care and treatment. When advance statements have legal status they are seen as 'forcing' the doctor to listen to the patient. The need for advance statements is perceived more strongly where patients feel coerced into accepting treatment they do not want. Where good relationships exist between patients and the mental health team, they may be seen as unnecessary.

Our conclusions

31. We support the greater use of advance statements, as a means by which service users may make their views and wishes known. We do not, however, recommend that legislative provision should be made in relation to advance statements in general. To do so would encroach on areas of health care which go beyond our remit.
32. Even in relation to the specific issue of treatment for mental disorder, our consultations did not identify a clear consensus which could readily form the basis of legislation in such a complex and contentious area. Although the fact that the common law in this area is unclear creates its own difficulties, attempting to legislate may only serve to increase the potential for confusion and litigation. It would also be difficult to justify having special legislation to deal with treatment for mental disorder and not physical treatments.

33. However, there remains the specific issue of whether advance statements should have some force in relation to treatment of patients subject to compulsion under the Mental Health Act. At the moment, this is perhaps the only situation where a validly made advance statement has no legal force at all. We considered the suggestion that advance statements would be binding unless there was a risk of harm to others or serious harm to the patient. Ultimately, we concluded that to do so would raise a range of practical problems, and that this was not the best way to achieve the desired aim: the greater involvement of service users in decisions concerning their care and treatment.
34. Our general view, then, is that valid advance statements should always be taken into account, but that they should not be legally binding when the relevant treatment is authorised by the Mental Health Act. We set out below our views as to how such statements might be incorporated into the arrangements for care and treatment under the Act.

Recommendation 15.1

Service users should be entitled to make advance statements, setting out their wishes in relation to future care and treatment, but these should not be legally binding when the relevant treatment is authorised by the Mental Health Act.

How the new system would work

What the advance statement would look like

35. It is neither necessary or desirable to set out a particular statutory form of advance statement. The known previous wishes of service users should always be taken into account, whether or not set out formally in an advance statement. However, the advance statement offers a convenient means for the service user to confirm his or her views. To give it the appropriate status, we believe that it is desirable that the statement should be entered into with a degree of formality. This will reinforce the significance of the document, and make it easier to be satisfied that the document is valid.
36. The purpose of such a statement may be similar to that of a welfare power of attorney under the Adults with Incapacity Act; indeed both could be encompassed within the same document. We propose that similar requirements operate for advance statements as for welfare powers of attorney²⁸, although it would not be necessary for advance statements to be registered²⁹.
37. In order, then, for an advance statement to be deemed validly made for the purposes of the Mental Health Act, it should be in written form, and signed by the granter (with alternative arrangements made for people unable to sign documents for whatever reason). The statement should also be signed by a doctor, solicitor, or other person of appropriate standing, that the person appeared able to understand the nature and effect of the advance statement and to make decisions regarding it.

²⁸ Adults with Incapacity (Scotland) Act 2000, s16

²⁹ Adults with Incapacity (Scotland) Act 2000, s19

When the advance statement would be drawn up

38. There need not be any specific legislative requirement concerning the circumstances in which an advance statement is drawn up. It might be appropriate for example for a statement to be drawn up, or an old one revised, when a service user is being discharged from hospital, or planning for another major change in circumstances; but one could be entered into at any time. There are obvious merits in statements being written in circumstances which maximise the chances that they are known about, accepted as valid, and taken into account.
39. For many patients, the best way to ensure this might be for the advance statement to be drawn up in consultation with their doctor, or another member of the health care team. Others may prefer to involve a social worker, or an advocate. In any event, it would be desirable that the advance statement be communicated to the people expected to have regard to its contents, before the issues which it is intended to cover arise. One means of ensuring this would be to have the statement placed with the service user's medical records or, as appropriate, incorporated within a community care assessment or plan of care.

The procedure when an advance statement is in existence

40. If a service user makes an advance statement in relation to treatment which is not covered by any compulsory order under the Mental Health Act, it would be for the relevant health care professionals to apply the common law in considering what weight to attach to the advance statement. The advance statement would only be of relevance where the patient was incapable of making a decision about treatment, since otherwise it would be the patient's current decision that would have precedence.
41. Where, however, a patient is subject to compulsion under the Mental Health Act, and the statement relates to treatment for mental disorder, the health care professionals would be expected to consider the validity of the advance statement, bearing in mind what is known about the person, the person's mental state at the time the statement was entered into, and other relevant circumstances.

Recommendation 15.2

In considering the validity of an advance statement, account should be taken of whether

- ♦ *the person was able to understand the implications of the statement at the time the statement was entered into;*
- ♦ *the statement covers the treatment which is being considered and*
- ♦ *there has been any material change of circumstances since it was entered into.*

42. The Code of Practice should contain guidance on factors which are relevant to the validity of the advance statement. In addition, it could contain recommendations as to good practice to improve the effectiveness of the system of advance statements. These might include that training should be given to medical practitioners and nurses in the use of advance statements.

Recommendation 15.3

The Code of Practice should contain guidance on advance statements, including guidance as to

- ♦ *the preferred format of such statements*
- ♦ *how such statements should be drawn up and recorded*
- ♦ *the requirements for execution of an advance statement*
- ♦ *the requirements for establishing the validity of an advance statement*
- ♦ *the circumstances in which it would be appropriate not to implement an advance statement.*

43. If satisfied that an advance statement is, on the face of it, valid, health care professionals would be expected to have proper regard to its terms. Any decision not to implement the terms of an advance statement should be recorded, together with reasons. Such reasons would include the potential risk of harm to the service user, or to third parties, if treatment is withheld in compliance with the statement. Except in the case of urgent necessity, treatment should not normally be given in breach of such a statement to a patient subject to emergency or short term detention.
44. Service users would also be able to indicate in advance that they would wish certain forms of treatment should they become unwell. Although this would not require service providers to honour the request, the reasons why the services requested by the service user could not be provided should be recorded.
45. In the case of long term compulsion, or an appeal against short term measures, the tribunal would consider the advance statement alongside the evidence led to justify compulsory measures. It would consider first of all whether the advance statement is valid, applying the criteria which we discuss above. Should the tribunal not be satisfied that the advance statement is valid, it would be disregarded.
46. Otherwise, the statement would be taken into account as part of the general consideration of whether compulsory measures are justified, and what they should be. The tribunal would not be bound to implement the terms of an advance statement, but would be required to give it due weight in agreeing to compulsory measures and any associated plan of care.

47. Although we hope it would happen rarely, it may be necessary to consider what might happen if an advance statement comes to light, after compulsory measures are in place, but having been completed before then. It would be for the responsible medical officer (RMO) to consider its terms, and whether it applies to any treatment authorised in terms of the compulsory measures. Should this be the case, the RMO would be expected to consider, so far as is practicable, whether the advance statement is valid. Should the RMO be satisfied that the advance statement is in fact valid, the reasons for giving any treatment in breach of the terms of the statement should be recorded in writing.

Recommendation 15.4

Advance statements should not be legally enforceable by patients subject to compulsory measures under mental health law, but the tribunal considering such measures, and any person authorised to act under such measures, should be required to take a valid advance statement into account.

Recommendation 15.5

Where the responsible medical officer authorises any treatment for mental disorder on a patient subject to compulsion which appears to contradict the terms of a valid advance statement, the responsible medical officer should record the reasons for doing so in writing.

Liability of professionals

48. One of the issues which causes particular concern about advance statements is the possibility that professionals might face legal action, because they have treated a patient in a way which is inconsistent with the terms of an advance statement, or because they have not made adequate enquiry into the validity of an advance statement upon which they relied.
49. Because we do not recommend that advance statements be legally binding for patients subject to compulsion, the risk of such legal action should be reduced. However, there may still be concern as to the possibility of adverse legal consequences. We recommend in Chapter 19 that there should continue to be a provision, similar to the current s122, which would protect people from acts done in pursuance of the Act, provided they were done in good faith and with reasonable care. A similar protection should operate for actions taken in relation to advance statements for patients subject to compulsory measures. Provided a professional has taken proper care, and paid regard to the existence of an advance statement in the context of his or her professional and other responsibilities, there should be no liability either for following or declining to follow an advance statement.

Recommendation 15.6

Professionals should not be legally liable for any actions or omissions which are inconsistent with an advance statement, or for failure to make adequate enquiry into the validity of an advance statement whose terms they have followed, provided they have acted in good faith and with reasonable care.

CHAPTER 16

RIGHTS OF INFORMAL CARERS

Introduction

1. Relatives are currently given certain rights and responsibilities under the 1984 Act. The 'nearest relative' may initiate detention or guardianship proceedings, may oppose an application by the mental health officer (MHO) for long term detention or guardianship, or may seek to have a detained patient discharged. There are duties to give the nearest relative information about proceedings taken under the Act. Where a patient is detained under emergency measures (s24), either a relative (not necessarily the nearest relative) or an MHO must consent to the detention, unless this is not practicable in the circumstances.
2. We discuss the role of relatives in relation to consent to detention in Chapter 7. In addition to reviewing these, we have also given consideration to how carers should be defined in the new Mental Health Act, and how that Act could help carers in their role and promote understanding and respect for the work that they carry out.
3. We propose a more flexible arrangement which would allow a relative or informal carer to be appointed as a 'named person', with rights to information and involvement in any proceedings under the Mental Health Act.

The nearest relative in the 1984 Act

Relatives and nearest relatives

4. At present, s53 of the Mental Health Act contains a lengthy description of what a 'relative' is and how a 'nearest relative' may be defined.
5. In essence, despite the elaborate drafting of the section, the reference to the person 'who is caring for the patient or was so caring immediately before the admission of a patient to hospital, or his reception into guardianship' means that the 'nearest relative' is the carer most closely related to, or married or cohabiting with, a patient subject to compulsion under the 1984 Act. There is a hierarchy of 'nearness' given in s53(1), and the nearest relative will normally be the person nearest the top of the list, unless they are not caring for the person, in which case the carer nearest the top of the list will be the 'nearest relative'. The carer, however, must fall within one of the categories of relative outlined in the section.

6. We have heard evidence that there are several problems with the way the nearest relative is defined.

Who may be the nearest relative

7. The current Act distinguishes between marital relationships and other types of relationships. A husband or wife is automatically the nearest relative, unless they are separated from the service user. Other partners may only achieve the status of 'spouse' after cohabiting for a period of six months³⁰.
8. A homosexual or lesbian partner cannot be treated as a 'spouse'. They therefore necessarily fall under the provisions of s53(6). A person who comes under this latter section can only be treated as a 'relative' after cohabiting for five years, even if they are the person's primary carer, and can only be treated as a 'nearest relative' for the purposes of the Act if no other nearest relative from the list given in s53(1) is caring for the service user. A person coming under s53(6) cannot gain the status of 'spouse', no matter how long their relationship with the service user.
9. In the Adults with Incapacity (Scotland) Act 2000, the definition of nearest relative in the 1984 Act is employed, but there is an additional provision that a person of the same sex who has been living, for a period of not less than six months, with the adult in a relationship which has the characteristics of the relationship between husband and wife, is given equivalent status to a spouse.³¹
10. The 1984 Act also lacks flexibility regarding the role of distant family members or unrelated people who may care for the service user. Again, they will have to have lived with and cared for the person for five years before they may qualify as a 'nearest relative'. A carer of four years' standing could thus be overruled by a relative who does not care for the service user. We do not believe that this is appropriate.
11. We also take the view that, in general, a hierarchy of family relationships as given at s53(1) is unlikely accurately to reflect the great variety of ways in which families may be living.
12. We believe that many of these difficulties are based upon the fact that the Act is specific about which family members have the right to be considered as nearest relatives, and does not mention certain possible significant others. In our view the rights of relatives and carers under the new Mental Health Act should be based primarily upon the existence of a caring or supportive role, rather than a family relationship.

Replacement of nearest relative

13. The powers attached to the nearest relative by the 1984 Act mean that it is important that a suitable person is given this designation. However, when the nearest relative is an inappropriate person it is extremely difficult to have him or her changed.

³⁰ 1984 Act s53(5)

³¹ Adults with Incapacity (Scotland) Act 2000, s87

14. The reasons why a nearest relative is inappropriate may vary. The service user may not in fact have a close relationship with the nearest relative, or there may even be hostility between them. Indeed on rare occasions a nearest relative may be physically, sexually or otherwise abusive towards the service user. It is clearly inappropriate that in such cases the person should remain as nearest relative.
15. Currently, an application for the nearest relative to be changed may be made to the sheriff by the nearest relative, a person with whom the service user lives or an MHO³². The service user him or herself does not have the right to petition for the nearest relative to be changed.
16. There are three grounds upon which a nearest relative may be changed:
 - ♦ the patient has no nearest relative, or it is impractical to find a nearest relative; or
 - ♦ the nearest relative cannot act as such because of mental disorder or another illness; or
 - ♦ the nearest relative has made the application, and he or she no longer wishes to act as nearest relative.
17. However, there are certain significant omissions from this list. The nearest relative cannot be changed because:
 - ♦ the service user does not wish him or her to be the nearest relative; or
 - ♦ he or she is unsuitable for a reason other than illness; or
 - ♦ he or she is not acting in the best interests of the service user.
18. This may be at risk of challenge under the European Convention on Human Rights. In a case brought under the Convention, the fact that the applicant, despite having good grounds to do so, was not able to change her nearest relative under the English Mental Health Act was ruled in breach of Article 8 of the Convention³³. However, it is important here to note that the general concept of the nearest relative having powers under the Act was not ruled to be in breach.
19. The Adults with Incapacity (Scotland) Act 2000 allows an incapable adult to apply to the sheriff to change the nearest relative or to stop certain information being disclosed to the nearest relative³⁴. A new person can be made nearest relative if the sheriff is satisfied that 'to do so will benefit the adult'. The grounds are not otherwise defined in the Act. However, the nearest relative must still be a person eligible to be a 'nearest relative', under the terms of the 2000 Act.

Proposals for the named person

20. Having considered these various concerns, we have concluded that there is a need for a new framework for families and carers in the Mental Health Act.

³² 1984 Act s56

³³ *JT v United Kingdom* 1998 Application No. 26494/95

³⁴ Adults with Incapacity (Scotland) Act 2000 s4

21. We believe that there are two separate issues which the Act must address in relation to relatives and carers. Many of the powers given to nearest relatives in the 1984 Act are intended to allow that person to represent the interests of the service user, for example by objecting to detention. This is essentially a role of advocacy and support.
22. However, there are also rights which we believe should apply to carers in their own right, to assist them in carrying out the caring role, particularly in relation to access to information. We discuss these later, and confine our discussions at this stage to the role of representing the interests of the service user.
23. Our proposed reforms have the following aims:
 - ♦ To give service users a greater opportunity to specify the person they wish to represent their interests, while providing protection against decisions taken which are the result of impaired judgement caused by illness.
 - ♦ To base legal rights and responsibilities more closely on the actual role played in relation to the service user.
 - ♦ To ensure that statutory definitions are flexible, and reflect the range of family relationships.
24. We propose procedures to identify an individual who would have the following rights in relation to a service user:
 - ♦ The right to seek an assessment of the service user's needs, including the possible need for compulsion.
 - ♦ The right to be notified and consulted in relation to applications for compulsory measures.
 - ♦ The right to be heard by the tribunal in relation to any such application.
 - ♦ The right to appeal against a decision to impose compulsory measures.
25. We call this individual the 'named person'.
26. In accordance with the principle of *Participation*, we propose that service users should have the right to nominate the person they would wish to act as their named person. Where there is no nominated person, the primary carer would assume the rights and responsibilities of the named person. Should there be no primary carer, the person who is the nearest relative, in terms of the Act, would take on the role. At each stage, it would be possible for the service user, or other interested parties, to challenge the appointment, and for the specified person to decline, or resign from, the appointment.
27. In many, perhaps most cases, the person nominated by the service user, the primary carer, and the nearest relative would be one and the same. As is the case with nearest relatives under the 1984 Act, it would be possible for a service user to have no named person.

Recommendation 16.1

There should be a 'named person', who should exercise powers comparable to those of the nearest relative under the 1984 Act (other than the power to consent to detention or to order discharge).

Nominating the named person

28. We believe that service users, when able to do so, should be able to determine who has powers under the Act relating to them.
29. We therefore recommend that service users should have the right, when able to do so, to nominate a person to take on the functions of the named person. The nominated person would not necessarily have to be the primary carer, nor a relative, although in many, perhaps most, cases the nominated person will be both.

Recommendation 16.2

A service user should have the right, when able to do so, to nominate a person to take on the functions of the 'named person'.

30. Such a nomination would not, of course, be mandatory. Service users should be made aware of their right to make a nomination but, if they are unable to do so because of the severity of their disorder, or they do not wish to do so, the primary carer would then assume the responsibilities (see below).
31. We asked in our second Consultation document about the concept of a nominated person, and found that there was widespread support for this proposal, especially from user, carer and voluntary sector groups.
32. There would require to be clear guidelines for how the nomination could take place. A nomination should be made in writing and be witnessed and signed by an appropriate person.
33. The procedure would be similar to that in relation to the granting of a continuing or welfare power of attorney under the Adults with Incapacity (Scotland) Act³⁵. The appropriate person would be drawn from a prescribed set of people to witness the document. This class would include solicitors and doctors, alongside other suitable people. The witness would certify that, so far as could be ascertained, the nominating person appeared to understand the nature and effect of the document and was not acting under any form of undue influence.
34. Notwithstanding this protection, there could clearly be concerns that the service user has not understood the implications of his or her actions, or is not well

³⁵ Adults with Incapacity (Scotland) Act 2000, ss 15 and 16

enough to take a rational decision, or was under inappropriate pressure from a third party. These concerns could be the basis for a challenge to the nomination.

35. Having nominated a person, the service user would, of course, be at liberty to change the nomination. Concerns have been raised with us that the nominated person arrangements might encourage a service user frequently to change his or her nominated person, causing administrative difficulties and upset to family members and carers. This is a matter which could also be borne in mind in a challenge to the nomination.

Recommendation 16.3

A nomination by a service user of a person to take on the functions of a 'named person' should be in writing, and should be witnessed by a person from a prescribed class, who should certify that the nominating person appeared to understand the nature and effect of the document, and appeared not to be acting under any form of undue influence.

The primary carer and nearest relative as the named person

36. Where the service user has not made a nomination, and either is not currently able or does not wish to do so, the primary carer would be next in line for the role.
37. We propose that 'primary carer' should have a broad definition. It would not be necessary for the carer to be living with the service user to be classed as the primary carer, and caring would include emotional support and practical help, in addition to physical care. The definition would include a person who had been giving such care prior to an admission to hospital or other institutional care.
38. The identity of the primary carer should be established by the MHO. If the primary carer is agreeable, he or she would then have the status of the named person until such time, if it occurs, as the service user is in a position to and wishes to make a nomination of his or her own.
39. If there is more than one person who could be classed as a carer, and it is unclear who the primary carer is, the MHO would decide which would be most appropriate for the role.
40. If there is no primary carer, the nearest relative would then, if agreeable, be given the status of the named person.
41. The nearest relative, for this purpose, would be defined in the same way as under the 1984 Act, but with the additional provision which has been made in the Adults with Incapacity (Scotland) Act to include same sex partners.

Recommendation 16.4

Where no nomination has been made by the service user, or the nominated person declines to act, the named person should be the primary carer, as determined by the mental health officer.

Recommendation 16.5

Where there is no primary carer, or the primary carer declines to act, the named person should be the nearest relative.

Recommendation 16.6

The definitions of primary carer and nearest relative should be in similar terms to those contained in the Adults with Incapacity (Scotland) Act 2000.

Removing or challenging the appointment of a named person

42. We take the view that it should be possible for a person with a legitimate interest to approach the tribunal, to seek the removal of the named person and, if appropriate, the appointment of another person to the role.
43. Such an application could be made by the service user, the MHO or responsible medical officer (RMO), any person purporting to be a carer or relative, or any other person who can demonstrate a legitimate interest to the tribunal. Amongst the possible grounds for a challenge would be:
 - ♦ where the named person was nominated by the service user, he or she was not capable of making the nomination or was subject to undue influence
 - ♦ there was evidence that the named person is unsuitable for the role
 - ♦ the MHO has incorrectly determined the identity of the primary carer
 - ♦ there has been a mistaken identification of the nearest relative.
44. It would also be possible, where there is no named person, for the tribunal to appoint someone who would not otherwise qualify under the above criteria.

Recommendation 16.7

Any person who can demonstrate an interest should be entitled to request that the tribunal remove the appointment of a named person, and, if appropriate, appoint a new named person. The tribunal would be entitled to appoint any individual whom it deemed suitable to the role of named person.

Right to information and support

45. Carers are the people most involved with service users, and they have particular understanding of the people for whom they care and the progress of their mental disorder. Carers want and need to be involved and consulted in care planning and treatment decisions for the service user for whom they care, whether the service user is in hospital or in the community. We have been considering whether a certain level of information, consultation and support for carers of mental health service users should be a statutory requirement.

Information

General issues

46. Voluntary caring by friends or family can be a fundamental part of the support network of a service user. We believe that it is vital to the success of a carer's relationship with a service user that the carer is given the appropriate information that he or she needs, to allow him or her to continue in the caring role. We received particularly helpful evidence on this issue from the National Schizophrenia Fellowship (Scotland) (NSF (Scotland)). A survey they conducted of carers found that failure to obtain information can lead to inability to monitor the progress of the illness, the treatment and signs of relapse and, in some cases, unrealistic expectations of the service user's progress. The results of this lack of shared knowledge can include an increase in family conflict, feelings of guilt and hopelessness, and breakdowns in relationships between carers, staff and service users.
47. As they point out, informal carers can have considerable influence on the outcome of the illness, and so their need for information should not be ignored.
48. We have heard evidence from carers of the difficulties that they have faced in attempting to obtain highly relevant information from service providers. One told us:
- 'It is as if a shutter comes down when you get a relative admitted to hospital and you, the person who has been giving all the care, is left on the outside.'
49. At present, the nearest relative has a right, under s111 the 1984 Act, to be informed of the proposed date of discharge of a detained patient (unless the discharge is because of a challenge by the nearest relative or the making of a community care order). However, the patient, or the nearest relative, can request that this information should not be given³⁶.

36 1984 Act s111(2)

50. The Chief Medical Officer's Bulletin of July 1999 included a communication to all GPs in Scotland emphasising the need to inform carers about the health and treatment of the cared-for person (with the cared-for person's consent and to consider on a case-by-case basis divulging information without that consent). The draft clinical standards for schizophrenia issued by the Clinical Standards Board for Scotland also place emphasis on the importance of sharing information with carers.
51. We believe that s111 requires updating in the light of our proposed changes to the 'nearest relative' system; our desire better to inform those who undertake a caring role; and the increased recognition of the importance of keeping carers informed, in a sensitive and appropriate manner. The general approach should be based on an expectation that informal carers will be kept informed and involved unless there is good reason not to do so.
52. Confidentiality should normally be respected, where the service user has requested this, but it should not be assumed that this is what the service user would wish. A distinction should also be made between those who expressly state that they do not wish carers or relatives to be given information, and those who, because of the severity of their mental disorder, are not able to consent to information being shared. For this latter group, it may well be appropriate for information to be shared.
53. It may also be appropriate in some cases to encourage the service user to consent to information being disclosed, or to seek consent again if their condition improves. The extent to which practical advice can be given without breaching confidentiality should also be explored.

Named person's rights to basic information

54. The 'named person', in particular, requires access to certain information in order to fulfil the responsibilities of the role.

Recommendation 16.8

The named person should be entitled to be notified of

- ♦ *the service user's legal status under the Mental Health Act, and any compulsion to which he or she is subject*
- ♦ *any application for compulsory measures*
- ♦ *any hearing by the tribunal in relation to the service user*
- ♦ *any decision to discharge the service user from compulsory measures.*

55. Except in an emergency, there should be an expectation that such information will be made available in good time to allow the named person to take any appropriate action, such as to oppose an application for compulsory measures. As we go on

to state, there should also be an expectation that the named person will be consulted in relation to these measures.

56. Because this information is seen as fundamental to the role of named person, the service user would not be entitled to refuse to allow the information to be given, although he or she could nominate a new named person, or ask the tribunal to discharge the current named person.

Primary carers: right to information

57. As we have already indicated, there is a balance to be struck between the right of the service user to confidentiality and the rights of those who may be intimately affected by the service user's movements and treatment to know what is happening. We believe that, in certain specific circumstances, the right of a carer to fulfil the caring role, or a party at risk to assure his or her own personal safety, must outweigh the right of a service user to confidentiality.
58. Such a balance is already struck, to some extent, when a community care order is made. At present, if an application for a community care order is being considered, the responsible medical officer (RMO) must consult with professional and care staff and:
- ♦ the nearest relative, if the patient so agrees;
 - ♦ 'any person who the responsible medical officer believes will play a substantial part in the care of the patient after the order comes into force but will not be professionally concerned with the aftercare services', (that is to say, the primary carer);
 - ♦ the nearest relative, whether or not the patient agrees, if 'the patient has a propensity to violent or dangerous behaviour'³⁷.
59. In most cases, the named person under our proposals is likely to be the primary carer. Whether or not this is the case, the primary carer may require access to information in order to undertake the caring role. It is notable that the requirements of confidentiality do not necessarily restrict information from being shared amongst a care team, and we believe it is unfortunate that this practice should sometimes cover everyone except a family member, purely on the basis that they are an unpaid, rather than paid, carer.
60. Where information is being passed on against the wishes of the service user, this should be on the basis of a need, rather than wish, to know. In our view, it would be extremely difficult to set out in legislation the precise nature of the information which the carer might need to know, since this will vary, depending on the nature of the relationship with the service user. It should, however, be addressed in the Code of Practice.

37 1984 Act s35B(2)

Recommendation 16.9

The Code of Practice should contain guidance on

- ♦ *the nature of information that should be provided to the primary carer of a person subject to compulsory measures, whether or not the primary carer is the named person, and*
- ♦ *when it is appropriate to provide information to the primary carer without the consent of the service user.*

Consultation on compulsion

61. We state elsewhere (Chapter 7) that we no longer believe that relatives should be asked to consent to detentions. However, we believe that in all cases where compulsion is being considered, there should be a statutory duty, where practicable, to ascertain and take into account the views of the named person. Written reasons should be given if this has not proven to be possible.

Recommendation 16.10

The Act should provide that the named person should, when practicable, be consulted where compulsion is being considered.

Challenging of compulsion by named person

62. The nearest relative currently has a right under ss.33 and 34 of the 1984 Act to challenge detentions. We make recommendations in Chapter 8 regarding the rights of the named person in relation to appeals against compulsory measures.

General information to carers and families

63. We believe that general information about available services, carers' legal rights, what mental disorders are and their causes and effects, should be more readily available to carers, including carers of mentally disordered persons generally, not just those subject to compulsion.
64. At present, there is a range of information available to carers in various forms, if carers know who to ask and where to look. However, the evidence that we have heard is that carers struggle to find the information appropriate to them, and that sources of appropriate information are scattered throughout the statutory, governmental and voluntary sectors.
65. In particular, family members have told us of the great distress caused at the time when a relative is being detained. Often the family feel completely unaware of who to approach for help, or what their rights are.

66. We are aware that there are a range of local information services which are designed to assist carers, but we believe that there is a need for a central information strategy for carers of mentally disordered persons. We therefore recommend that the Scottish Executive should consider how a single point of contact may be made available for carers wishing information on their rights and on mental disorder in general. This may be as straightforward as a single helpline, well advertised, and manned by knowledgeable people, who would have sources of information to hand and be able to refer carers to local resources. In addition, new technologies should be harnessed to improve information availability.

Recommendation 16.11

The Scottish Executive should formulate a central information strategy for carers of mentally disordered persons, including giving consideration to a single contact point for carers seeking information.

Carers' needs

67. Carers currently have a legal right, under the Social Work (Scotland) Act 1968 s12A (3A)³⁸, to an assessment of their needs by social work services, in cases where a community care assessment is being carried out on the person for whom they care. To qualify as a carer, the person does not have to be living with the person for whom they care, but they do have to be providing or intending to provide 'a substantial amount of care on a regular basis'³⁹.
68. Carers' organisations have commented to us that the statutory definition may not reflect well the situation of informal carers of adults with mental health problems, where the care may be more sporadic, but still highly intensive should the service user experience a crisis.
69. It is also possible that a carer might him or herself be a 'person in need', in which case he or she would be eligible for a community care assessment of his or her own (see Chapter 13).
70. The right to a carer's assessment does not lead to any right to services, nor a separate plan of care for the carer, but the assessment should be considered alongside the community care assessment in formulating decisions about services for the user and his or her carer(s).
71. Unlike the assessment of 'persons in need' under the 1968 Act, the assessment of carers is not automatic. It depends upon a request being made by the carer, and is therefore dependent upon the carer knowing that a community care assessment is being carried out, and that he or she has the right to a carer's assessment.

38 Inserted by the Carers (Recognition and Services) Act 1995

39 Social Work (Scotland) Act 1968 s12A(3A)(b)

72. The evidence that we have received is that most carers have not been in receipt of such an assessment. In most cases it seems that the carer has not been not aware of his or her right to such an assessment. We therefore believe that local authorities should consider ways in which carers might be better informed about their rights in this respect. In particular, we suggest that local authorities should work with mental health services to provide a coherent package of information to carers of mental health service users, which would include information on carers' legal right to an assessment of needs.
73. We note the commitment in 'A Strategy for Carers in Scotland'⁴⁰ that the Scottish Executive will introduce legislation to enable carers to have their needs directly assessed for the first time. We welcome these proposals, and note the setting-up of the Carers' Legislation Working Group, which is considering how this commitment may be taken forward.
74. We asked in our first Consultation whether the right to an assessment for carers should continue to be a social work duty, or whether it should be broadened to include mental health services. A clear majority of those respondents that answered this question were in favour of the duty remaining with social work.
75. We concur, and hope that the Scottish Executive's proposed direct assessment of the carer's needs by social work services, if introduced and consistently applied, will help to ensure that any needs that a carer may have are positively identified.

Recommendation 16.12

Carers should continue to have the right to an assessment of their needs by social work services. Local authorities should consider how carers might be better informed of their right to such an assessment.

Consideration of carers' needs by the tribunal

76. The tribunal, in considering compulsory measures of care, should base its decision on the individual needs of the service user. The issue arises as to whether the carer's needs should also be taken into account. Clearly, the primary responsibility is towards the person who may be subject to compulsory intervention. However, it is important that any order, for example for compulsory treatment in the community, is not based on unrealistic or unfair expectations about the support that may be available from informal carers.
77. In carers' assessments, the local authority is expected to have regard to the ability and willingness of the carer to undertake caring responsibilities. We believe that the tribunal should have a similar responsibility.

⁴⁰ A strategy for carers in Scotland Scottish Executive (1999).

Recommendation 16.13

In considering compulsory measures of care, the tribunal should be required to consider the extent to which any informal carer is willing and able to undertake any caring responsibilities which may be implied by any order they make.

Young carers

78. In Chapter 18, we discuss the needs of children and young people who experience mental health problems. We are also concerned about children and young people who may be caring for adults with mental disorders.
79. At the seminar organised for us by Children in Scotland (see Annex 6), there was discussion of the needs of young carers. It was observed that young carers face specific problems, such as fear of stigmatisation, concerns that they may be taken into care of the local authority if they ask for help, or a lack of information about available services. There is a need for any information produced for young carers to be age-appropriate.
80. It appears that carers under the age of 16 years do not currently have the right to request an assessment of their needs, as adult carers do⁴¹. The evidence that we have received is that this is placing an already disadvantaged group at greater disadvantage. There is provision for an assessment to be carried out under the Children (Scotland) Act 1995 on the basis that the young carer is a 'child affected by disability', but the child has no right to initiate this. We believe that a direct assessment of young carers' needs should be a legal right.
81. We therefore welcome the commitment in the Strategy for Carers in Scotland that the Executive's proposals for carers' assessments will extend to carers under the age of 16. We believe that this could make a significant difference to the lives of many young carers.

Recommendation 16.14

Young carers should be given the right to an assessment of needs, whether or not a new type of carers' assessment is introduced by the Scottish Executive.

Respite

82. Some respondents to our consultation with users and carers told us of the importance of services designed specifically for the carer rather than the service user. The most commonly mentioned of these was respite.

⁴¹ *Carers (Recognition Services) Act 1995: Policy and Practice Guidance*, SWSG Circular 11/96, para 11. However, this appears to run contrary to the commitment given during the passage of the Carers Bill that young carers would be included (Hansard Vol 258 cols 424-434). See McKay C., and Patrick H. *The Care Maze: Update*. (Enable, 1997)

83. We agree with the view expressed by several major carers' organisations that respite is a key factor in allowing carers effectively to undertake their role. We visited a respite facility in the north-east of Scotland and were impressed by the work that was being undertaken there.
84. We note the stated commitment of the Scottish Executive to providing quality respite care. As we have said, in its Strategy for Carers in Scotland, the Executive announced that it plans to introduce assessments of carers' own needs, which is likely, in many cases, to include the need for respite. The Executive also announced that national standards for residential respite care will shortly be introduced. These are both encouraging developments.
85. We are in favour of the greater use of respite services to help carers undertake the difficult role of caring. Although we do not believe that mental health legislation is the appropriate place to encourage the development of respite services for carers, we hope that the Scottish Executive will consider how the legal position of carers seeking respite may be strengthened.

Recommendation 16.15

The Scottish Executive should consider strengthening the legal position of carers seeking respite.

CHAPTER 17

CIVIL AND SOCIAL RIGHTS

1. We heard evidence that people with mental disorders can face specific disadvantages in respect of their civil and social rights.

Voting rights

2. In our first Consultation, we sought views on what effect, if any, treatment for mental disorder should have on the right to vote. Respondents made a number of criticisms regarding the voting system, particularly the fact that there were restrictions on the rights of detained patients to vote. These turned on the fact that, after a period of detention, such patients were deemed not to be resident at their home address, and the hospital could not be treated as a home address for voting purposes. Criticisms were also made concerning the additional procedures which voluntary patients in learning disability and psychiatric hospitals had to undergo in order to be allowed to vote.
3. We felt that these restrictions were unjustified, and made representations to the Home Office Working Party which was, at the time, considering a number of issues concerning electoral procedures. We were pleased that the Working Party shared our general concerns, and recommended that such restrictions be removed.⁴²
4. Since then, the UK parliament has passed the Representation of the People Act 2000. This makes provision for voluntary and detained patients (other than detained offenders) to register to vote. Such patients will be able to register either at the hospital where they are living or at their former address, or some other place where they have a local connection⁴³. The requirement for a 'patient's declaration' is removed. The Act also makes new provision for assistance to people with physical disabilities, or who are unable to read. As a result, we need make no further recommendation on this issue.

Housing and benefits

5. People with mental disorders often rely on public services, and are affected by housing, social work, health and welfare benefit legislation. This other legislation may not pay sufficient regard to the needs of people with mental disorder, or the interaction between different pieces of legislation may disadvantage some people. People with mental health problems can also have difficulty using mainstream information and advice agencies.

⁴² Home Office Working Party on Electoral Procedures, chaired by George Howarth: report (Home Office, 1999)

⁴³ Representation of the People Act 2000, s4.

6. It has not been possible for us to consider every aspect of the law where people with a mental disorder, amongst other vulnerable groups, may not receive adequate support. We consider that particular areas, which impact adversely on people with a mental disorder, include welfare benefits legislation and housing policy.

Housing

7. The Disability Discrimination Act 1995 gives disabled people rights not to be discriminated against in access to housing. However, many landlords are reluctant to have people with mental health needs as tenants. We were also told that some public sector landlords impose conditions on people with community care needs by insisting that they agree a care package before granting a tenancy.
8. Respondents to our consultation also highlighted the detrimental effect of the practice of housing vulnerable people in hard to let accommodation. This practice compounds the difficulties of community integration. We were advised that allocation systems for housing often award priority on the grounds of physical ill health but may not adequately recognise mental illness.
9. These concerns should of course be set against the general background of the difficulties that local authorities face, for financial and other reasons, in meeting the demand in their area for good quality housing.
10. People who move in and out of hospital often face particular difficulties in maintaining tenancies. Sometimes this relates to problems with welfare benefits, but there may also be difficulties with the policies of some landlords regarding the recovery of properties.
11. We were not able to consider these problems in detail, but we consider that they are of relevance to our remit. The recommendations we make regarding compulsory measures are designed to reflect the aim of current mental health policy in supporting more people within their own homes, and it is important that this is not frustrated by problems in obtaining and retaining suitable housing. We believe that further action to address the issue of the housing needs of people with mental disorders is necessary.
12. In July 2000, the Scottish Executive issued proposals in relation to social housing⁴⁴. These include several proposals which bear on the issues described above.
13. It is intended that Scottish Homes should be superseded by a regulatory body for all social landlords, including local authorities and housing associations⁴⁵. This would appear to offer scope to develop best practice guidance in relation to meeting the housing needs of people with mental illness, in collaboration with mental health organisations.
14. It is also proposed that a single social tenancy be created, but that for some tenancies, this will be a 'short tenancy' which can be terminated after six months⁴⁶.

44 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive 2000)

45 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive 2000) section three

46 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive 2000) pages 21-22

Such tenancies are stated as possibly covering certain types of special needs housing where there is sharing of common facilities, or services are provided to all tenants, or both. People with mental disorder may be affected by such tenancies, and we would be concerned that they should not be overused. We strongly agree with the comment in the Paper that, in general, tenants with particular needs should have full tenancies wherever this is possible. While in our view, the short tenancy would be a better alternative than the current practice of granting 'occupancy agreements' with no security of tenure, we would expect their use in relation to people with mental health needs to be limited.

15. We welcome the proposed introduction of succession rights for carers⁴⁷.
16. New arrangements are proposed for funding extra support for vulnerable people⁴⁸. We are not in a position to comment in detail on these arrangements, but we note the comment⁴⁹ that the new grant should not be spent on services funded under existing mechanisms, including 'services which deprive people of their liberty (such as detention under mental health legislation)'.
17. Our proposals for compulsory measures will mean that people may be subject to a range of compulsory measures, in a range of settings. We believe that any new funding arrangements should take account of this, and should facilitate more flexible and innovative forms of offering care and support to people with mental disorders, including those who are under some form of compulsion under mental health law.

Recommendation 17.1

The Scottish Executive should develop guidance on positive action and non-discriminatory practice in relation to the housing needs of people with mental disorders. This guidance should be developed in collaboration with mental health organisations, and its implementation overseen by the proposed Housing Regulator.

Housing Benefit and DSS Benefits

18. While many people with mental health problems or learning disabilities are in employment, others are unable to work, or do not receive the necessary support to maintain employment. As a result, the benefits system is of considerable importance.
19. Respondents to our consultation exercises felt the system needed to be improved, and highlighted the following inadequacies in particular among those that they felt needed attention:
 - ♦ Housing benefit restrictions apply to those in hospital for over 52 weeks.
 - ♦ Patients on leave of absence can be disadvantaged by housing benefit regulations because they are still treated as hospital inpatients.

47 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive) page 15

48 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive) section seven

49 *Better Homes for Scotland's Communities: the Executive's proposals for the Housing Bill* (Scottish Executive) page 77

- ◆ Hospital in-patients forfeit the right to the mobility component of Disability Living Allowance, on the basis that the NHS can meet the cost of any transport needs they have.
 - ◆ The low level of benefit payments paid to people in hospital and supported accommodation inhibits integration and community participation. Many people in such settings receive no more than an inadequate 'personal allowance' for their own needs.
20. DSS benefits were also of major concern to respondents to the consultation carried out by the Scottish Executive Learning Disabilities Review. This Review has recommended that the Scottish Executive should consider raising, with the Department of Social Security, specific areas of concern related to benefits and support for people with learning disabilities⁵⁰.
21. We feel that the issues we highlight above also require to be addressed.

Recommendation 17.2

There should be a review of the extent to which the rules regarding Social Security benefits may adversely affect people with mental disorders, particularly those who are subject to detention. The Scottish Executive should seek to ensure that such a review is undertaken by the Department of Social Security, and that it takes due account of the implications of mental health law in Scotland.

Stigma

22. We have heard a great deal of evidence to suggest that the stigma associated with mental disorder is a major problem for many service users.
23. Stigma arises from a lack of awareness of and misconceptions about mental disorder. We firmly believe there is a need for action to address this. However, we do not believe that a new Mental Health Act would be the most effective vehicle to address stigma. This requires shifts in public perceptions and attitudes, which are unlikely to be affected significantly by any change in mental health legislation.
24. Respondents to our consultation also generally felt these issues would be more appropriately tackled through wider human rights legislation, such as the Disability Discrimination Act 1995 and the Disability Rights Commission Act 1999, rather than through mental health legislation.
25. We agree with this general approach, although we feel that such legislation could be strengthened. We heard evidence in particular of the great deal of harassment experienced by people with mental disorders. We note that, in 1998, an offence of racially aggravated harassment was introduced⁵¹. We believe that consideration

⁵⁰ *The same as you? A review of services for people with learning disabilities*; Scottish Executive (2000) Recommendation 17

⁵¹ Criminal Law Consolidation (Scotland) Act 1995, s50A

should be given as to whether it would be desirable to introduce similar protection for people with mental disorders.

Recommendation 17.3

The Scottish Executive should consider the introduction of an offence of harassment which would protect people with disabilities, including mental disorders.

26. We also believe there is a need to develop a strategy to address the complex issues of public attitudes and understanding of mental health and to foster more accepting attitudes within society as a whole. The review of services for people with learning disabilities recommended a long-term programme to promote public awareness about people with learning disabilities⁵². We support this recommendation. We also feel that similar action is needed in relation to mental disorder generally. While initiatives such as the 'Changing Minds' campaign run by the Royal College of Psychiatrists, and others initiated by voluntary organisations are important, we feel that the problem demands action by government, and by agencies such as the Health Education Board for Scotland.
27. Any such campaign should seek to promote positive mental health, but should not be restricted to this. It should take particular account of the need to promote better public attitudes towards people with mental disorders, including those with more severe and enduring disorders, who may be subject to compulsory measures.

Recommendation 17.4

The Scottish Executive should promote a major campaign of public education to improve public understanding of mental disorder, and attitudes towards people with mental disorders.

Visiting rights

28. Patients who are detained have no formal rights to receive visitors. It was pointed out to us that the denial of visits could be subject to challenge under the European Convention on Human Rights. This may not only apply to visits generally, but to conjugal visits, perhaps including in secure establishments.
29. This is not a matter which the Committee was able to consider in detail. We believe however, that it should not be possible to deny visits to a detained patient, where the patient wishes such a visit to take place, unless there is a clinical justification, or there are justifiable concerns regarding security, or the interests of children have to be taken into account.

52 *The same as you? A review of services for people with learning disabilities*; Scottish Executive (2000) Recommendation 21

30. All establishments with detained patients should have a written policy on visits which should be subject to monitoring by the Mental Welfare Commission. Guidance could appropriately be contained in the Code of practice.

Recommendation 17.5

All establishments under the Mental Health Act which accommodate patients subject to compulsion should have a written policy on visits to the establishment, and the Code of Practice should provide guidance on such policies.

CHAPTER 18

GROUPS WITH SPECIFIC NEEDS

1. We recognise that certain groups of people with a mental disorder have specific needs which may not be adequately addressed at present by existing legislation and services. This includes people with physical and sensory disabilities, children and young people, women and members of ethnic minorities.
2. We have considered what particular measures may be appropriate to put into effect for these groups the principles of *Non discrimination* and *Respect for diversity*.

Physical and sensory disability

3. The needs of a person with a mental disorder can be further complicated by physical disability, particularly if the ability to communicate is impaired.
4. We received evidence of particular problems which affect people with hearing impairments. A key publication on this topic, which was drawn to our attention, recommended that deaf people should have access to specialist mental health services where staff have a range of skills and expertise, including communication skills⁵³. So far as we can ascertain, there are no such specialist services in Scotland.
5. Respondents to our second Consultation said the complex communication difficulties for deafblind people could not easily be addressed by the provision of general interpreting services. Communication support needs to be highly individualised.
6. People with learning disabilities may also have particular communication difficulties. Many will have difficulties with written information, and some will communicate by specialised methods rather than speech.
7. We would wish to see the development of better mental health services generally for people with disabilities. This is not only an issue of good practice, but reflects the responsibility of service providers under the Disability Discrimination Act 1995 to ensure equality of access to services. However, our particular concern is the rights of this group in relation to mental health law. A compulsory intervention under the Mental Health Act raises major issues of civil liberties, and it is of fundamental importance that a person subject to such an intervention is enabled to understand what is happening, and to obtain advice and support if wished.

53 Denmark, John C., *Deafness and Mental Health*, (Jessica Kingsley Publ., 1994)

8. We received a considerable body of evidence that patients generally and their carers experience significant difficulty in understanding the procedures in relation to detention under the Act and their rights, among other things, to information. For people with disabilities, the difficulties may be compounded.
9. In respect of such patients, we believe that the current general requirement, to take 'such steps as are practicable' to ensure that the patient understands the effects of the detention and rights of appeal⁵⁴ requires to be strengthened.
10. It is of course also the case that carers and family members may have particular communication needs, and it is important that these also be met.

Recommendation 18.1

Local authorities and health boards should be required to secure access to services for interpretation and assisted communication for mental health service users and carers who have particular communication needs as a result of physical or sensory disability.

Recommendation 18.2

Where a person, who has particular communication needs as a result of disability, is subject to compulsory measures, the mental health officer (in emergency detentions, the detaining doctor) should be required to take all reasonable steps to ensure that the person has been made aware of the implications of the compulsory measures, and the person's rights in relation to those measures. In any appeal, or application for long term compulsory measures, the mental health officer should be required to demonstrate to the tribunal that this has been done.

Children and young people

11. Children and young people are subject to the provisions of the Mental Health Act, but are nowhere mentioned in it. The 1984 Act applies to children largely in the same way as it does to adults, even in relation to detention powers. This is despite the fact that children and young people have different needs from those of adults⁵⁵.
12. The law relating to children has, in the last decade, been radically amended by the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995. These set out rules about when children can consent in their own right to medical treatment, related to the maturity and understanding of the child, and also revised procedures for protection of children who are in need or at risk. In addition, the principles of the UN Convention on the Rights of the Child have gained widespread acceptance.

⁵⁴ 1984 Act, s110

⁵⁵ We use children to mean people aged under 16, and young people to mean those aged 16-18.

13. There are difficulties in having two different systems of legislation for children at risk. In particular, it is sometimes not clear whether to invoke the Children (Scotland) Act or Mental Health Act.
14. The Committee commissioned Children in Scotland to arrange a consultation seminar to discuss some of these issues. A report of the seminar has been separately published by Children in Scotland, and a summary of the key findings is at Annex 6.
15. We considered whether it would be appropriate to remove children from the Mental Health Act, on the basis that compulsory measures of care could be considered under the Children (Scotland) Act. The evidence we received, including oral evidence from psychiatrists who specialise in working with children and young people, was that this would not be desirable. There are a small number of children who require to be subject to compulsory measures of care because of their mental state and for whom the provisions of the Mental Health Act are considered necessary.
16. However, we believe that there needs to be consistency between the different legislative frameworks which allow compulsory measures of care in relation to children. We recommend in Chapter 3 that the principles which underlie mental health law should include a principle of the paramountcy of the *Welfare of the child*. This principle is also set out in the Children (Scotland) Act.
17. In accordance with that principle, where children are not able to make treatment decisions, it would often be inappropriate to base compulsory treatment for mental disorder on the consent of parents since, among other considerations such reliance on parental consent would mean that children would not have the benefit of the safeguards that accompany compulsory treatments under the Mental Health Act.
18. There are particular concerns about the use without consent of certain kinds of treatment, such as electro-convulsive therapy (ECT), on children and young people. We deal with this in Chapter 10.
19. Advocacy may also be important in this context. In relation to child care, there is an expectation that children being looked after by local authorities will have access to an independent children's rights officer. Similar safeguards should apply to children who are subject to compulsion under mental health law.

Recommendation 18.3

Children subject to compulsory measures of care under the Mental Health Act should have a legal right of access to an independent advocate.

20. While we accept that two different frameworks for compulsory care of children should remain, we feel that more could be done to ensure that the overlap is properly managed. In particular, the Royal College of Psychiatrists and the Law Society of Scotland both suggested that there should be guidance to deal with the issue of when parental consent could be relied upon, and when mental health law should be invoked. More broadly, the British Association of Social Workers (BASW) suggested that the Code of Practice should contain guidance on interventions with children and young people, which should reflect the safeguards and principles of the Children (Scotland) Act.
21. We believe that the Code of Practice, and the appropriate guidance under the Children (Scotland) Act, should address the issue of how and when both systems should interact: for example, when mental health services should involve the Reporter to the Children's Panel, and when the Reporter or a Hearing should be able to expect mental health services to intervene if compulsory measures appear to be necessary.

Recommendation 18.4

The Code of Practice should contain guidance on

- ♦ *the circumstances in which treatment without the consent of the child should be provided under mental health law, rather than on the basis of consent by an adult with parental responsibilities,*
- ♦ *how the principles underlying the Children (Scotland) Act 1995, and the UN Convention on the Rights of the Child, should be applied to mental health interventions, and*
- ♦ *how mental health and child protection systems should interact.*

22. There is scope to develop better ways of working. We were advised that, in Lothian, multi-disciplinary working parties, involving health, education and social work, have been established to develop care pathways for children and adolescents with mental health and behavioural problems. Such initiatives appear to be a useful and practical start to develop joint working.
23. We heard concerns about services for children and young people. Children and young people in a period of acute mental illness are frequently placed in adult wards. Young people between the age of 16 and 18 are no longer regarded in law as children, but it may not be appropriate for them to be cared for in adult facilities. Respondents to our consultations were strongly opposed to the placing of this age group with adults. The development of alternative resources was regarded as imperative.
24. Apart from the general shortage of specialist mental health services for children and young people, particular concern was expressed about the lack of adolescent forensic psychiatry services. The absence of secure provision for adolescents

with mental illnesses who have offended means that young people may have to receive care outside Scotland. (See Chapter 26 paragraph 1).

25. We consider that children and young people with a mental disorder should not be detained in adult wards, but we understand that there are parts of Scotland where no specialist units exist. In such cases, rather than send the child or young person away for treatment, we understand why it may be felt necessary at the moment to manage him or her in a local adult ward. However, this does not appear to us to be an acceptable solution.
26. In general, we do not believe that mental health law is necessarily the most appropriate vehicle for promoting more or better mental health services. However, in relation to children and young people, we are sufficiently concerned by the current situation to make a specific recommendation that health boards should have a statutory duty to secure appropriate services for children and young people. This need not mean that each board must have a complete range of services, since some are highly specialised. For these services, boards would be expected to cooperate to ensure that a full range of services, including secure services, is available for children and young people with mental disorders.

Recommendation 18.5

Health boards should be placed under a statutory obligation to provide or secure age-appropriate mental health services including secure services, for children and young people in their area.

27. A number of people commented on the difficulty in obtaining social work input in relation to young people with mental health problems. We consider that it is of great importance that any young person in the mental health system, particularly one who is subject to compulsory measure of care, should have access to appropriately trained social workers.

Recommendation 18.6

Any young person who is subject to compulsory measures of care under the Mental Health Act should have a named social worker.

28. We were also advised that there is a lack of educational support for young in-patients. Indeed, s131 of the Education (Scotland) Act 1980 provides that education authorities have no statutory duties to provide education to children or young people detained under the 1984 Act. While we recognise that there may be times when a child or young person experiencing an acute mental illness may not be well enough to participate in education, the same can be said for children who are physically ill, for whom the general duty remains. Indeed, education authorities have enhanced duties in respect of children with special educational

needs. We therefore believe that this derogation from the duties of education authorities in respect of children and young people with mental disorders should be ended.

Recommendation 18.7

The provisions of s131 of the Education (Scotland) Act 1980, insofar as they remove the duties of education authorities towards children and young people subject to compulsion under mental health law, should be repealed.

Gender issues and the rights of parents with mental disorder

29. Some women who use mental health services feel extremely vulnerable, particularly if placed with men who have a history of violence against women.
30. Respondents to our first Consultation generally supported the promotion of single sex accommodation, although not all thought this should be incorporated in legislation. Particular attention was drawn to the position of women in the State hospital and in other secure facilities, where there were worries that women's needs for intensive support and a safe and supportive environment might not be being adequately met.
31. We recognise that both women and men may have a need for privacy in relation to their surroundings, and the provision of intimate care.

Recommendation 18.8

Single sex accommodation should be available to men and women with a mental disorder.

32. In responding to our second Consultation, BASW drew attention to the rights of mentally disordered parents to care for their children, unless there are concerns relating to child protection. People to whom we spoke on our visits also commented on the lack of facilities for service users with babies and young children, even in large psychiatric hospitals. There is also a need for appropriate community support to service users and families. Local authorities are under a statutory obligation to promote personal relations and direct contact between any child being looked after by them and any person with parental responsibilities⁵⁶, and we believe that similar obligations should apply in relation to mental health services in respect of parents who use these services.

⁵⁶ Children (Scotland) Act 1995, s17

Recommendation 18.9

Local authorities and health bodies should have a statutory responsibility to promote personal relations and direct contact between mental health service users and children for whom such service users have parental responsibility, where this is in the interests of the child.

Ethnic minorities

33. Throughout the consultation process, we have heard evidence of issues of particular concern to members of ethnic minorities. We also arranged a meeting with representatives of a number of organisations with experience in the provision of mental health services to people from black and minority ethnic communities and knowledge of the particular problems such people faced.
34. Issues which were raised include: access to interpreting and translating services, especially in conjunction with advocacy, and the provision of services that are responsive to individual religious, cultural and dietary needs. Reference was also made to the need for racial awareness training and for culturally sensitive services that would promote accessibility and equity. We understand that MHOs receive such training, but it would not appear to be provided to all mental health professionals.
35. Currently, s112 of the Act requires that, in arrangements that may be made for the detention of a patient under the Act, regard shall be had to the religious persuasion to which the patient belongs. This provision appears to us to be too narrow to accommodate the range of cultural issues which now arise.
36. We believe that the general principle of s112 should be replaced by the principles of *Respect for diversity* and *Non-discrimination*, which we discuss in Chapter 3. We go on to make some more specific recommendations.
37. A key problem is the lack of information regarding the extent to which service users come from ethnic minorities, and the level of unmet need amongst minority ethnic communities. This makes it extremely difficult to plan appropriate services, or to evaluate the quality of current services.
38. There has been some research in England regarding the use of the Mental Health Act on people from minority ethnic backgrounds, but such information does not appear to have been collected in Scotland.
39. Ethnic monitoring raises sensitive issues. If not carried out carefully, it can both cause offence and provide unreliable data. For example, we were advised that many people whose parents or grandparents came from India or Pakistan would identify themselves as Scottish rather than Asian. However, this should not be a

bar to appropriate information collection, which should be directed at identifying the need for particular facilities, such as interpreting services, rather than simply a 'head count' of different groups. If such information is to allow for meaningful comparisons between services, it is also vital that the methodology used is consistent.

40. We were advised that the Mental Welfare Commission is considering this issue, but is hampered in its task by the lack of systematic information collection at local level.

Recommendation 18.10

Local authorities and health boards should be required to obtain information regarding the mental health service needs of people from black and ethnic minority communities in their area. Such information should be obtained using standardised methodologies.

Recommendation 18.11

Arrangements should be made by the Scottish Executive to obtain information regarding the extent to which compulsory measures under the Mental Health Act are applied to particular minority ethnic communities.

Recommendation 18.12

Local authorities and health bodies should be required to promote racial awareness training amongst staff employed in mental health services.

41. Concerns have been raised that putting out publicity in ethnic minority languages may not be an adequate response to communication problems. It is not necessarily the case that written information is the correct medium for people with mental health problems. Problems faced by ethnic minorities are not limited to possible problems in understanding the English language but also the complexity of the law. Producing leaflets in different languages is only one step. Also, a person may not require only an interpreter. Advocacy may also be very important.
42. We have also heard evidence that there is a need to ensure that mental health professionals are more culturally aware. There is a lack of knowledge amongst many patients from minority ethnic communities of models of service such as befriending, advocacy and counselling, and a lack of ethnic minority professionals involved in mental health care. Communication problems can sometimes make staff feel de-skilled, and pull away from working with ethnic minorities. There is a need for more people with awareness of these issues to liaise with patients, for

example to assist in discharge arrangements. It was suggested that an Ethnic Minorities Liaison Officer being available in each health board area could assist with the whole process.

43. A lack of communication can mean there is not enough choice for patients and this can lead to indirect discrimination. A person's cultural, linguistic and dietary needs have to be addressed in order to provide an adequate service for that individual.
44. Many of the above issues relate primarily to service provision, rather than mental health law. However, we were left in no doubt as to the view, from experts in the field, that statements of desirable practice are of little value without firm strategies for their implementation. We looked at current local mental health strategies, which have been prepared under the Framework for Mental Health Services in Scotland. Of those seen by us, only two made specific mention of provision for people from ethnic minorities.

Recommendation 18.13

Local authorities and health boards should be placed under a statutory obligation to develop policies for meeting the needs of service users from ethnic minorities in their area.

45. In keeping with the principle of *Non-discrimination*, we believe that there is an obligation to ensure a person's understanding of their rights in relation to compulsory detention. We believe that interpreting and translating services should be available, as of right, when compulsory measures are being considered or implemented. These rights should also apply in relation to family members.
46. We were advised that, at present, there is no national system to ensure access to such services, and arrangements differ widely in different localities.
47. Particular concerns have been raised in relation to refugees and asylum seekers. We heard evidence that a significant proportion of asylum seekers have some form of mental health problem ranging from mild to severe. The problem needs to be taken seriously, as more refugees and asylum seekers are expected in Scotland and their needs of access to services generally and interpretation in particular are becoming increasingly urgent. The need for interpretation may relate both to involvement with local services, and any consideration of return to the country of origin, which we discuss further in Chapter 31 (paragraphs 35-36).

Recommendation 18.14

Local authorities and health boards should be required to ensure that they have access to services for interpretation and translation for service users and carers whose first language is not English.

Recommendation 18.15

Where a person whose first language is not English is subject to compulsory measures, the mental health officer (or, in the case of emergency detention, the detaining doctor) should be required to take all reasonable steps to ensure that the person has been made aware of the implications of the compulsory measures, and the person's rights in relation to those measures. In any appeal or application for long term compulsory measures, the mental health officer should be required to demonstrate to the tribunal that this has been done.

SECTION 4

SAFEGUARDS FOR VULNERABLE PEOPLE

CHAPTER 19

PROTECTION OF VULNERABLE ADULTS

Vulnerable adults

1. The main provisions in the 1984 Act, which are intended to protect mentally disordered people from abuse and neglect, are those relating to guardianship (sections 36 to 52). These will be superseded by the guardianship provisions of the Adults with Incapacity (Scotland) Act 2000 when these provisions come into effect. However, the 1984 Act also contains, in Section 117, provisions for emergency interventions, where there is reason to believe that a mentally disordered person is being ill treated or neglected, or is without adequate care.
2. There are also separate provisions in Section 47 of the National Assistance Act 1948 to remove vulnerable adults to a place of safety. These do not apply only to people with mental disorder, but they could be used in a case of, for example, an elderly person where mental disorder is suspected.
3. Section 117 of the 1984 Act confers a power on a mental health officer (MHO) or a Medical Commissioner of the Mental Welfare Commission, to take action if they have reasonable cause to believe that a person suffering from mental disorder is suffering ill-treatment or neglect or is being kept “otherwise than under control”, or else is living alone or uncared for and is unable to care for him or herself. The power allows the MHO or Medical Commissioner to demand entry to premises and to inspect them if admission is not refused. If admission is refused or anticipated, a justice of the peace, sheriff or stipendiary magistrate may issue a warrant authorising a named constable to enter, if need be by force, and to remove the person to a place of safety with a view to the making of an emergency recommendation or an application for admission under Part V of the Act. The constable must be accompanied by a doctor. The patient once removed can be detained in a place of safety for up to 72 hours. “Place of safety” is not intended to include a police station unless in an emergency there is no other suitable place.
4. Section 117 is open to a number of criticisms. First of all it does not cover all situations where someone vulnerable through mental disorder may be difficult to access at home. There is no power to remove the person if access is granted to see the person, even although there may be grounds to suspect abuse. Where a vulnerable person is being abused or exploited the only remedy is to remove the person to a place of safety. The power must be exercised by a ‘named constable’, which brings operational problems. There is no power to exclude the abuser. The power is rather “all or nothing” in character, failing to allow for grades of intervention.

5. The National Assistance Act 1948, s47, as amended by the National Assistance (Amendment) Act 1951, provides a power to remove from home to a hospital or other place a person suffering from chronic disease who lacks proper care and attention. This power is exercisable by the local authority after the granting of an order by a sheriff. This is an out-dated provision which has no express right of appeal and the expedited procedure normally used allows removal on an order from the sheriff which is granted without the person being given an opportunity to oppose it. People removed to hospital under this provision do not have the safeguards contained in the Mental Health Act applied directly to them. It has been suggested that the procedure is probably in breach of the European Convention on Human Rights¹. The power is hardly ever used, and we believe it should be repealed so far as it applies in Scotland.
6. In 1993, the Scottish Law Commission (SLC) issued discussion paper No 96 "Mentally Disordered and Vulnerable Adults: Public Authority Powers". In 1997 it went on to publish its Report on Vulnerable Adults², which included a draft Vulnerable Adults Bill. The Scottish Executive has not to date expressed any legislative intention in relation to this.
7. The Scottish Law Commission Report proposes a new range of graduated interventions to a group whose vulnerability extends beyond that associated with mental disorder. While mental disorder is likely to be the predominant condition associated with vulnerability, the provisions would also apply to those vulnerable through age or infirmity. The Mental Welfare Commission's role under the provisions however would apply only to those whose vulnerability is associated with mental disorder.
8. A vulnerable adult is defined as an adult who is unable to safeguard his or her personal welfare, property or financial affairs and is:
 - ♦ in need of care and attention arising out of age or infirmity, or
 - ♦ suffering from illness or mental disorder, or
 - ♦ substantially handicapped by any disability.
9. The proposals would create a new statutory duty for local authorities to inquire as to whether steps need to be taken to protect the welfare or property of adults who are or whom they believe to be, vulnerable.
10. Interventions would only be authorised in the face of the adult's objection if those authorising or carrying out the intervention reasonably believe that the adult is vulnerable and is either mentally disordered or subject to undue pressure. Local authorities are given the primary role in dealing with vulnerable adults but the Mental Welfare Commission is also entitled to act if necessary.

1 Scottish Law Commission *Mentally Disordered and Vulnerable Adults: Public Authority Powers*, Discussion Paper 96, paras 2.46-2.52

2 Scottish Law Commission *Report on Vulnerable Adults*, (Scot Law Com No 158)

11. The report envisages a staged set of interventions. These include:
 - ♦ a right to demand admission to premises
 - ♦ a right of forcible entry under warrant
 - ♦ a power to interview and medically examine the vulnerable adult
 - ♦ a power to inspect documents
 - ♦ a power to remove the vulnerable adult to a specified place for up to 7 days
 - ♦ a power to exclude a suspected abuser from the home of a vulnerable adult in certain situations.
12. More serious interventions can only be undertaken with the approval of the sheriff and there are procedures for representation to be made, except in emergency cases.
13. The complete list of recommendations is given at Annex 9.
14. We found strong support for the SLC proposals. In our second Consultation, we proposed that they be incorporated in the new Mental Health Act, insofar as they applied to people with mental disorder. This suggestion was supported by almost everyone who responded on this point.
15. We are satisfied that the current provisions in Section 117 and Section 47 of the 1948 Act, do require to be reformed, and that the SLC proposals offer a comprehensive and well considered set of proposals for such reform. Having considered the recommendations, we believe that they should be implemented, with only minor adjustments.
16. The SLC proposals include people who are not mentally disordered. It would be beyond our remit to make firm recommendations in relation to this broader group. We do wish to see the recommendations implemented for people with mental disorder. It will be for the Executive and Parliament to decide if others should also be included.

Recommendation 19.1

The Scottish Law Commission proposals, contained in their Report on Vulnerable Adults, should be implemented in respect of adults with mental disorder.

17. The decision as to the scope of the legislation would affect the legislative vehicle which should be used for its implementation. If it is decided to confine the implementation of the Report to adults with mental disorder, we believe that this should be done within the new Mental Health Act. If a wider group is chosen, this may be inappropriate. However, we believe that, ultimately, the range of provisions for mentally disordered, vulnerable and incapable adults should be brought together within a comprehensive framework. (See Chapter 2.)

18. The SLC proposals incorporate the definition of mental disorder contained within the 1984 Act. We propose that this be replaced by the definition of mental disorder which we set out in Chapter 4. Where the 'nearest relative' is mentioned, this should be replaced by the arrangements we outline in Chapter 16 for a 'named person'.
19. Recommendation 11 of the SLC report proposes a power to remove the vulnerable adult from home for a specified period not exceeding seven days. We considered whether this should be restricted to 72 hours, in line with emergency detention under mental health law. On balance, we have concluded that the seven day period should remain. Unlike emergency detention, there will have been prior approval by a judicial body. The next step following removal from home may be to seek an order under the Adults with Incapacity (Scotland) Act, or to follow the procedures under the Mental Health Act, including where necessary procedures for detention under that Act, and this may require more than 72 hours to arrange.
20. We would envisage, where measures under the Mental Health Act are thought necessary, that arrangements would be made to proceed to short term (28 day) detention.
21. There are some changes that will require to be made to the SLC proposals to reflect the introduction of the Adults with Incapacity (Scotland) Act 2000. For example, the references to *curators bonis* would be replaced by guardians.
22. A number of the proposals of the SLC involve proceedings before a sheriff. For example, the sheriff considers whether to grant an order authorising a private interview and private examination by a doctor (Recommendation 9), and also considers orders authorising the removal of an adult (Recommendation 11). Where hearings take place, the procedures should be broadly consistent with the recommendations we make in relation to reviews of compulsory measures of care (see Chapter 9). In particular, there should be automatic legal representation, and hearings should be held in private, unless the adult or the adult's representative requests otherwise. On balance, we believe that the sheriff should be retained for hearings under the provisions for vulnerable adults, and not be replaced by a mental health tribunal, as we recommend for other mental health hearings. However, if a mental health disposal is subsequently considered necessary, then the normal procedures under the Mental Health Act would apply.
23. Recommendation 21 proposes a Code of Practice. This should be subsumed into the Mental Health Code of Practice (see Chapter 36).

Recommendation 19.2

Rules of Court for proceedings under the Vulnerable Adults proposals should be broadly consistent with those which we recommend for hearings concerning compulsory measures of care under the Mental Health Act.

Recommendation 19.3

Where a person is removed from home under the Vulnerable Adults proposals, and it is determined that the person requires compulsory measures of care under the Mental Health Act, the normal procedures under that Act should apply.

Recommendation 19.4

It should not be possible for a person to be made subject to emergency (72 hour) detention under the Mental Health Act immediately following a period of removal from home under the Vulnerable Adults proposals.

Recommendation 19.5

The Mental Health Act Code of Practice should include guidance as to the exercise of functions under the Vulnerable Adults proposals.

Ill treatment and neglect

24. Section 105 of the 1984 Act makes it an offence for a member of staff of a hospital or nursing home to wilfully neglect or ill treat a patient, for a guardian to ill treat someone under their guardianship or for anyone to ill treat someone subject to a community care order. Once the Adults with Incapacity (Scotland) Act 2000 is implemented, the reference to guardianship will be deleted. There is a new offence in s83 of that Act, relating to ill-treatment and wilful neglect by anyone exercising powers under the Act relating to the personal welfare of an adult.
25. The rather selective provision in the 1984 Act would not protect people living in supported accommodation, residential care homes, people on leave of absence or people attending day services run by the local authority. As we go on to discuss, there is a more sweeping provision later in Section 105, which applies to anyone who ill-treats or neglects a person 'in his custody or care'. Nevertheless, we feel that the particular staff/service user relationships which are spelled out in s105 should be brought up-to-date.
26. We are informed that there has been one conviction under s105 in the last 5 years. However, we received evidence that the provision is regarded as an important safeguard, striking at a breadth of conduct which would include wilful neglect but also including conduct which might not amount to, for example, an assault.

27. In our first Consultation, people were asked whether any special protections were needed for people with mental disorders or whether this could be left to the general criminal law. There was considerable support for the abuse of a mentally disordered person to be a specific criminal offence.
28. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) said that it should be an offence if professionals abuse their position of authority and ill treat their patients or clients and that this should cover physical, sexual and financial abuse. Others said that the principles of normalisation would suggest that the general criminal law should be used, but pointed out the difficulty of obtaining evidence from vulnerable people. The rules of evidence might need to be relaxed. The Greater Glasgow Primary Care NHS Trust suggested that a lower standard of proof might be required. These are matters which we understand the Scottish Executive will be taking forward in their current review of vulnerable witnesses, which we discuss later in this chapter.
29. We believe that a special offence to protect people with mental disorder is justified. In many cases of abuse, the behaviour would be a crime at common law, such as assault. However, some mentally disordered people are particularly vulnerable, and could be victimised by behaviour which would not be a crime when done to another adult. It would be almost impossible to compile a comprehensive list of such behaviour, but it might include failure to ensure the person was adequately fed, or verbal intimidation.
30. The statutory offence would be mainly directed at members of staff abusing persons in their care. It should apply to the full range of care settings, and be flexible enough to accommodate developments in the provision of care.
31. Section 105 is not however solely directed at staff, but includes anyone who has a mentally disordered person in his or her “custody and care”. This could potentially include family members and informal carers.
32. This is an extremely difficult and sensitive area. Family carers are taking responsibility for the welfare of another adult. They may feel a strong moral obligation, but have no legal obligation to do so. Many carers live under conditions of extreme stress; often with inadequate support, and sometimes caring for a person who may not appreciate the carer’s efforts, or even be actively hostile to them. Large numbers of carers are themselves elderly or disabled.
33. There may be concern that a criminal charge could be brought where a carer has simply failed to cope under intolerable pressure. Even when this does not happen, the fact that such a charge may be feared could lead carers to fail to seek support, or disclose difficulties, for fear of prosecution for neglect.
34. Against that, it is clear that the current statutory offence is rarely, if ever, used against informal carers and family members. We do not foresee that this is likely to change. The same objections to the statutory offence could be made in relation to offences which are crimes at common law, such as assault. It has not been

suggested that these crimes should not apply in principle to carers. Finally, the law protects others who are vulnerable, particularly children, from ill treatment and neglect.

35. We consider, therefore, that the offence of ill treatment and neglect should continue to be potentially applicable to all situations where a mentally disordered person is in the care of others. We considered whether the statutory provisions should seek to identify all the potential situations where a person has some responsibility for the welfare of a mentally disordered adult, and where abuse or neglect of that responsibility would be so serious as to justify a criminal charge. We decided it would be better to set the offence out in broad terms, and to allow the courts to apply these to individual situations as appropriate. This approach is consistent with the tradition of Scots law. It also reduces the risk that, as has happened with s105, the provisions become out of date as patterns of care change. It should only apply where someone in a position of power over another abuses that power, as in the case of a member of staff abusing a person in his or her care.
36. We do not envisage for example, a family member whose relative has broken off contact or refused help, being prosecuted for neglect. We also recognise that the obligation on carers not to wilfully ill-treat or neglect the vulnerable adult is balanced by a legitimate expectation that society will not allow the carers' task to become intolerable. We discuss the rights of carers further at Chapter 16.

Recommendation 19.6

It should be an offence for a person wilfully to ill-treat or neglect a person with mental disorder who is in his or her care.

Recommendation 19.7

The following persons would be among those who could potentially commit the offence of wilful ill-treatment or neglect of a person with mental disorder:

- ♦ *any member of staff or manager at any hospital or healthcare facility, where the patient is receiving treatment, whether as an in-patient or out-patient;*
- ♦ *any manager or member of staff, whether paid or unpaid, in any residential care facility where the mentally disordered person is living;*
- ♦ *any person employed to deliver care services in the community to the mentally disordered person; or*
- ♦ *any other person who undertakes substantial responsibilities for the care of the mentally disordered person.*

Protection for staff and carers

37. Section 122 of the 1984 Act provides that no person will be liable to criminal prosecution for any acts they perform in carrying out their duties under the Mental Health Act, unless it can be shown that they acted in bad faith or without reasonable care. This would mean that if, for example, staff restrained a patient who was being detained under the Act, they would not normally be liable to be prosecuted for assault.
38. On consultation, many respondents stressed the need to have proper policies on the use of and reporting of restraint, but many felt that staff should be protected if they are doing their job. It was not unusual for people with dementia, for example, to make false accusations. Whilst these should be investigated, staff need protection.
39. On the other hand, it is not clear that staff require special protection which is not available to others, including informal carers. The protection is also not entirely clear in its effect. Staff are not employed 'under the 1984 Act', and it is by no means clear what activities by staff could be said to be carried out under that Act, as opposed to some other authority.
40. We have concluded that prosecution or civil action would be unlikely to be successful in cases other than those of bad faith or lack of reasonable care, in any case. Nevertheless, to express this in the Act provides useful reassurance for staff. We, therefore, believe that a special reference should be retained. We also propose that the defence be explicitly extended to the offence of wilful ill treatment and neglect, discussed above. This may serve to reassure informal carers that they are not at risk from inappropriate legal action.

Recommendation 19.8

There should be a provision in the Act which protects any person from liability in civil or criminal proceedings for acts purporting to be done in pursuance of the Act, unless done in bad faith or without reasonable care. This protection should also apply to liability under the above offence of wilful ill treatment or neglect.

Obstruction

41. Section 109 of the 1984 Act makes it an offence to refuse to allow access to any premises or individual by a person authorised in that behalf by or under the Act.
42. We received little evidence relating to this section. It would appear that it is very rarely, if ever, used. Nevertheless, we believe that it should be retained, as a safeguard. The Mental Welfare Commission has indicated that the provision can be useful in reminding people of the importance of allowing access by the proper authorities to individuals who may be vulnerable by reason of mental disorder.

43. Recommendation 22 of the Scottish Law Commission Report on Vulnerable Adults proposes that it should be an offence for any person, other than the vulnerable adult concerned, to obstruct or hinder a duly authorised person from the local authority or Mental Welfare Commission in carrying out the functions recommended in that Report in relation to that adult. If, as we recommend, the Vulnerable Adults proposals are implemented, this offence should be consolidated with the offence of obstruction currently in s109.
44. Recommendation 22 excludes the vulnerable adult from the potential commission of an offence. There is no such exclusion in s109. This could in theory mean that a mentally disordered person could be charged for refusing to allow entry to his or her home. We do not believe this would be desirable, and we recommend that the offence of obstruction should not be capable of being committed by the mentally disordered person who is the subject of proceedings under the Act.

Recommendation 19.9

There should continue to be an offence relating to obstruction, similar to that contained in Section 109 of the 1984 Act.

Recommendation 19.10

It should not be possible for a mentally disordered person to be prosecuted for obstruction, in relation to compulsory measures of care or protective measures directed at the mentally disordered person.

Vulnerable witnesses

45. Provision has been made for vulnerable witnesses in s271 of the Criminal Procedure (Scotland) Act 1995, as amended by the Crime and Punishment (Scotland) Act 1997. This allows evidence to be taken by video link, or behind screens. The issue of vulnerable witnesses was not a matter which we could consider in detail. We are pleased to note, however, that it is under separate consideration by the Scottish Executive. In the 'Towards a Just Conclusion Action Plan' published in June 2000, the Executive has undertaken to improve arrangements for the identification of vulnerable witnesses, and to invite the Criminal Court Rules Council to prepare rules relating to the operation of s271. Further research into the experience of vulnerable witnesses is also under consideration.
46. There is one aspect of s271 which particularly concerns us, namely the definition of 'vulnerable witness'. This includes any person who 'appears to the court to be suffering from significant impairment of intelligence and social functioning', which

would cover a person with a significant learning disability. However, for other kinds of mental disorder, it is necessary for the person to be ‘subject to an order made in consequence of a finding of a court... that he is suffering from mental disorder within the meaning of section 1(2) of the Mental Health (Scotland) Act 1984’, or the comparable legislation in England, Wales and Northern Ireland. This would mean that a person who is detained under the Act would be entitled to be treated as a vulnerable witness, but a person who is a voluntary patient, who may be equally, or even more, affected by mental illness, would not be so covered.

47. We see no justification for this distinction. It is not for us to say how the Executive should define vulnerable witnesses, outwith the field of mental disorder. However, if it is felt necessary to have a definition of mental disorder as a qualifying criterion for consideration as a vulnerable witness, it should simply be a broad definition, such as that we propose at recommendation 4.2 for the Mental Health Act. The court would then have the discretion to consider whether the person required special measures, in the light of that mental disorder, and any other special circumstances.

Recommendation 19.11

The definition of vulnerable person in s271 of the Criminal Procedure (Scotland) Act 1995 should be amended to include any person with a mental disorder, as defined in Chapter 4.

CHAPTER 20

POLICE POWERS AND RESPONSIBILITIES

Place of safety

1. The police are one of the agencies who may be called upon to deal with a person who is mentally disturbed. It is a task which calls for skill and sensitivity. They may have to intervene at a time of crisis, with limited or no information about the person and his or her situation. We have considered whether the legislative powers the police have to undertake this responsibility are appropriate.
2. Under s118 of the 1984 Act, a constable who finds a person in a public place who appears 'to be suffering from mental disorder and to be in immediate need of care or control' may, if he or she thinks it necessary in the interests of the person or for the protection of other people, remove the person to a place of safety. The definition of 'place of safety'³ includes a hospital or residential home or any other suitable place which is willing to admit the person. It should not include a police station unless by reason of emergency there is no other suitable place available for receiving the patient.
3. The removal to a place of safety is for the purposes of enabling the person to be examined by a medical practitioner and of making any necessary arrangements for treatment or care. The maximum duration of the power to detain is 72 hours, but the power ends once the medical examination has concluded and either arrangements have been made for the treatment or care of the person, or the decision has been made by the doctor that no such arrangements are necessary. If the person requires admission to hospital and is unwilling to be admitted, the examining doctor can detain him or her under the emergency provisions of s24 or s25.
4. Evidence given to us suggested there was a degree of inconsistency in the use of this power. This did not only depend on the attitudes of local police officers, but also the working arrangements with local health and social work services.
5. In December 1999, the Scottish Executive Health Department issued guidance on the roles of GPs and the police in dealing with mentally disordered people who may be potentially violent⁴. This recommended that there should be locally agreed procedures for obtaining health and social work information and (where appropriate) support, where an individual appears to be suffering from a mental disorder. These local arrangements should involve round the clock access to an appropriate source of such information.

3 1984 Act, s117 (7)

4 'Roles and responsibilities of general practitioners and police dealing with potentially violent mentally disordered persons in the community' Community Care Circular 3/99

6. In respect of the 'place of safety' where the person should be held to allow for examination, the guidance suggests that this might be the incident site, the person's home or, where the doctor thinks it appropriate, a hospital. It should not normally be a GP surgery or a health centre. The police and doctors are encouraged to consider whether a mental health officer (MHO) could assist in deciding on the best course of action.
7. The guidance relates specifically to potentially violent incidents. Of course, many of the situations which might involve the police in dealing with a mentally disordered person would not involve the risk of violence to others, but may involve the person acting in an inappropriate way, or putting himself or herself at risk. Nevertheless, much of the guidance would seem to be equally relevant to these situations.
8. The evidence we received would suggest that, despite this guidance, there is need for improvement in some areas of Scotland in the degree of co-ordination between the police and care agencies in responding to people with mental disorders who come to police attention.
9. We received oral evidence from the Association of Chief Police Officers (Scotland) (ACPOS). They pointed out that police officers will often come across people who appear to be behaving in a way which suggests mental disorder. Police officers generally are loath to detain a person in such a condition in a police cell, but may also be extremely concerned for the person's safety. In such circumstances, they may either seek to secure the attendance of a police surgeon (or, in some cases, the person's own GP), or take the person to local psychiatric services.
10. We also received evidence suggesting that there can be difficulty in persuading psychiatric services to admit such people, particularly where it is suspected that the person is under the influence of alcohol or illegal drugs. Police officers may then feel obliged to arrest the person on a criminal charge such as breach of the peace, partly to ensure the person is in safe custody rather than returned to the streets.
11. This attitude is understandable. Nevertheless, it was pointed out to us by, among others, the Fife Advocacy Project that detaining a person who is mentally unwell in a police cell, without input from trained mental health workers, could cause an unacceptable risk of self harm.
12. From the point of view of the health services, there may of course be good reasons for the reluctance to admit. In many services, beds are at a premium. Such patients can be extremely disruptive, and can put other vulnerable patients at risk. In some cases, a person's behaviour may be judged to be due solely to intoxication, rather than by mental disorder.
13. We are not in a position to identify whether difficulties in liaison between the police and psychiatric services in particular areas can be attributed to faults on either side. We are satisfied, however, that there is considerable variation in practice, and that it is necessary for more robust arrangements to be put in place.

14. In general, it would seem that the powers given to the police in s118 are appropriate, although we consider that the duration of the power should be reduced. The power exists in order to allow a person to be medically assessed, after which the emergency detention powers of the assessing doctor can then be brought into play if appropriate. Even in rural areas, we believe that the police ought to be able to have the person assessed by a doctor well before 72 hours have elapsed.

Recommendation 20.1

The police should retain the power granted by s118 of the 1984 Act to take persons appearing to be suffering from mental disorder to a place of safety. The duration of the power should be limited to 24 hours.

15. Section 118(3) requires the constable who has removed the patient, where practicable, to notify 'some responsible person residing with the patient' and the nearest relative. We believe that, with slight amendments, such a power should remain.

Recommendation 20.2

Where a person has been removed to a place of safety, the constable should be required to notify the person or persons who appears to be the primary carer and nearest relative of the person so removed, whom failing, any responsible person who appears to reside with or provide support to the person. If no such person can be identified, the social work department should be notified. Such notification should take place within six hours of the person being removed.

16. There would seem to be a need for better training and greater co-ordination between agencies. The 1999 guidance on the role of GPs and the police in dealing with potentially violent mentally disordered persons recommends that joint training involving the police and mental health services is carried out. Amongst the issues it should cover is the application of the Mental Health (Scotland) Act. (We discuss police training further in Chapter 30).
17. In their evidence to us, ACPOS pointed to the considerable improvements in child protection practice which had come about through the development of joint working arrangements, and suggested that this approach could be beneficial in relation to people with mental disorders who may be offending or at risk.
18. Many of these issues relate to practice rather than legislation. We understand that they have been considered by the review which was commissioned by the Scottish Executive of the operation of the current strategy on mentally disordered offenders. We do, however, feel that the legislation and the associated Code of

Practice could do more to encourage an appropriate response to people with mental disorders who come to the attention of the police.

19. We are particularly concerned about the availability of suitable 'places of safety'. Despite the legislative requirement that this should not be a police station except in an emergency, it appears that there is no suitable alternative in some parts of Scotland, and the 'place of safety' may be in acute psychiatric in-patient facilities. This may also be inappropriate, since it can mean placing at short notice a person who may be potentially violent alongside vulnerable patients.
20. We propose that health boards should be under a duty to ensure that there are appropriate places of safety in their area, and to notify the police of their whereabouts. The Code of Practice should set out minimum standards for places of safety.
21. We also believe that the use of the powers vested in the police should be monitored by the Mental Welfare Commission. This would help to identify problems in particular areas, but also good practice, which could be more widely shared. More generally, it is important that there continues to be monitoring of the extent to which local protocols and arrangements are developed in accordance with the national strategy and guidance.
22. The Scottish Association for Mental Health (SAMH) raised concerns about the dangers of using CS spray on people with mental health problems, suggesting that there could be harmful interaction with antipsychotic medication. It was also suggested that this be reported to the Mental Welfare Commission. We agree that such incidents are potentially serious and should be so reported.

Recommendation 20.3

Health boards should be under a legal duty to secure the provision of places of safety, to accommodate people detained by the police, under Mental Health Act powers.

Recommendation 20.4

A place of safety should not be a police station except in an emergency, or where it is impossible safely to accommodate the mentally disordered person in the facilities provided under arrangements made with health boards.

Recommendation 20.5

The Code of Practice should set out minimum standards for such places of safety.

Recommendation 20.6

The police should be required to report to the Mental Welfare Commission any use of police powers to detain a mentally disordered person, and provide details of the place of safety which was used.

Recommendation 20.7

The Mental Welfare Commission should monitor the development of local protocols and joint training initiatives concerning the detention and assessment of mentally disordered persons who come to the attention of the police.

Recommendation 20.8

The police should be required to notify the Mental Welfare Commission of the use of CS gas on any person who is, or appears to be, mentally disordered.

CHAPTER 21

PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

The current position

1. Part XI of the 1984 Act contains a number of provisions designed to protect people, who may be vulnerable by reason of mental disorder, from sexual exploitation. There are also some related provisions in the general criminal law.
2. Section 106 is designed to protect women with learning disabilities from sexual exploitation. Section 13 of the Criminal Law Consolidation (Scotland) Act 1995 is intended to protect men with learning disabilities from sexual exploitation by other men. Section 107 of the 1984 Act is intended to protect women and men with mental disorders from abuse by male staff. Section 105 is not specifically directed at sexual exploitation, but could be so used. It makes it an offence for any individual to ill treat or wilfully neglect a person suffering from mental disorder who is in his custody or care. We have discussed s105 in Chapter 19.
3. Of course, people with mental disorders are also protected by the general criminal law concerning sexual offences. Many of these are based in common law, such as the crime of rape. As we go on to discuss, the way in which these offences are defined can make it difficult to secure a conviction in the case of a victim with a mental disorder.

Protection of people with learning disabilities-the current law

4. Section 106 of the 1984 Act makes it an offence for a man to have sexual intercourse (outwith marriage) with a woman who is 'suffering from a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning'. This definition applies to women with learning disabilities, and would not include women with mental illness, dementia, or acquired brain injury. The Act does not define 'significant impairment'.
5. It is not a defence that the woman consented to sexual intercourse. The crucial question is whether the woman comes within the protected category. There is a defence, if the man can show that he did not know and had no reason to suspect that the woman was so disabled.
6. Section 106 also includes a prohibition against procuring or encouraging a woman covered by the above definition to have unlawful sexual intercourse.

7. The maximum prison sentence for a conviction under the above provisions is two years. We note that, by comparison, the common law offences which apply more generally, such as rape and indecent assault, can result in sentences of any length, up to and including life imprisonment.
8. Section 13 of the Criminal Law (Consolidation) (Scotland) Act 1995 provides that a male homosexual act⁵, which would not otherwise be an offence, will be a crime if one of the parties is 'suffering from mental deficiency which is of such a nature or degree that he is incapable of living an independent life or of guarding himself against serious exploitation'⁶. As with s106, the maximum prison term on conviction is two years, and there is a defence if the other male can prove that he did not know and had no reason to suspect the man to be suffering from such mental deficiency.

Criticisms of the current law regarding people with learning disabilities

9. There are a number of problems with the law. These can result in some vulnerable people not being protected, while others may find their right to enter into a sexual relationship unduly restricted.
10. The law creates a category of people who are deemed never to be able to consent to a sexual relationship, because they have a learning disability. It does not consider the person's capacity or wish to have a sexual relationship, or whether there is exploitation involved.
11. The law is unequal in its application to men and women. There is no protection against sexual abuse by women.
12. Section 106 does not protect against assault by boys. It states that 'woman' includes 'girl', but not that 'man' includes 'boy'.
13. The definitions of prohibited sexual behaviour are inconsistent. Section 106 only covers sexual intercourse, and not other potentially abusive sexual acts, while s13 of the 1995 Act covers a range of homosexual acts.
14. The definition of the protected class of men is different from that of women. The effect of this is not clear.
15. The prohibition on 'encouraging' a sexual relationship in s106 may discourage staff from giving sex education or assisting with contraception.
16. The provisions may be inconsistent with the right to respect for private and family life guaranteed by Article 8 of the European Convention on Human Rights.

The need for special legislation

17. The principles of *Non-discrimination* and *Equality* require that any legislation which is specifically directed at protecting people with mental disorders should be

5 Section 13(4) states that 'a homosexual act' means sodomy or an act of gross indecency or shameless indecency by one male person with another male person'.

6 This definition is derived from that for one of the categories of people who could be detained under the Mental Health (Scotland) Act 1960.

justified by reference to a particular difficulty which cannot be met by the normal provisions of the criminal law.

18. The right of adults with learning disabilities to choose to enter into sexual relationships is now widely acknowledged. A number of respondents to our leaflet directed at people with learning disabilities stressed this.
19. One commented:

“ I don’t think people should be stopped from having sex and I know whether I would want to or not”,

and another said

“As an adult with learning disabilities I should have the right to choose who I have sex with”.

20. Section 106 of the 1984 Act and s13 of the Criminal Law (Consolidation) (Scotland) Act 1995 would appear to restrict this right, and we believe they must be reformed. Nevertheless, we believe that some form of special legislation is appropriate, if vulnerable people are to be properly protected. Indeed, a failure to provide such protection could, in itself, be a breach of the European Convention on Human Rights. In the case of *X and Y v Netherlands*⁷, Dutch law was found to breach the Convention, on the basis that it did not protect a woman with learning disabilities who alleged that she had been sexually assaulted.

21. There is considerable evidence that people with learning disabilities are particularly at risk of sexual abuse. Unfortunately, we do not believe it is possible to deal with this abuse solely by using the general law covering sexual offences.

22. The fundamental problem is that most sexual offences concerning adults can only be established if a lack of consent by the victim can be proved. Where a person is severely mentally impaired, it may be difficult to establish such a lack of consent.

23. In rape, for example, the crime is committed where a woman’s will is overcome by violence or the threat of violence. If a man has sex with a woman who does not have the capacity to understand what is happening, but who does not actively resist, this legal test may not be met.

24. We understand that some older definitions of rape in Scots law include ‘intercourse with a defective’. This terminology is of course out of date and offensive. Even if it were brought up to date, it would still present the same difficulty as s106: that the crime depends on the characteristics of the woman, not the nature of the relationship.

25. The problem is not simply one of possible incapacity to consent, but also one of vulnerability. It may well be possible for a man to coerce a woman with learning

⁷ *X & Y v Netherlands*, Case no. 16/1983/72/110, judgement issued 26 March 1985.

disabilities into having a sexual relationship without having to use threats of a degree which would be sufficient to sustain a rape charge.

26. Even where a woman has not in fact consented, proof of this requires corroboration. Such corroboration is often difficult to establish, and may be even more difficult where the victim has a learning disability. In cases where rape has been charged but not established, perhaps because of the problem of showing a lack of consent, it is possible to convict the accused person of an offence under s106 of unlawful sexual intercourse.
27. Section 106 and s13 are not used frequently. We understand that there were eight convictions under s106 between 1994 and 1998. Nevertheless, we have received evidence that the sections are useful, because of the difficulties inherent in proving mainstream sexual offences. We are satisfied that a special offence is required, for the reasons given above.
28. Although the wording of s106 and s13 appears to be highly restrictive of the sexual freedom of people with learning disabilities, the application of the law appears to be more liberal. We are not aware of cases of genuinely consensual relationships involving people with learning disabilities being prosecuted. The Crown will only bring a prosecution when satisfied that to do so is in the public interest. In correspondence with Adrian Ward, a solicitor, the then Lord Advocate said in 1985 that the Crown would have regard to the purpose of the section, namely to protect women from abuse, in deciding whether to prosecute in a particular case. It would also take account of the developments and advances intended to assist people with learning disabilities to live in as normal a way as possible⁸.
29. Nevertheless, the fact that the law is applied sympathetically is not a justification for a bad law. Even if a prosecution is not in fact likely, the fact that a sexual relationship may be seen as illegal because one of the couple has a learning disability (or both have) has the effect of devaluing the rights of a group of citizens. It may also make staff reluctant to assist people to exercise a genuinely free choice in sexual relationships.
30. In particular, the wording of the current prohibition against 'encouraging' a woman to have sex has led to concerns that staff cannot offer contraceptive advice or sex education, or make arrangements, for example for a learning disabled woman to share a room with a man with whom she has formed a relationship. The correspondence which we have earlier referred to sought to dispel some of these fears, but some problems may remain. ENABLE proposed to us that legal protection should be provided for care staff who seek to ensure a normal sexual life for people with learning disabilities, and that there should be a code of practice incorporating the need to provide sex education.
31. We agree that staff should not feel constrained from offering appropriate advice and support in relation to sexual issues. This would not appear to be the intention of the relevant provisions of s106 which could be worded more clearly to avoid its being interpreted as a ban on, or discouragement of, sex education.

8 see Ward, A. *The Power to Act*, (Scottish Society for the Mentally Handicapped), 1990, Chapter 9

A new framework

32. We believe that the law should be amended, so that the offences relate more directly to what is unacceptable about certain types of sexual behaviour, which is that they are in some way abusive or exploitative.
33. We also believe the scope of the law should be widened to cover people with mental disorders generally, and not be restricted to people with learning disabilities. Although people with learning disabilities may often be particularly vulnerable, the same can be said of some people with, for example, dementia or acute mental illness.
34. There are a number of features which we believe should apply to reformed legislation to protect people with mental disorders from sexual abuse.
 - ♦ It should apply equally to men and women who are vulnerable, and to activities of a heterosexual or homosexual nature, whether engaged in by men or women.
 - ♦ It should be based on the factors in a situation which may create barriers to true consent, not simply on diagnosis of a mental disorder.
 - ♦ It should cover sexual intercourse, but also other sexual acts.

Recommendation 21.1

Sections 106 and 107 of the 1984 Act, and s13 of the Criminal Law (Consolidation) (Scotland) Act 1995 should be replaced by two new statutory offences: sexual abuse of a mentally disordered adult, and sexual abuse by staff and formal carers.

Recommendation 21.2

Both new offences should apply to male and female perpetrators and victims, and to perpetrators of any age (above the age of criminal responsibility).

Recommendation 21.3

Both new offences should apply to all types of mental disorder, as defined in Chapter 4.

Recommendation 21.4

Both offences should apply to sexual intercourse, and other acts which could constitute sexual offences at common law.

A statutory offence of sexual abuse of a mentally disordered adult

35. The new statutory offence, which would replace s106 and s13 of the 1995 Act, would be based on a new test, which should concentrate on one or other of two elements: capacity and exploitation.

Capacity

36. It would be an offence to have a sexual relationship with a woman or man who, because of mental disorder, is unable to understand, or make a decision about, the nature of the act and its consequences at the time when the sexual activity takes place.

Exploitation

37. It would be an offence to have a sexual relationship with someone who is unable to give free agreement to the relationship. Free agreement would be held not to exist where there is a significant degree of mental disorder, and evidence that the other party is in a position of trust or influence over the mentally disordered person and has exploited that position. This would not be restricted to those who may be involved formally or informally in the care of the mentally disordered person, but would include anyone who is in a position to exploit that position of trust or influence in relation to the vulnerable person.
38. So far as learning disabilities are concerned, we understand that psychologists are developing instruments to assess the ability of people with learning disabilities to make sexual choices. We appreciate that there may be practical problems in assessing capacity to consent in relation to some people with mental disorders, for example a person who behaves in a sexually disinhibited way during a hypomanic episode. Ultimately, however, this would be an evidential question in any particular case, and does not affect the principles underlying our recommendations.
39. The wording of our proposed capacity test has been influenced by the recommendations of the Law Commission in England and Wales in their paper 'Consent in Sex Offences'⁹. Guidance on assessing capacity could be given in the Code of Practice. Some of the proposals to the Home Office Review of Sexual Offences gave examples of issues which would be relevant to the assessment of capacity, such as understanding that sex is different from personal care; and that it can lead to pregnancy¹⁰.
40. The 'exploitation' test is more complex, since it requires consideration of the relationship between the parties, not simply the degree of impairment of one party. However, we believe that this is an element in deciding whether to prosecute at the moment, and it should be possible for it to be made more explicit and transparent.
41. In both situations, there would continue to be a defence that the accused person did not know, and could not reasonably have known, of the person's mental disorder. There should also be provision to ensure that couples with a pre-existing

⁹ *Consent in Sex Offences: A Report to the Home Office Sex Offences Review* (2000)

¹⁰ 'Setting the Boundaries' Vol 1, (Home Office, July 2000) paras 4.5.7 – 4.5.13

relationship are not inappropriately brought within the scope of the offence because one of them develops a mental disorder.

42. Where both parties have a mental disorder, there are additional complications. We do not recommend that such relationships should never be a concern of the criminal law. We heard evidence that people with mental disorders can be perpetrators, as well as victims of abuse. Prosecution may seldom be appropriate, but we do not think the possibility should be ruled out.
43. The law will still require to be applied humanely and with discretion. For example, there will be some people with severe learning disabilities who could not be said to have legal capacity to consent to sexual relationships, yet who may be involved in sexual activity which they enjoy and which is not exploitative. It would be wrong to seek to proscribe such activity by the operation of the criminal law. In responding to our second Consultation, Scottish Human Services commented that there is danger of criminalising behaviour which might be 'foolish and unethical' but not 'malicious or evil'. They suggest that if the risk of exposure is too high, this may lead to denial and cover up.
44. These are matters which rightly fall within prosecutorial discretion. However, it would be desirable to provide reassurance to staff and service users. Although we do not believe that it is necessary for such protection to be spelled out in the Mental Health Act, it would be helpful if guidance could be set out by the Crown Office. This would be an extension and updating of the guidance already given by the then Lord Advocate in 1985.
45. We believe that the offence of 'encouraging' a person with learning disabilities to have sexual intercourse should be abolished. This appears to offer little practical protection and, as we have said, may act to inhibit legitimate education and support. There may, however, be a justification for retaining some protection against 'procuring' a mentally disordered person to have intercourse, although it would seem that prosecutions under this provision are extremely rare.

Recommendation 21.5

The offence of sexual abuse of a mentally disordered adult would be committed where

- (a) because of a mental disorder, the adult is unable to understand, or make a decision about, the nature of the sexual act or its consequences, or*
- (b) the adult has a mental disorder and is unable to give free agreement to the relationship.*

Recommendation 21.6

It should be an offence to procure a mentally disordered adult to commit a sexual act.

Recommendation 21.7

In establishing whether an adult is able to give free agreement to a relationship the court should have regard to the nature and degree of the adult's mental disorder, and the nature of the relationship between the parties.

Recommendation 21.8

It should be a defence to the crime of sexual abuse of a mentally disordered adult to show that the accused person did not know, and could not be expected to know, that the adult came within the category protected by the provisions of the legislation.

Recommendation 21.9

The Crown Office should issue guidance on its policy in relation to sexual activity between adults with mental disorders, and sex education for people with learning disabilities.

Sexual relationships with staff and carers

46. Section 107 of the 1984 Act is intended to protect female patients from exploitation by staff. It makes it an offence for someone employed by, or managing a hospital or nursing home, to have sex outwith marriage with a woman receiving treatment for mental disorder as an in-patient or outpatient. It is also an offence for a man to have such intercourse with a woman suffering from mental disorder who is resident in a house provided by a local authority under the Social Work (Scotland) Act 1968.
47. Section 107 protects all women suffering from mental disorder: whether mental illness or learning disability. It also applies to members of staff who are involved in male homosexual acts with patients¹¹.
48. The provisions of s107 now seem arbitrary and inappropriate. It would be an offence under s107 for a male member of staff to have sex with an outpatient in a room at the hospital, but not outside the hospital. Phrases such as 'in the custody and care' of a man, or 'in the care' of the local authority do not have clear meanings. It is not clear whether s107 would include, for example, a supported accommodation project which is funded by the local authority. There is no protection for people using day services, living in hostels, or subject to community care orders.

¹¹ s107(3) incorporates male homosexual activity by adding homosexual acts under s13 of the Criminal Law (Consolidation) Scotland Act 1995 to the prohibited behaviours under s107

49. In other respects, it appears too wide in its effect. It makes a crime of any sexual relationship with a woman who has a mental disorder and who lives in a house provided under the Social Work (Scotland) Act.
50. Many of the criticisms that can be made of s106 apply equally to s107. In particular, it deals only with sexual intercourse and not other forms of sexual activity, and it does not cover sexual abuse of any kind committed by a woman.
51. The criminal law needs to protect vulnerable people against sexual abuse by staff, because of the unequal power relationship. However the current provisions need to be redrafted to cover the wide variety of situations in which a mentally disordered person may find themselves receiving care. We propose that the law should prohibit sexual relationships between
 - ♦ a patient with a mental disorder, whether inpatient or outpatient of a hospital, and a member of staff, whether paid or unpaid
 - ♦ a mentally disordered person in residential care and a member of staff, whether paid or unpaid
 - ♦ a mentally disordered person and a person employed to deliver care services in the community to that person
 - ♦ a mentally disordered person and a doctor or therapist involved in a professional relationship with that person.
52. In such situations, it should not be necessary to prove lack of consent, or incapacity to consent. The fact that staff are in a position of trust in relation to clients with mental disorder, which would be breached by a sexual relationship, is enough to justify treating such relationships as criminal offences.
53. There are however particularly complex problems where a person may, because of severe learning disability, or learning disability combined with physical disability, require a high degree of intimate support, involving some physical contact and assistance, if he or she is to be assisted to manage their sexual behaviour. This could be legitimate in the context of a person's individual needs, but there is a danger that providing such physical assistance could fall within a definition of prohibited sexual relationships with staff. The same considerations might apply in some forms of sex therapy by psychiatrists and others.
54. It would be difficult to formulate a statutory defence to encompass such a situation, but it would be desirable for the position to be clarified in guidance in order to protect staff. It should emphasise the need for agreed procedures and the responsibility of employers to set clear guidelines for staff. These guidelines in turn would deal with issues such as multi-disciplinary discussion and proper recording of decisions.

Recommendation 21.10

The offence of sexual abuse by staff and formal carers would be committed where there is a sexual relationship between

- (a) a patient with a mental disorder, whether inpatient or outpatient, and a member of staff, whether paid or unpaid;*
- (b) a mentally disordered person in residential care and a member of staff, whether paid or unpaid;*
- (c) a mentally disordered person and a person employed to deliver care services in the community to that person; or*
- (d) a mentally disordered person and a doctor or therapist involved in a professional relationship with that person.*

Problems with the general law

- 55. Several respondents to our consultation identified wider difficulties with the general law relating to sexual offences, and the way in which it is applied, which may contribute to the difficulties in prosecuting the sexual abuse of mentally disordered adults. Some of these problems relate to the way consent is defined. An alternative approach to the special offences discussed above would be to redefine consent generally in relation to sexual behaviour to something closer to 'free agreement'. This approach could avoid the need for special offences to protect people with mental disorders, by bringing abuse of this group within the definition of generally applicable crimes such as rape.
- 56. This approach has the attraction of being more consistent with the principle of *Non-discrimination*. It would help to avoid the impression that people with mental disorders, particularly learning disabilities, are in a special position in relation to sexual activity, where such activity is almost assumed to be wrong unless proven otherwise.
- 57. Nevertheless, we do not recommend such an approach at this stage. It would involve a radical reform to general sexual offences, which would have consequences for a wider group than people with mental disorders. We were not in a position to consider the implications of such a change. If the law concerning sexual offences is reviewed in future, we would hope that consideration would be given to how it applies to people with mental disorders. In the meantime, however, reform to the special offences appears to us to be a more practical way forward.
- 58. There are also concerns regarding the way in which evidence is taken from victims of abuse. Many people with mental disorders find the court system confusing and intimidating. In such circumstances, it is not surprising if they do not always make

convincing witnesses. We consider vulnerable witnesses in Chapter 19 (paragraphs 45-47). We discuss one way of assisting mentally disordered people involved in the criminal justice system, the Appropriate Adult scheme, in Chapter 30. The benefits of an appropriate adult apply equally to victims with mental disorders as they do to suspects.

Sex Offenders Act

59. The Sex Offenders Act 1997 has established a register of sex offenders, and lists a range of offences which require the offender to be placed on the register. The current Mental Health Act offences are not included in this list. We see no reason for their exclusion. The proposed new offences should be included in the list in the Sex Offenders Act.

Recommendation 21.11

The offences of sexual abuse of a mentally disordered adult and sexual abuse by staff and formal carers should be included in Schedule One of the Sex Offenders Act 1997.

CHAPTER 22

THE REGULATION OF PRIVATE HOSPITALS

1. The 1984 Act contains provisions on the regulation of private hospitals. We have given consideration to whether these provisions are still appropriate, given other developments in the regulation of care. We have concluded that all settings caring for people with mental disorders outside the NHS should be regulated by the same body, the Scottish Commission for the Regulation of Care (CRC).

The regulation of private hospitals in the 1984 Act

2. Part IV of the Mental Health (Scotland) Act 1984 contains provisions on the registration of private hospitals treating detained patients. Under the terms of the Act, private hospitals which wish to treat detained patients must register with Scottish Ministers. However, private hospitals providing psychiatric services to non-detained patients instead require to be registered and regulated by health boards, under the provisions of the Nursing Homes Registration (Scotland) Act 1938. There are not, at present, any hospitals registered under the Mental Health (Scotland) Act in Scotland, although similar facilities are relatively widespread in England. The position of Scottish Ministers is anomalous, in that they do not have responsibility for registering other comparable health care establishments.

The Scottish Commission for the Regulation of Care

3. In addition to Part IV of the 1984 Act, a number of different pieces of regulatory legislation apply in different care settings: amongst these are the Nursing Homes Registration (Scotland) Act 1938, the Social Work (Scotland) Act 1968, and the Children Act 1989. Each of these requires a different set of standards from the care setting(s) to which they relate and the monitoring of these standards falls to a variety of different authorities to undertake.
4. Prior to 1999, concerns had been raised with the UK Government that the complexity of the legislative situation was leading to inconsistencies in the standards of care provided. In response to this, the Government's White Paper "Aiming for Excellence"¹² contained a proposal that a new body, the Scottish Commission for the Regulation of Care, should be set up. This body was to be charged with undertaking all registration, inspection, enforcement and complaints investigation functions relating to residential and nursing homes.
5. Since publication of the White Paper there have been two related consultations undertaken by the Scottish Executive. One is on the proposals contained in the

12. *Aiming for Excellence: A White Paper*, The Scottish Office (1999), Cm 4288.

White Paper¹³ and the other is on the future regulation of private and voluntary healthcare¹⁴. The latter consultation paper asked questions, relevant to our Committee, on what the most appropriate body would be to undertake the registration and inspection of private hospitals caring for detained patients. It has been followed by a policy position paper: 'Regulating the Independent Healthcare Sector' issued in November 2000.

6. Subject to consultation and the completion of the Parliamentary process, we understand that the Scottish Executive intends that the CRC should be operational from April 2002.

The role of the Commission for the Regulation of Care in relation to private psychiatric hospitals

7. In our first Consultation document we asked whether respondents were in favour of the transfer of the regulation of private hospitals caring for detained patients to the CRC. The majority of responses that we received on this matter were in favour of such a transfer.
8. We agree with the majority view that the role should not remain with Ministers. We considered whether any other body, other than the CRC, could take on this responsibility. Given the lack of such establishments in Scotland, a new and separate body would seem unjustified. We considered whether the Mental Welfare Commission could take on this responsibility, but the registration role would not seem to fit well with the Mental Welfare Commission's responsibility independently to monitor the welfare of individual patients.
9. There is a case that could be made for such a role being carried out by the Scottish Health Advisory Service (SHAS). This might ensure consistency in standards between NHS and independent sector care for detained patients. However it would require changes to the organisation of SHAS, which is a non-statutory body, and would perpetuate two different regimes for detained and non detained patients.
10. We believe that detained and non-detained patients should not be subject to separate registration and inspection, as this has the potential to cause confusion and inconsistencies in approach. We also believe that, given the expertise in standards-setting and monitoring which the CRC will have, monitoring of mental health care in all private hospitals by the CRC will help to ensure that there are high standards of care in place for all mental health service users, irrespective of their legal status.
11. We therefore take the view that should the CRC, as proposed, take over from health boards the registration and inspection of private hospitals treating non-detained psychiatric patients, it should also take over these functions from Scottish Ministers, in relation to private hospitals treating detained patients.

13 *Regulating Care and the Social Services Workforce (Consultation)*, Scottish Executive (1999).

14 *Regulating Private and Voluntary Healthcare – A Consultation*, Scottish Executive Health Department (2000).

12. We welcome the fact that the Scottish Executive's view, as described in its recent consultation paper on the regulation of private and voluntary healthcare, accords with our view on this matter.

Recommendation 22.1

The role of Ministers in regulating private mental hospitals, currently in Part IV of the 1984 Act should be abolished.

Recommendation 22.2

Should the Scottish Commission for the Regulation of Care be given responsibility for registration of private hospitals, it should be the primary regulatory body for all private hospitals caring for psychiatric patients, whether subject to compulsion or not.

The role of the Commission for the Regulation of Care in relation to nursing and residential care homes

13. The 1984 Act does not currently permit nursing or residential care homes to care for patients subject to detention. Any such patients must be cared for in an establishment registered as a private hospital. This may lead to artificial barriers being raised, for example, between elderly patients with symptoms of dementia who may be cared for in a nursing home setting and those who may have similar disorders but are subject to detention, who must be cared for in a hospital.
14. As we say in Chapter 6, the Committee is in favour of a relaxation of the link between compulsion and detention in hospital. It is in line with our recommendations there that a person may be subject to compulsion relating to their treatment and care yet be able to reside in a place of their own choosing. We take the view that there should be no legal barrier to this place of residence being a nursing or residential care home, if that is appropriate and in keeping with the person's wishes.
15. Alternatively, the obligation to reside in a named place could be one element of the compulsion to which a person is subject. This would be detailed in the person's plan of care. There may be circumstances when that place would most appropriately be a nursing or residential care home rather than a hospital. We believe that there should be no legal barrier to this being permissible.

Recommendation 22.3

The Scottish Commission for the Regulation of Care should be permitted to designate nursing and residential care homes as appropriate accommodation for mentally disordered patients subject to compulsion, if the care and facilities available are of an appropriate standard.

Standards

16. The CRC will set standards for the establishments caring for people with mental disorders. Clearly, appropriate, well-defined standards of accommodation, staffing and care will have to be set and met before an establishment may undertake the care of people with mental disorders. However, there is a question as to whether there should be different criteria set for establishments caring for people subject to compulsion, and establishments caring only for voluntary patients.
17. In favour of having specific criteria for services for patients subject to compulsion is the principle of *Reciprocity*: in other words, there is a need for a high standard of care to be made available when a person is being denied certain key rights and freedoms as a result of his or her mental disorder.
18. When dealing with patients subject to compulsion, there may also be security needs which do not apply to establishments caring only for voluntary patients. Similarly, there may be a need to ensure the competency of staff in techniques of, for example, humane restraint.
19. It has been suggested to us that some establishments may wish to deal only with voluntary patients as they have a therapeutic approach which seeks to avoid the need for coercion. Potentially, this could be undermined by the need for inappropriate security standards to be met.
20. To have different standards in place for the two groups might also dissuade some establishments from caring for patients subject to compulsion, on the grounds of cost or inconvenience. This would reinforce the distinction between the two groups, and perhaps make finding appropriate accommodation for patients subject to compulsion more difficult.
21. We note that in the Scottish Executive's consultation document on the regulation of private and voluntary healthcare, the Executive proposes that the CRC would have reference to a basic core set of standards, which would apply to all establishments. Beyond that, the document suggests, specific standards for each type of establishment would be in place:

"These standards would be proportionate to the type of services provided and the risks to the patients involved... Appropriate standards will need to be set for the care of vulnerable groups including children"¹⁵.
22. This flexible approach is attractive. Within that general context, we have concluded that it is not appropriate for us to seek to restrict unduly the discretion of the CRC in setting standards appropriate for residents or patients with mental disorder. The CRC will be an expert body, and best placed to make decisions on the level and types of standards it wishes to set.
23. We therefore recommend that standards for care of mentally disordered persons in private accommodation should be set by the CRC, and the CRC should address

¹⁵ *Regulatory Private and Voluntary Healthcare - A consultation* (Scottish Executive 2000), para 5.3

the question of whether there should be different standards for client groups with different legal status.

Recommendation 22.4

The Scottish Commission for the Regulation of Care should issue appropriately rigorous standards of care relating to the care of people with mental disorders, including those subject to compulsory measures of care under mental health law.

The Scottish Commission for the Regulation of Care should address the question of whether these standards should be the same or different for groups of mentally disordered persons with different status in law.

The role of the Mental Welfare Commission

24. The Mental Welfare Commission has a protective role relating to all patients with mental disorders. We recommend in Chapter 23 that it should have the power to visit community services and facilities, with the same power to conduct interviews and inspect records as it has for hospitals. This power would encompass establishments registered by the CRC, and it will be important for the two organisations to work together effectively.

SECTION 5

THE MENTAL WELFARE COMMISSION

CHAPTER 23

THE MENTAL WELFARE COMMISSION

Background

1. Our terms of reference require us to have particular regard to the role of the Mental Welfare Commission for Scotland. The Commission is established under Part II of the 1984 Act, and has functions under both this Act and the Adults with Incapacity (Scotland) Act 2000.
2. The Commission was originally established under the Mental Health (Scotland) Act 1960, and replaced the General Board of Control for Scotland. Its main duty is 'to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests'¹. In the exercise of this role, the Commission has a wide range of other powers and duties, which we discuss below.
3. The Commission differs from the English Mental Health Act Commission, which was, in part, modelled on the Scottish Commission, in having a wider remit. The English body is solely concerned with patients subject to compulsory measures, while the Mental Welfare Commission has an overall protective responsibility for all people with mental disorder, whether in hospital or elsewhere. This broad remit is something which both the Commission and others strongly support, but may contribute to the pressures on the Commission in targeting its limited resources.
4. The Commission is not an especially large body. In the financial year 1999-00, it had a total income of just under one and a half million pounds².
5. We go on to suggest a number of ways in which the remit and powers of the Commission could be improved. Views of consultees differed to some extent about what the remit should be, and how the Commission's role should fit with the complex network of bodies charged with ensuring good practice in mental health care. However, there was an overwhelming view that the Commission provided an important safeguard for the rights of people with mental disorders. There was also general support for this role not being restricted to people subject to compulsory measures.

Recommendation 23.1

The Mental Welfare Commission should continue to exercise protective functions in respect of people with mental disorders, whether or not they are subject to compulsory measures.

1 1984 Act, s3(1)

2 *Mental Welfare Commission Annual Report 1999-00*, Section 6

Composition of the Commission

6. The overall control of the organisation is vested in the Commissioners. This is a group of people selected for their skills and expertise who serve, mostly on a part time basis, for a time limited period. The Commissioners are appointed by Her Majesty on the recommendation of Scottish Ministers.
7. The 1984 Act sets out certain requirements as to the composition of the Commission. There must be at least 10 Commissioners, including three women, three medical practitioners and one advocate or solicitor of at least five years standing³.
8. In addition to these statutory requirements, the Commission seeks to ensure that it has a broad range of experience and expertise. Present membership includes people with backgrounds in nursing, social work, health management, psychology, the legal profession and the voluntary sector. In recent years, the Commission has taken steps to have a Commissioner appointed with interest in ethnic minority issues, and one who has publicly identified herself as having experience as a user of psychiatric services.
9. We believe that the wide range of experience which Commissioners bring to their role is important. Our consultation found evidence of a belief in some quarters that the Commission is dominated by psychiatry. This may partly reflect the fact that much of the Commission's work in reviewing detentions is carried out by the Medical Commissioners, and by psychiatrists working under contract to the Commission. In addition, the current Director is a consultant psychiatrist. However, this point of view would not seem to take account of the breadth of membership of the current Commission.
10. We consulted on the membership of the Commission and received a wide range of suggestions. In particular, many people felt that user and carer representation needed to be strengthened. Other suggestions included a full time Nursing Commissioner,⁴ a Complaints Commissioner, a Police Commissioner, and people from lower down the promotion scale in various professions so that the views and experience of 'front line' professionals are better represented.
11. In general, we feel that it would be a mistake to specify the composition of the Commission too precisely in the Act. Any detailed list would be likely to become outdated as professional roles develop, and might exclude high calibre candidates from outwith the specified backgrounds. We feel it is appropriate to retain the requirement that the Commission include medical and legal expertise, but believe that Scottish Ministers should have flexibility to appoint a range of other people to the Commission to provide a multi-disciplinary and balanced approach to its work.
12. The current Act does not specify that the minimum of three doctors should have particular expertise in relation to mental health. Given the responsibilities of the Commission, particularly their power to discharge patients, we feel that it would be appropriate to specify that these three doctors be psychiatrists. Of course, as at present, it is likely that other doctors, particularly GPs, would be represented.

³ 1984 Act, s2(2)

⁴ We understand that such an appointment is in fact being made

13. We agree with the need to have adequate representation from both men and women in the Commission, but we are not convinced that the statutory requirement to have at least three female Commissioners is still necessary. Currently there are nine women who are Commissioners, and the number has always been well above three in recent years.
14. The one new area where we feel the Act should make specific provision is that of service users and carers. The proposal that user and carer involvement be strengthened was the most strongly supported of the specific suggestions made in our second Consultation.
15. In 1960, and even in 1983, when the Act was revised, the notion that service users and their families should have a role alongside professionals in monitoring the quality of care, and establishing care standards, was not developed. Since then, the user and carer movements have grown in strength and importance.
16. As a comparison, the Disability Rights Commission, which was established recently to promote the rights of disabled people, is required to have people who are, or have been, disabled, as a majority of its membership⁵. We understand that one of the current members has a learning disability.
17. The Mental Welfare Commission plays a different role, but this does not lessen the importance of having adequate representation from users and carers. In addition to the appointment of a service user to its membership the Commission is now considering the appointment of a person with experience of informal caring. (It is of course likely that others who have served in the Commission will have had such experience, without it having been formally acknowledged.)
18. These developments are welcome, but many people commented to us that more should be done. There is concern that a single user representative may be expected to represent the experiences of all users, which is unrealistic. Also, should a service user have a period of ill health, that perspective would be lost. The same problem arises for a carer who may also have to deal with family pressures from time to time. Even when these difficulties are not present, there are dangers that the service user or carer may feel isolated in a body which is otherwise predominantly led and staffed by professionals.
19. We therefore recommend that user and carer involvement be strengthened, providing specifically for at least two of each.
20. This would mean that eight of the posts in the Commission were set aside for doctors, lawyers, users and carers. This may make the current minimum membership of 10 unduly small. We understand that there are currently 21 posts, and it would seem that this is not excessive for the Commission's needs. We believe, therefore, that the minimum membership should be increased.

5 Disability Rights Commission Act 1999, Schedule One

Recommendation 23.2

There should be a requirement in the Act for three psychiatrists and one experienced legally qualified person to be members of the Commission.

Recommendation 23.3

The Act should require that at least two members of the Commission should have personal experience of mental disorder, and at least two members should have personal experience of caring for a person with mental disorder.

Recommendation 23.4

The minimum number of members of the Commission should be increased from 10 to 18.

21. In recent years, the Commission has strengthened its arrangements for the induction and training of Commissioners. However, there is no statutory requirement that Commissioners receive such training. Given the importance and complexity of the Commission's work, we believe that such training is essential.

Recommendation 23.5

There should be a statutory requirement that Commissioners receive such induction and training as may be specified by Ministers.

22. Section 2(5) of the Act states that, before recommending the appointment of a new Commissioner to Her Majesty, Scottish Ministers shall consult such bodies as appear to them to be concerned. We understand that it used to be the practice that the relevant professional body was invited to suggest new Commissioners; for example the Law Society of Scotland when it was proposed to appoint a solicitor. However, the practice has now changed in the light of the guidance on public appointments issued by the Commissioner for Public Appointments. The procedure now is that almost all posts are publicly advertised, and the only involvement of the relevant professional bodies is that they are notified of the vacancy. This is important, to encourage suitable applications, but serves a different purpose from consultation. In the light of these changes, the requirement to consult appears to be no longer appropriate. We believe that the arrangements for advertising vacancies should be extended to all posts.

Recommendation 23.6

The requirement to consult interested parties prior to appointment of Commissioners should be removed.

Recommendation 23.7

All vacant Commissioner posts should be publicly advertised.

23. Section 6 states that the Commission may appoint officers and servants on such terms as to remuneration and conditions of service as Scottish Ministers may determine. The Act does not prescribe however the way in which the Commission and its staff should be organised.
24. More detailed provisions are contained in a Memorandum of Agreement between the Commission and the Scottish Executive Health Department. This can be varied from time to time. The current arrangements are that the day to day management of the Commission is the responsibility of the Director, who is a full-time Commissioner. There are other full-time Medical and Social Work Commissioners, and we understand that a full-time Nursing Commissioner is being recruited. The Commission currently employs around 37 staff, including a Secretary, five (three full time equivalent) medical officers, a nursing officer and two social work officers.

Organisational arrangements

25. In recent years, there have been a number of developments, both affecting public bodies generally, and in the Commission's activities, which may have implications for the way the Commission should be organised.
26. We have already mentioned the effect which guidance from the Commissioner on Public Appointments has had on the process of appointing Commissioners. More broadly, the Ethical Standards in Public Life etc. (Scotland) Act 2000 will require the Commission, alongside other public bodies, to prepare a draft Code of Conduct for its members.
27. The Commission has already reviewed its procedures for reviews of detention in light of the introduction into domestic law of the European Convention on Human Rights. It may be that the Convention will have further implications for the work of the Commission.
28. A constant factor in recent years has been the growth in the Commission's workload - partly caused by the continuing increase in the number of patients subject to detention and guardianship. For example, in 1992/3 there were 2080

episodes of detention under s26 (up to 28 days) and 745 episodes of detention under s18 (up to six months). In 1999/00 the respective figures were 2500 and 1011.

29. The Adults with Incapacity (Scotland) Act 2000 has imposed new duties on the Commission, and our recommendations will, to some extent, also increase the responsibilities of the Commission.
30. These developments raise questions as to whether the current organisational arrangements are still the most appropriate. We asked in our second Consultation whether the internal structure of the Commission should be altered, perhaps with the creation of a distinction between executive and non-executive members. We received few substantive responses. However, this may be because, apart from current and previous Commissioners and staff, many respondents would be unlikely to be familiar with the Commission's internal workings.
31. One issue which might bear examination is the role of the Director. The Director is, at present, and has been in the past, also a Medical Commissioner. This involves a heavy range of responsibilities. The Memorandum of Agreement with the Scottish Office sets out administrative responsibilities as accounting officer for the Commission, and these must be combined with providing medical input to the Commission's work, and leadership for the organisation. As the work grows, this workload may in time prove to be unmanageable.
32. The role and responsibilities of the Chairman may also fall to be considered, as may the responsibilities of full time Commissioners and the wider group of part time Commissioners. It seems likely that the number of Commissioners will increase, as indicated by our earlier recommendations. While this would bring an even broader range of knowledge and experience to the Commission it may make it more difficult to maintain the valuable principle that all Commissioners have equal status.
33. We have not taken a view on exactly how the Commission should be organised. Indeed, it would not be appropriate for us to do so, since the precise arrangements will change over time, and are not spelled out in the legislation itself. We believe that the flexibility within the current Act is an advantage, which should be retained in a new Act. However, we also take the view that there should be a review of the organisational arrangements, which should consider the implications of the new Act, and the other developments we outline above, for the structure of the Commission.
34. The Commission is currently located in Edinburgh. We received some comments, particularly from rural areas, that it may not always be easily accessible to people in other parts of the country. We asked in our second Consultation whether some form of geographical dispersal of the Commission was desirable, for example, through a series of local officers around Scotland. There was some support for this, but the balance of opinion was that the advantages of accessibility were outweighed by the problems of dilution of expertise. We therefore make no

specific recommendation on this point, but we believe the issue of accessibility across Scotland is one which should be considered as part of the review of the Commission structure.

35. The review, and any changes which may arise therefrom, should be conducted openly, involving not only the Commission and the Scottish Executive but other interested parties.

Recommendation 23.8

The Mental Health Act should continue to be flexible regarding the structure and internal management arrangements of the Mental Welfare Commission.

Recommendation 23.9

There should be a review of the structure and internal management arrangements of the Commission, and the current Memorandum of Agreement with the Scottish Executive, to consider changes which might be desirable in the light of a proposed new Mental Health Act, and other recent developments. The review should involve other interested parties.

Recommendation 23.10

The Memorandum of Agreement between the Commission and the Scottish Executive should be published.

Accountability of the Commission

36. The Commission is financially accountable to Scottish Ministers, who set its annual budget and any necessary financial guidelines. The financial procedures are similar to those in place for NHS bodies⁶. Under the current Memorandum of Agreement between the Commission and the Scottish Executive Health Department, Ministers are responsible for setting the broad policy framework within which the Commission will operate, and require to be satisfied that the Commission's activities are consistent with those statutory duties and powers. Within this framework, the Commission sets its own targets and priorities.
37. The evidence we received suggested that the Commission functions, as it should, in an independent way, and has, when it has considered it necessary, been prepared to express its views strongly, even when they might not be welcomed by the government of the day. However, we have been considering whether, particularly under the new constitutional arrangements, there is a case for broadening the accountability of the Commission.

6 1984 Act, s2(8), which imports provisions of the National Health Service (Scotland) Act 1978

38. Currently, the Scottish Parliament has very little formal oversight of the work of the Commission. The Annual Report of the Commission is presented to Scottish Ministers, who lay copies before the Parliament. In the past, Scottish Ministers have responded to the Commission's Annual Report, but there has been no formal debate in Parliament regarding this. Nor does the Commission have any power to draw matters of concern to the attention of the Parliament (other than a general power to bring certain matters to the attention of Scottish Ministers, a health board, a local authority 'or any other body'⁷).
39. In response to our second Consultation, there was overwhelming support from those who responded to the suggestion that the Commission should be answerable directly to the Scottish Parliament by reporting on a regular basis to the Health and Community Care Committee. The Commission itself supported this suggestion.

Recommendation 23.11

The Commission's Annual Report should be submitted jointly to Scottish Ministers and the Scottish Parliament, and arrangements should be made for it to be debated in Parliament

Recommendation 23.12

The Commission should be specifically entitled to draw matters concerning the welfare of people with mental disorder to the attention of the Scottish Parliament (and, where appropriate, the UK Parliament).

Role and duties of the Commission

40. The Commission has a number of specific duties, including duties to visit every patient whose detention has already been renewed for a year and is renewed for a further year, and to administer the system of notification of matters such as detention and administration of treatment under Part X of the Act. Other functions, such as that of making enquiries into apparent deficiency in care, are expressed as duties, but are so broadly expressed that the Commission has to be selective in deciding when to carry them out.
41. There are overlaps between much of the work of the Commission and that of other bodies. For example, both the Commission and the Scottish Health Advisory Service (SHAS) visit psychiatric and learning disability hospitals. Deaths of psychiatric patients may be investigated by the Commission as well as by the procurator fiscal. In relation to investigating complaints about NHS mental health services, there are complex arrangements, partly based in statute and partly by agreement, concerning the respective roles of the Mental Welfare Commission and the NHS Ombudsman.

⁷ 1984 Act, s3(2)(f)

42. Given the potential breadth of the Commission's role, the limited resources at its disposal, and the range of other bodies with related functions, it is important that the Commission should have clear priorities, with appropriate powers to implement these priorities effectively.
43. The Commission has always taken the view that one way of identifying its particular role is that it has a focus on the individual with mental disorder. This distinguishes it from bodies such as SHAS, who are more concerned with monitoring the performance of hospitals or other health establishments.
44. This does not, however, tell the whole story. Firstly, it is simply not possible for the Commission to monitor the care of every individual with mental disorder, or even every individual with mental disorder who is the subject of concern. Secondly, the Commission has rightly been concerned to see that where it has identified problems in relation to the care of individuals, lessons are learned from this, and applied more broadly.
45. Also, much of the work of the Commission has in fact been concerned with improving practice more generally. For example, it has issued information and guidance to GPs on emergency detention; to nursing homes on restraint; and to patients subject to hospital orders on the provisions of the Criminal Procedure (Scotland) Act. It has expressed views in relation to legislative proposals of both the Scottish and Westminster parliaments.
46. It would appear that, in addition to the focus on the individual, the other key distinguishing feature of the Commission is that it has unique expertise concerning the interface between issues of care, and issues of human rights, which is at the heart of the Mental Health Act.
47. We recommend in Chapter 3 that the new Act should be based on a series of principles. The Commission would seem to us to be well placed to act as a 'guardian' of these principles. This would help to give an additional focus to the work of the Commission. To some degree, it would give the Commission a comparable role in relation to its founding Act as that of other bodies intended to promote the rights of particular groups, such as the Equal Opportunities Commission and the Commission for Racial Equality.
48. In dealing with specific powers and duties below we have, then, had regard to this general overview:
 - ♦ The Commission should maintain its focus on the individual
 - ♦ Its core responsibilities are in relation to the operation of mental health (and incapacity) legislation
 - ♦ Its core expertise is in relation to the rights of mental health service users and the duties of care to such service users, and the interaction between these rights and duties
 - ♦ In exercising its functions, the Commission should seek to promote the principles of the Act.

Recommendation 23.13

The Mental Welfare Commission should have a responsibility to promote the principles of the Mental Health Act, as set out in Chapter 3.

Reviews of compulsory measures

Current arrangements

49. The Commission is empowered to discharge patients subject to detention (other than restricted patients) or to revoke community care orders⁸. It may also recall the powers of a guardian appointed under the Adults with Incapacity (Scotland) Act, subject to a right of appeal to the sheriff⁹.
50. The 1999-00 Annual Report of the Commission sets out the normal procedure under which reviews of detention are considered. On receiving a request from the patient or interested party, the Commission arranges for the patient to be visited by a Medical Commissioner or a doctor employed by the Commission. The case is then reported to a weekly meeting of Commission members. In relation to s26 (28 day) detention, the Commission seeks to deal with cases within ten days of the request.
51. In the year 1999-00, there were 521 requests under the various powers of review which the Commission has, including 200 requests for discharge from long term detention under s18, and 207 requests for discharge from 28 day detention under s26. There were, four cases in that year where the Commission discharged a patient contrary to the wishes of the responsible medical officer (RMO), and in a small number of other cases the RMO chose to discharge the patient after discussion with the Commission.

Criticisms

52. The fact that very few patients are discharged as the result of requesting a review by the Commission has been the subject of some comment and criticism. Some people have taken the view that the Commission is simply acting as a rubber stamp for the medical profession. On the other hand, it might be argued that the lack of discharges shows that doctors are clearly not detaining people inappropriately. Furthermore, patients already have another means to challenge their detention, by appeal to the sheriff.
53. The point can also be made that such reviews impose a considerable burden on the limited resources provided by the Scottish Executive to the Commission and that more effective use could be made of the available time and professional skills. In particular, to focus on those who are able to request a review might mean not paying sufficient attention to more vulnerable patients, who find it more difficult to make their views known to the Commission. Reviews of patients on short term

⁸ 1984 Act, sections 3(1), 33, 35I

⁹ Adults with Incapacity (Scotland) Act 2000, s73

detention are particularly difficult, since they involve a considerable amount of effort to organise. Even then, they rarely lead to a discharge of a patient and matters may well have moved on by the time the review takes place.

54. Notwithstanding these concerns, our consultations found wide support for the retention of the power of the Commission to review compulsory measures. Justifications for this include the relative ease of access to the Commission, compared with an appeal to the sheriff. This is amply borne out by the great disparity between the number of appeals to the sheriff against detention, which is only a small fraction of the number of requests for review by the Commission. The Commission also pointed out to us that, in reviewing detention, they may investigate issues concerning the care of the patient which would be outwith the remit of a sheriff.
55. However, if reforms are made to the procedure by which compulsory orders are made, and to the appeals process, some of these arguments may carry less weight. The Scottish Association for Mental Health (SAMH) and the Law Society suggested that, should the sheriff be replaced by a tribunal, with automatic access to representation, and the tribunal be empowered to consider issues relating to the care of the patient, then the function of the Commission in reviewing patients could be removed. The Commission's own response to our second Consultation appeared to accept that this might be appropriate.

Our proposals

56. We hope that the reforms we propose will give service users greater access to and confidence in the formal appeals process. Nevertheless we have concluded that it would be premature to consider removing the powers of the Commission to discharge patients. We feel that they still provide a useful safeguard, particularly for patients who may find it difficult to use the appeals process.
57. That said, we are not convinced that, in the future, it may always be necessary for the Commission to be obliged by law to conduct a formal review for every patient who requests one. (Indeed, it is not required to do so at the moment, although it does do this for all but emergency detentions). If the Commission were satisfied that patients had appropriate access to review by the tribunal, and that patients were taking advantage of the opportunity to appeal to the tribunal in more significant numbers than happens at the moment regarding appeals to the sheriff, it should be possible for the Commission to choose to target particular cases for review – either as a check on the system, or where particular issues are raised. For example, it might choose to review all detentions of children over a period.
58. Of course, it would be possible for the Commission to do this without the power of discharge, but we feel that this is an essential power, even if it is resorted to only rarely.
59. We understand that the Commission is currently revising the way in which it conducts reviews. Formerly a Medical Commissioner or doctor appointed by

the Commission visited and interviewed the patient and consulted nursing staff and relevant others as well as the medical records. Information from the RMO was often obtained by telephone. A report collating this information was then considered by a meeting of Commissioners. The proposed procedure would seek written reports from the RMO and the mental health officer (MHO) and the patient would be given these before being seen by the Commission doctor. The patient would also be invited to give a written statement to the Commission indicating why detention was not appropriate and encouraged to have a supporter or advocacy worker at the interview with the Commission representative if desired. The Commission would give more feed-back about the basis of its decision about the detention.

60. We welcome the proposed reforms, and note that the greater opportunity for the patient to contribute to the review highlights the importance of advocacy, which we discuss in Chapter 14.
61. At the moment, the Commission's decisions in relation to orders under the Mental Health Act are not subject to appeal (other than by judicial review) but those in relation to guardianship orders under the Adults with Incapacity (Scotland) Act 2000 are appealable to the sheriff.
62. In relation to a decision by the Commission to discharge an order, there may be a justification for the distinction, in that a discharge of a guardianship order affects the rights of a third party, the guardian, in a way which does not apply to detention. However we accept that, where the Commission refuses a request to discharge a patient, it may be hard to justify the presence of an appeal if the discharge relates to guardianship, but not where it relates to detention.
63. Despite this, we do not believe that an appeal to the tribunal is appropriate in relation to reviews by the Commission of mental health orders, given that there is a separate mechanism to allow the tribunal to become directly involved. Another consideration is that, as we have indicated above, we envisage that the Commission may in future choose to exercise its review power selectively, and we feel that an appeal process would be likely to impose constraints on the way the Commission exercised this discretion.

Recommendation 23.14

The Commission should continue to be entitled to revoke compulsory measures on non-restricted patients under the Mental Health Act or to recall guardianship under the Adults with Incapacity (Scotland) Act 2000.

Recommendation 23.15

The Commission should not be obliged to review, with a view to considering whether discharge is appropriate, every request for discharge from compulsory measures.

Recommendation 23.16

There should be no appeal against a decision by the Commission in relation to compulsory measures under the Mental Health Act, other than by judicial review.

Visits

Current arrangements

64. The Commission has a duty to visit regularly patients who are liable to be detained in hospital or are subject to community care orders. On any such visit they must afford the patient an opportunity for a private interview. Where the patient is in hospital, they must also afford an opportunity for a private interview to any other patient at the hospital¹⁰.
65. In particular, the Commission must visit, at least every two years, any patient who has been detained for a period of over two years and who has not appealed against detention.
66. Under Section 9 of the Adults with Incapacity (Scotland) Act 2000, the Commission is also under a duty to visit, as often as they think appropriate, adults who have mental disorder and to whom the Act applies. This would include, in particular, people who are subject to guardianship under that Act.
67. Should our proposals for community orders be adopted, we anticipate that the duty to visit would apply equally to patients subject to these orders.
68. The Committee fulfils its obligations under the 1984 Act by visiting every psychiatric and learning disability hospital annually, and the State Hospital once a month. In 1999-00, representatives of the Commission visited 61 hospitals or NHS units. One hundred and eighty-three people who had been detained in hospital for longer than two years were visited, and a further 445 patients requested interviews with the Commission and were seen during these visits. Sixty one patients detained longer than two years were seen at the State Hospital, and 39 patients on request. In addition to hospital visits, the Commission also visited 259 patients on leave of absence, and 236 visits were made to people subject to guardianship under the Mental Health Act.
69. The Commission views the annual hospital visits as an opportunity not only to fulfil its statutory responsibilities in relation to individual detained patients, but also to carry out a number of other responsibilities, including to
 - ♦ monitor hospitals' management of legally incapable patients' funds
 - ♦ offer guidance to staff on the implementation of the Act
 - ♦ discuss with senior management any matters concerning the welfare of persons suffering from mental disorder which the Commission consider ought to be brought to their attention, and

¹⁰ 1984 Act, s3(2)

- ♦ inform the Commission about any matters which should be brought to the attention of Scottish Ministers or health boards or local authorities, and in future, to the Scottish Commission for the Regulation of Care.

70. The visits involve a considerable input of resources from the Commission, and take up a large percentage of the time spent by individual Commissioners on Commission duties. They also, of course, take up a significant amount of staff time at the establishments which are visited.

Issues arising

71. This raises a number of issues. The first is a concern that the Visiting Programme contributes to an emphasis in the Commission's work on people in hospitals, when services are increasingly moving towards care and treatment in the community. In particular, all the large learning disability hospitals are intended to be closed over the next few years. The Commission is aware of the need to maintain a presence in the community, and also visits community services. However, it is clearly impossible to visit every community based mental health service.
72. The Commission has pointed out that it does not have statutory rights in relation to interviewing patients in the community, except in relation to formal enquiries, for example into deficiencies in care. In hospital visits, Commissioners have a legal right to interview patients in private, carry out a medical examination, and examine medical records. (These powers also apply when visiting patients on guardianship or leave of absence.)
73. Hospitals are also visited regularly by the Scottish Health Advisory Service (SHAS). There have been suggestions that there could be duplication in hospitals being visited by two separate monitoring bodies, and certainly there exists a possibility for staff and patients to be confused about the respective purposes of the visits.
74. In oral evidence to us, SHAS and the Commission stressed the different purposes of their visits. SHAS stated that their role was to look at the entire system of health care on any particular visit, including at ward level, hospital level and at a strategic level. The Commission's role on the other hand was to look at health care provision at the level of the individual patient. SHAS and the Commission view their roles as complementary and liaise in order to try to avoid duplication or gaps in their work.
75. Nevertheless, comments were made to us by service providers that they sometimes found it difficult to discern the difference between the two roles. A number of the issues raised by the Commission in its report on its Visiting Programme in 1998-99, such as lack of day activities, poor environmental conditions, and anxiety about hospital contraction, would also be issues which would be of concern to SHAS.
76. One clear area of difference is the emphasis which the Commission attaches to individual patient interviews. These allow patients, whether detained or informal,

to raise any matters of concern about their care or welfare. However, there were also a number of concerns about how well this operates.

77. Firstly, it is normally necessary for the patient, or someone on the patient's behalf, to request an interview. In some hospitals, very few interviews are requested. There is concern that this may not necessarily reflect satisfaction with the care being provided, but rather a lack of awareness of the Commission's visits or the role played by the Commission.
78. In particular, it may mean that Commissioners rarely see some of the most vulnerable patients, such as people with severe learning disabilities, or dementia. (We note that the Commission is now seeking to address this by selecting patients at random to visit, to look at the standard of their care.)
79. Also, because the Commission is not a primary complaints body, it can be difficult for individual Commissioners on any visit to resolve matters to the patient's satisfaction. Unless there is *prima facie* evidence of a significant deficiency in care, the Commission may simply have to encourage the patient to use the local complaints procedure.
80. A further potential shortcoming in the current system is that, even if the Commission uncovers significant problems, it may lack the appropriate powers to ensure that these problems are dealt with. We have some evidence of the Commission returning to hospitals, sometimes on more than one occasion, to find similar problems to those identified on previous visits.
81. The Commission has, on occasion, reported such concerns in relation to individual hospitals in its Annual Report. However, it does not, as is the practice of SHAS, publish an individual report regarding particular hospital visits.

Conclusions

82. Notwithstanding these concerns, we are satisfied that visits by the Commission serve a number of important functions. Apart from allowing the Commission to carry out its function of protecting the rights of individual patients, the visits help to maintain the visibility of the Commission with professionals and service users. They allow access to an independent source of information and advice for both groups. They are also potentially an extremely valuable source of information to the Commission.
83. In recent years, the Commission has sought to use its Visiting Programme as a means of gathering systematic information about particular themes or areas of concern. We go on to propose that the Commission should have a formal responsibility to monitor the implementation of the Mental Health Act, and to audit issues relating to the Mental Health Act and its underlying principles. Visits by the Commission would be an important means by which this could be achieved. We therefore believe that the duty to visit hospitals and other establishments should remain.

84. We go on to recommend greater flexibility in relation to the Commission's publications, in order that it can promote best practice in relation to the Act. This might include producing reports on particular aspects of the Visiting Programme, for publication and subsequent monitoring and review.

Recommendation 23.17

The Mental Welfare Commission should publish reports on issues arising from its visiting programme.

85. We feel that some of the Commission's visiting activities should be increased. For example, we recommend in Chapter 31 that detained patients who have been transferred to Scotland from other parts of the UK should be visited within three months by the Commission.
86. The Commission has the power to make unannounced visits. This power has been exercised only rarely, partly because of resource constraints. However, the Commission recently conducted some unannounced visits to hospitals, and felt that these had been extremely successful. In our second Consultation, we asked whether there should be a statutory requirement for the Commission to undertake unannounced visits. There was widespread support, including from the Commission itself.
87. There was also general support for the proposal that the Commission should be entitled to meet with mentally disordered persons living in the community, without concern first being raised about the individual's welfare, or the visit having been requested by the service user. This would allow the Commission to visit those who may be most vulnerable, who may not seek the Commission's involvement.
88. Some concerns were expressed about the implications of this for the rights of privacy of individual service users. Clearly, we would not envisage the Commission forcing itself on individuals, particularly those living in their own homes. (We discuss the Commission's powers in relation to vulnerable adults at risk in Chapter 19.)
89. The Commission does not currently have a statutory duty to visit prisons but it has done so in recent years. There is evidence that a significant number of prisoners have some degree of mental disorder, and such prisoners are of course a vulnerable group. We therefore believe that this should be established as one of the responsibilities of the Commission.
90. It is important that the Commission work closely with other bodies which visit the same establishments, including SHAS, the proposed Scottish Commission for the Regulation of Care and the Prisons Inspectorate. However, the means by which this should be done are better left to discussion and agreement between the agencies, rather than laid down in statute.

91. We believe that the powers of the Commission to inspect records relating to people with mental disorders should be broadened, to apply to community based mental health services, as well as hospitals, and that the current restriction to medical personnel of the power to view medical records should be removed.

Recommendation 23.18

The Commission should continue to have a duty to visit psychiatric and learning disability hospitals, and a power to request interviews with patients.

Recommendation 23.19

The Commission should also have the power to visit community services and facilities, and to conduct private interviews with service users at such facilities.

Recommendation 23.20

The Commission should have a statutory duty to conduct unannounced visits to hospitals and community psychiatric facilities.

Recommendation 23.21

The Commission should have a statutory duty to visit prisons.

Recommendation 23.22

Commissioners, and Commission staff, should have the power to inspect medical and other records relating to a person with mental disorder, whether in hospital, prison or community based mental health services.

Deficiency in care enquiries

92. The Commission has a duty to ‘make enquiry into any case where it appears that there may be ill-treatment, deficiency in care or treatment, or improper detention of any person who may be suffering from mental disorder, or where the property of any such person may, by reason of mental disorder, be exposed to loss or damage’¹¹. Section 4 of the Act sets out formal powers which the Commission may exercise should it choose to hold such an enquiry, including the power to compel witnesses, and to require evidence to be given on oath. However, this power to hold a formal enquiry has never been exercised by the Commission since the 1984 Act was put in operation. Instead, it has preferred to conduct enquiries on a more informal basis.

¹¹ 1984 Act, s3(2)(a)

93. The Commission holds around three or four major enquiries every year into possible deficiencies in care. These are reported to the Scottish Executive and or local health bodies or local authorities. In some cases, the enquiries are summarised in the Commission's Annual Report¹². Normally, the Commission instigates such enquiries at its own initiative, but on occasion they have been requested to undertake such an enquiry by Ministers¹³.
94. Such enquiries reflect the Commission's focus on the welfare of individuals. However, in most cases, the enquiry is retrospective in nature, in that any deficiency in care has already occurred, and there may be relatively little that can be done to improve the situation of the individual concerned. It is therefore considered important by the Commission that lessons are learned, to prevent similar deficiencies arising in the future.
95. There are some problems with the current legislation so far as this aim is concerned. The Commission has no formal power to publish the outcome of its enquiries. The enquiry into the care of Noel Ruddle, for example, was published by the Scottish Parliament. A summary in the Annual Report may not appear for some months, lessening the impact of the report.
96. There have also been difficulties regarding the extent to which the service user (or, in some cases, the victim of a crime by a mentally disordered person) should be told of the outcome of a deficiency in care enquiry. Some years ago, the Commission's practice was to interview professionals on a confidential basis, and to restrict circulation of its report to the Secretary of State and local agencies. This reflected the fact that the Act does not mention any duty, or even power, to report to service users. It was also felt desirable to encourage openness from professionals, who might be reluctant to admit shortcomings in their practice if these were likely to be made public.
97. More recently, the Commission has moved to a position where, in the normal course of events, the service user will be advised of the outcome of a deficiency in care enquiry. To date, this does not appear to have resulted in a loss of candour from witnesses.
98. We agree with the general presumption in favour of openness. In our second Consultation, we asked whether the Commission should have the power to publish its findings in deficiency in care enquiries. This was generally supported. The Commission pointed out that the issue of legal privilege would be an issue to be resolved. We believe it would be appropriate for the Commission's reports to have qualified privilege, which would prevent any legal liability for defamation, except where a lack of good faith could be shown.
99. Publishing reports also raises the issue of patient confidentiality. In most cases, where the Commission has chosen to publish a report, we anticipate that reports could be anonymised or consent could be obtained from the patient. We appreciate that this may not always be possible, particularly where the matter is already in the public domain. Be that as it may, we feel it is important that the

12 See, for example, the report of the inquiry into the care and treatment of Ms P in the 1998-9 Annual Report

13 As with the enquiry into the care and treatment of Noel Ruddle, carried out in 1999 (SP Paper 98, Session 1 Scottish Parliament, 2000)

Commission has the power to make known matters which require to be brought to public attention concerning the care of people with mental disorders.

Recommendation 23.23

The Commission should continue to have the power to hold enquiries into deficiency in care, either on a formal or informal basis.

Recommendation 23.24

The Commission should have the power to publish reports of its enquiries. Such reports should attract qualified privilege.

Annual reports and other information

100. The Commission is required to publish a report on its activities every year, and to submit copies of the report to Scottish Ministers¹⁴.
101. The Annual Report contains a range of information, including statistical information, guidance and good practice advice, and details of the activities of the Commission during the year, and particular issues of concern.
102. Many people commented to us that the Commission's Annual Reports contained a great deal of very useful information. However, not everyone who might benefit from the information receives it. Also, much of the guidance may be of continuing relevance, but it can be hard for people to know that such guidance might be in an old Annual Report, or how to find it.
103. We believe that the Commission's role in providing information and guidance, and promoting good practice in relation to the Act, is one which should be strengthened. For example, a number of people mentioned the Commission's advice on restraint as an extremely useful document, but it has not, to our knowledge, been made widely available. It might assist in this aim if the Commission were to have a wider power to publish relevant materials, rather than focus most of its energies on the production of an Annual Report. As with the Code of Practice (see Chapter 36), arrangements could be made to allow anyone with an interest to have ready access to a complete and up to date set of the Commission's advice on any particular area of concern. We anticipate that this could be both in printed form and using information technology.
104. We also feel that many people would welcome a summary of the Annual Report, which should be accessible both in style and format, and should be widely distributed.
105. The main purpose of the materials produced by the Commission would be to assist people who use, or are affected by, the Mental Health Act. However, it

¹⁴ 1984 Act, s3(7)

might also be helpful if the work of the Commission itself were made more widely known. We were impressed by the amount of useful and important work carried out by the Commission, but also by the fact that many people were not aware of this work.

Recommendation 23.25

The Commission should continue to publish an Annual Report.

Recommendation 23.26

The Commission should publish an accessible summary of its Annual Report.

Recommendation 23.27

In addition to the Annual Report, the Commission should be specifically entitled to publish and disseminate from time to time information, guidance and advice about any matters relevant to the Mental Health Act.

Recommendation 23.28

The Commission should strengthen its efforts to make its own work more widely known, and to ensure that its information, guidance and advice reaches all who would benefit from it.

Complaints

Current arrangements

106. The Commission is not placed under a statutory obligation to deal with complaints relating to mental health care. Nevertheless, it does so as part of its general responsibility under s3 of the Act to protect the interests of people with mental disorder.
107. The Commission does not see itself as a primary complaints body. Both the NHS and social work departments of local authorities have formal complaints procedures. Most complaints made to the Commission are referred to local procedures for resolution- in 1998-9 the Commission dealt with 105 complaints, and this was done in 87 cases. The Commission will however often seek to assist complainants by forwarding complaints to the appropriate body and asking to be kept informed of the outcome.

108. The Commission may become directly involved with a complaint where complainants are dissatisfied with the outcome of local complaints procedures. This role is similar to that of the Health Service Commissioner (or 'NHS Ombudsman') who is prohibited, under the terms of the Health Service Commissioners Act 1993, from investigating matters within the remit of the Mental Welfare Commission. A Memorandum of Understanding has been entered into between the MWC and the NHS Ombudsman. In essence, this provides that the MWC will investigate the way in which complaints relating to a patient's treatment for mental disorder have been dealt with, and the Ombudsman deals with all other cases (which may of course relate to patients who happen to have a mental disorder). We understand that this Memorandum is currently not in the public domain.

Recommendation 23.29

The Memorandum of Understanding between the Mental Welfare Commission and the Health Service Commissioner should be published.

109. In 1999, the Scottish Office published 'Revised Procedures for NHS Complaints'. This contains information about appropriate procedures for the investigation of complaints involving people with mental disorder, and asks that the Commission be informed of any significant complaints and their outcome.
110. No such arrangement is in place regarding complaints concerning local authorities, where presumably either the local government ombudsman or the Commission might investigate the way in which social work departments dealt with a complaint by a mental health service user. The Commission has identified this as a weakness in current arrangements.
111. In 1999, the Commission appointed a Complaints Officer. The Commission hopes that this will allow greater consistency in dealing with complaints, and a more proactive role for the Commission.

Issues arising

112. We agree that it would be wrong for the Commission to seek to be the first port of call for people with a complaint about mental health care. This would be very costly, and would undermine attempts to resolve complaints at a local level. However, we are conscious that many patients, particularly detained patients, may not find local complaints procedures easy to use, and may even fear victimisation for complaining. This is perhaps a broader issue than that of the role of the Commission, but highlights that the Commission may still, at the very least, need to guide those wishing to complain as to the procedure and encourage them to use it.
113. If the Commission is to continue in its current role, it may require increased powers. The Commission suggested to us that it should have clear powers to

make public reports on its investigation of complaints which might identify the bodies complained against. It also suggested that there should be legislation, similar to the Health Service Commissioner's Acts 1993, to clarify its role in relation to complaints concerning local authorities and independent bodies.

114. On the other hand, there are arguments for changing the current position of having two separate bodies monitoring the handling of complaints under the NHS procedure. This can lead to confusion amongst complainants and local bodies, and may add to delay if it is not clear into which sphere of responsibility a complaint falls.
115. The justification for a separate role for the MWC is that it has greater expertise in issues concerning mental health care. On the other hand, the ombudsman may have greater expertise in the investigation of complaints, and may be better resourced to undertake such investigations. It may be more consistent with the aim of treating mental health care in the same manner as other health care if the same body dealt with all such complaints.
116. There may also be confusion between the various roles of the Commission. In particular, where a complaint indicates that there may be a case of deficiency in care, the Commission may choose, or even be under a duty, to investigate this, notwithstanding that the complaint has not been taken through local procedures.
117. In our second Consultation, we asked whether the monitoring of complaints about all types of health care should be dealt with by the same authority. Views were fairly evenly divided.

Conclusions

118. On balance, we feel that the formal responsibility to deal with the investigation of complaints about health care should rest with the body which has this as its core function, namely the NHS Ombudsman. We accept that there may be particular issues concerning mental health services which require to be considered, (although this could also be said about other specialist aspects of the Health Service). The best way to deal with this might be for the NHS Ombudsman to be placed under a formal responsibility to consult with the Commission where matters concerning mental health care arise.
119. In relation to local authorities, we would not propose that the Commission be situated within the formal complaints procedure, but it should of course have powers to investigate matters of concern, and to provide advice and guidance. This would include guidance to the Local Government Ombudsman, where appropriate.
120. In general then, where the Commission receives complaints it should consider these in relation to whether action needs to be taken in respect of an alleged deficiency in care, or whether there are ways in which the Commission's general advisory and guidance role in relation to the Act might help to resolve matters.

Dealing with complaints directly would primarily be a matter for the normal complaints procedures of the relevant agencies, although the Commission may continue, as at present, to play a role in helping complaints to be taken forward. As the Commission suggested in its 1998-99 Annual Report, it could also play a valuable role in liaising with trusts, boards and local authorities to improve responses to complaints relevant to mental health services, and to promote more analysis of circumstances leading to such complaints.

Recommendation 23.30

The investigation of the handling of complaints by NHS bodies under the NHS complaints procedure concerning people with mental disorders should be the responsibility of the Health Service Commissioner.

Recommendation 23.31

Where the Health Service Commissioner or the Commissioner for Local Administration in Scotland deals with a complaint which includes issues concerning the provision of care for a person with a mental disorder, the Commissioner should be required to consult with the Mental Welfare Commission. The Commission should offer such advice and support as it deems appropriate.

Recommendation 23.32

As part of its responsibility to promote the principles of the Mental Health Act, the Commission should be entitled to offer advice and guidance on dealing with complaints affecting mental health service users, and may make enquiries as to the way in which such complaints are dealt with.

Auditing the quality of mental health services

121. The Commission currently has a responsibility to bring matters concerning the welfare of people with mental disorders to the attention of Scottish Ministers, or to other bodies¹⁵. It may do this in relation to the exercise of various of its functions, including visits, reviews, and enquiries into deficiency in care. However, the basis on which it is expected to decide to draw matters to the attention of relevant bodies is not particularly clear. We considered whether there would be merit in giving the Commission a more specific responsibility to audit mental health care. In our second Consultation, we asked for views on such a responsibility, either in relation to the quality of mental health services generally, or in relation to the operation of, and principles underlying, the Mental Health Act in particular.

15 1984 Act, s3(2)(f)

122. There was some support for the Commission to have a general responsibility to monitor care standards, but also opposition from a number of important organisations, including the Commission itself. It was pointed out that there already exist a number of organisations with responsibilities for monitoring the quality of mental health care. These include registration and inspection bodies, such as the proposed Scottish Commission for the Regulation of Care and SHAS, and others such as the Clinical Standards Board for Scotland, which has recently published draft standards in relation to schizophrenia. In addition, there are also local arrangements being developed for clinical governance. A statutory duty was recently introduced for every board and trust to put and keep in place arrangements for monitoring the quality of health care which it provides¹⁶.
123. We are satisfied that such a broad responsibility is not appropriate for the Commission. It would be extremely resource intensive, and would take the Commission into areas which are properly the concern of others. However, we do believe that it would be desirable for the Commission to have a formal responsibility to monitor the implementation of the Mental Health Act.
124. In many ways, this would be a logical development of work which the Commission currently undertakes. For example, it has investigated local policies on locked wards, and management of funds of legally incapable patients, and considered the extent to which formal policies on these matters are in fact implemented. This investigatory function would link with the functions we discuss above, of promoting the principles of the Act, and issuing advice and guidance as appropriate.
125. Of course, it would be important that there be close liaison between the Commission, in carrying out this role, and the range of other bodies mentioned above, to ensure that the standards they set for their respective purposes are complementary.

Recommendation 23.33

The Commission should have a responsibility to monitor the implementation and operation of the Mental Health Act, and the degree to which this is consistent with the principles of the Act.

Powers of enforcement

126. Currently, the Commission has few powers to enforce any recommendations it makes, other than in relation to discharge. This has led to a perception by some people that the Commission is 'toothless'. We therefore asked in our second Consultation whether the Commission should be given greater powers of enforcement.
127. Some respondents strongly supported this, and suggested particular powers which might be relevant. The Royal College of General Practitioners considered the Commission could be given the power to suspend hospital managers,

¹⁶ National Health Service (Scotland) Act 1978, s12H, inserted by Health Act 1999, s51

psychiatrists and nurses. The Scottish Users Network, among others, proposed that the Commission should be able to close services deemed to fall below standard and to impose financial penalties.

128. However others, including the Commission itself, felt that the responsibility for enforcing action lay with Ministers. The Commission pointed out that if, (as we recommend above), it also had a reporting role in relation to the Health and Social Care Committee, this might strengthen its power to achieve change.
129. Others suggested that publicity was one of the most effective weapons, and the powers we recommend above to publish reports in relation to visits and deficiency in care enquiries might have a powerful effect. (See paragraphs 84 and 95-99).
130. Although there are attractions in giving the Commission enforcement powers, we have decided it would not be appropriate to recommend this. To do so would cut across both democratic accountability to local authorities and Ministers, and other regulatory mechanisms, including professional bodies and inspection authorities. Should the Commission seek to enforce sanctions against an individual or organisation, it could well find itself involved in lengthy disputes and litigation.
131. We feel that the powers available to the Commission, which we outline above, are appropriate to its role. Where the principles of the Act, or its procedures, are not being met, it should offer guidance and advice. Where failures are serious, or repeated, it should be able to say so, and make recommendations for change.
132. The Commission should also be able to follow up any such recommendations, to ensure they have been heeded. Ultimately, it should have the power to draw the public and Parliament's attention to ongoing failings in the mental health system.

Recommendation 23.34

The Commission should have the power to follow up enquiries into deficiency in care, and publish reports on whether and how its recommendations have been implemented.

Statistical information

133. The Commission receives a great deal of important information regarding the operation of the Mental Health Act. This is published in its Annual Report, and can also be made use of by researchers. There are however gaps, since the information is essentially a by product of the statutory responsibilities to notify the Commission of various matters. For example, it receives no information regarding applications for detention which are withdrawn, or of what happens to patients who are discharged from detention. Current records do not allow for information such as the ethnic background, or even the clinical diagnosis, of patients subject to detention to be readily obtained.

134. Such information is of general interest, but is also important as a means of identifying ways in which the Act may not be working effectively.
135. We found it extremely difficult to obtain statistical information concerning many aspects of the working of the Act. We therefore believe that there should be a formal responsibility for such information to be gathered, and the Commission is well placed to obtain much of it.

Recommendation 23.35

The Commission should be under a duty to collect and publish such statistical and other information as it deems appropriate in relation to the operation of the Act.

Reporting of incidents

136. In the Commission's 1992/1993 Annual Report, it highlighted guidance to NHS bodies to report significant incidents and accidents affecting people with mental disorders to the Commission, in order to assist the Commission in exercising its protective function. This includes, for example, sudden deaths or attempted suicides. The Commission is seeking to develop similar reporting arrangements with local authorities and independent care providers.
137. We agree that the responsibilities in this area should be clarified, and should apply to all agencies who care for people with mental disorder.

Recommendation 23.36

The Code of Practice should set out guidance on the reporting of significant incidents to the Commission.

SECTION 6

OFFENDERS WITH MENTAL DISORDER

CHAPTER 24

THE LEGISLATIVE FRAMEWORK

Introduction

1. The 1984 Act, read alongside the Criminal Procedure (Scotland) Act 1995, contains a complex framework for dealing with mentally disordered persons who come before the criminal courts. This builds on the provisions for the detention of patients under the civil law, discussed earlier in this report. We deal with it in the following way.
2. Firstly, in this Chapter, we discuss the broad relationship between the legislation concerning mental health and that concerning criminal procedure. We then consider in sequence the various stages at which mental health legislation affects those before the criminal courts.
3. Chapter 25 deals with those who have not been convicted and considers diversion from the criminal justice system, remand to mental health services, and those who are acquitted of criminal charges.
4. In Chapter 26 we consider convicted offenders with mental disorders, dealing in turn with the assessment of the appropriate disposal; the arrangements for investigation into the suitability of a mental health disposal; hospital based disposals, and community based disposals. We also consider issues affecting prisoners, namely the arrangements for transfer to hospital, and the possibility of compulsory treatment in prison.
5. Chapter 27 is concerned with patients who present a high risk to public safety. On this issue, our work overlaps with that of the MacLean Committee on Serious Violent and Sexual Offenders, and we discuss briefly their report. We then go on to consider the legislation concerning 'restricted patients', including the role of Ministers in decisions affecting this group, and the arrangements for conditional discharge. The chapter also discusses the criteria for admission to the State Hospital.
6. In Chapter 28 we go on to consider and make recommendations on the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.
7. The subsequent chapters deal with some specific areas of concern, outwith the general framework for mental health disposals in criminal cases. Chapter 29 discusses the pleas of insanity and diminished responsibility, and in particular how such defences are defined in law. Chapter 30 considers the operation of 'appropriate adult' schemes.

The interaction of the Criminal Procedure (Scotland) Act and the 1984 Act

Part VI of the Criminal Procedure (Scotland) Act 1995

8. Part VI of the 1984 Act contains provisions relating to the detention of patients concerned in criminal proceedings, and the transfer of prisoners to hospital. It sets out the effect of various disposals, including hospital orders, restriction orders and hospital directions, and the appeal rights of patients. However, the circumstances in which a person may receive any of these disposals are set out separately, in Part VI of the Criminal Procedure (Scotland) Act 1995 ('the CPSA'). In order to receive a hospital order, or other mental health disposal, it is normally a requirement that the person be detainable under the 1984 Act, so the CPSA frequently cross-refers to the 1984 Act.
9. For example, s58 of the CPSA states that for a hospital order to be made, the court must be satisfied, on the evidence of two medical practitioners, that the grounds set out in s17(1) of the 1984 Act apply in relation to the offender. Conversely, s62 of the 1984 Act sets out the effect of a restriction order, but it is necessary to read s59 of the CPSA to find out the grounds on which the court may impose such an order.
10. It has been pointed out to us that to divide the statutory provision for mentally disordered offenders in this way is confusing. We considered whether there was any way in which the legislation could be set out in a way which would be easier to follow. The options appear to be
 - ♦ To consolidate provision for mentally disordered offenders in mental health legislation
 - ♦ To consolidate such provision in criminal procedure legislation
 - ♦ To duplicate the provision in both pieces of legislation.
11. We consulted on these options in our second Consultation. Our provisional preference was to consolidate the legislation within the Mental Health Act (as was in fact the case when the Mental Health (Scotland) Act 1960 was passed). Arguably, this would make the law easier to follow for doctors, social workers, and other non-legal specialists who have to work with mental health law. It may be less advantageous for lawyers operating in the criminal courts, but they might be expected to be able to read between different statutes as necessary.
12. Furthermore, the general aim of the legislation is that mentally disordered offenders receive a mental health disposal on the basis of similar criteria to those who are subject to compulsion under civil mental health law, and remain subject to compulsion while the civil criteria continue to apply (except for those subject to additional restrictions on the basis of the risk they present).
13. Our consultation elicited relatively few responses on this issue. Of those who did respond, most were in favour of consolidating provision for mentally disordered

offenders into the Mental Health Act. However, there were significant dissenting voices. The Mental Welfare Commission argued that there were advantages in dealing with mentally disordered offenders under the CPSA, as this promotes a more integrated response within the criminal justice system. The Faculty of Advocates considered that the CPSA provided a comprehensive procedural code and there would be disadvantages in removing provisions from it. The Law Society of Scotland regarded the current distinction as logical and workable, avoiding both inappropriate criminalisation and decriminalisation.

14. We accept that there is a basis for the way in which the law is presently separated: that the CPSA regulates the nature of disposals made by a criminal court, and that one of these disposals is to place a person under the provisions of the 1984 Act. However, we remain of the view that the division is confusing. We would be content to see the legislation on mentally disordered offenders consolidated in the Mental Health Act. The current provisions in Part VI of the CPSA do not seem to be inextricably entwined with the more general aspects of criminal procedure, and contain more cross references to the 1984 Act than to other parts of the CPSA.
15. So far as the third option, of duplicating the provisions in both statutes is concerned, this would be inconsistent with normal legislative practice, and we have concluded that repeating the legislation in different places could create more confusion than it would prevent.
16. However, the primary problem is perhaps not the Act in which the legislation is placed, but how best to ensure that people with an interest have access to all the relevant legislation, and can see how it interrelates. This might best be achieved by the production of a single document for the use of practitioners, patients, and other interested parties, setting out the provisions and how they interact. This could perhaps build on the existing booklet produced by the Mental Welfare Commission, entitled 'In Your Interests'.

Recommendation 24.1

Consideration should be given to consolidating the provisions of Part VI of the Criminal Procedure (Scotland) Act 1995 within the Mental Health Act.

Recommendation 24.2

If the Criminal Procedure (Scotland) Act continues to contain provisions regarding mentally disordered offenders, the Scottish Executive should ensure that information is made available in a single document to professionals, service users and carers, which deals with both pieces of legislation and how they interact. This document should be regularly updated.

CHAPTER 25

UNCONVICTED PERSONS WITH MENTAL DISORDER

Introduction

1. There are various stages at which a person who is charged with a criminal offence may be made subject to a mental health disposal. In later chapters, we deal with those who are convicted of an offence or found 'insane'. This chapter deals with the committal to hospital of accused persons who are yet to be tried, or who have been acquitted on grounds other than insanity.

Diversion from prosecution

2. Where it is clear that an accused person is mentally disordered, a trial might not proceed. The Crown may decide that it would be better for the person to be diverted to mental health services, either on an informal or formal basis. If the person were to be detained in hospital at that stage, it would be on the basis of a detention under civil procedures.
3. The issues surrounding diversion out of the criminal justice system prior to conviction would seem to relate primarily to the provision and co-ordination of services, and the sharing of information between agencies, rather than the statutory framework of the Mental Health Act. We understand that these issues have been considered in the review of services for mentally disordered offenders, which has been commissioned by the Scottish Executive and which we assume will be made public. We have, therefore, not addressed these issues in detail.

Untried prisoners

4. Under s52 of the Criminal Procedure (Scotland) Act 1995 ('CPSA'), untried prisoners who are thought to be suffering from mental disorder may be committed to hospital on the written or oral evidence of a single registered medical practitioner. If thereafter the responsible medical officer (RMO) is satisfied that the patient's mental disorder would warrant admission to hospital under Part V of the 1984 Act, the patient may be detained in hospital for the period for which he is remanded.
5. It has been argued that Part X of the 1984 Act, which regulates compulsory treatment, does not apply to such patients, meaning that they cannot be treated for mental disorder without their consent. The Mental Welfare Commission discussed this matter in their Annual Reports for 1996/7¹ and 1997-8². In the

1 Mental Welfare Commission for Scotland Annual Report 1996-7, p34

2 Mental Welfare Commission for Scotland Annual Report 1997-8, p34

earlier Report, it was suggested that prisoners transferred to hospital under s52 were not brought within the scope of Part X of the 1984 Act. Therefore, if treatment without consent were to be given, it might be necessary to detain the person under the civil provisions of the 1984 Act, effectively resulting in a 'double detention'. However, in the subsequent Report, the Commission stated that it had explored further the legal advice it had received, and that the effect of s125(5) of the 1984 Act was that those admitted to hospital under the CPSA fell within the scope of Part X of the 1984 Act. For patients admitted under s52, compulsory treatment for a mental disorder could be given, but probably only after the responsible medical officer was satisfied that the patient met the criteria for detention under Part V of the 1984 Act. Despite this revised advice from the Commission, our consultations suggest that there is still confusion about the position of remanded prisoners with respect to compulsory treatment and we believe the law should be clarified.

6. In our second Consultation, we set out our provisional view that it is wrong that an untried prisoner suffering from mental disorder should be held in hospital without treatment for a lengthy period. While it is possible to detain the person under s18, to have a person subject to two forms of detention at once (s18 detention and remand) seems likely to create practical difficulties. On the other hand, to allow a remand prisoner to be subject to compulsory detention and treatment for up to 110 days, on the basis of a single medical recommendation, would seem to give such prisoners fewer safeguards than other patients, including convicted prisoners given a hospital order (which requires two medical opinions). We therefore proposed that, for remanded prisoners, treatment without consent should require the approval of a second doctor with appropriate expertise.
7. Most of those who responded agreed that it should be possible, with appropriate safeguards, for remanded prisoners to be compulsorily treated for mental disorder. The Faculty of Advocates commented that a prisoner might be entitled to refuse treatment until tried, on the grounds that he or she had a right not to have his or her ability to conduct or instruct a defence compromised, for example by medication. Against this, though, there may well be situations where medication may improve the ability of a mentally ill patient to instruct his or her legal representatives.
8. The British Association of Social Workers (BASW) argued that there should be no discrimination in the way a person receives compulsory treatment, whether detained under the CPSA or mental health legislation. The Scottish Association for Mental Health (SAMH) felt that treatment should not be possible without consent, unless all the safeguards applicable to detained patients applied.
9. There is a strong argument for treating all patients in a consistent way. Taken to its full extent, this would mean admitting remand prisoners to hospital on a similar basis to patients detained under civil mental health law. Under our proposals for civil admission, this would imply that a remand prisoner should not be admitted to hospital and treated compulsorily without the approval of a medical practitioner and a mental health officer. Furthermore, if the detention were to last for more than 28 days, it would require the approval of a second doctor, in addition to

authorisation by a tribunal. Treatment without consent would be possible, but after two months, medication would require a second opinion.

10. SAMH argued in their response to our second Consultation that prisoners held on remand who are mentally disordered should be in hospital rather than prison. We are not convinced that this would be appropriate in every case. There could be people with a diagnosis of mental disorder, which is well managed, where there would be no basis for a hospital admission. However, we agree with the general point that there should not be unnecessary obstacles to ensuring that prisoners who require treatment in hospital can receive it. Furthermore, there is a distinction from the position of a mentally disordered person living in the community, in that there is no specific mechanism for a remanded prisoner to be admitted to hospital on a voluntary basis. We are, therefore, satisfied that the approval of one medical practitioner should be all that is required to divert a remand prisoner to hospital, in situations where a hospital place is available for the prisoner.
11. Under s52 (3), the RMO is then required to consider whether the patient meets the criteria for detention under the 1984 Act, and must report his or her findings to the court. If the RMO is satisfied that the patient meets the criteria for detention, the court need take no further action, and the patient will remain in hospital until the expiry of the period of remand. The court needs only to take a decision if the RMO decides that detention is inappropriate.
12. Our first concern with this procedure is that the decision on continued detention is therefore taken by the RMO alone. We feel it would be preferable for the RMO to report to the Court, say within a 28 day period, to advise whether the criteria for admission to hospital are met; and that the formal decision as to whether the detention in hospital should be continued would then be taken by the Court. This would have the benefit of giving remanded prisoners similar protection to patients detained under the civil law.
13. In addition, if it is to be made explicit that treatment can be given to patients on remand without consent, we believe that the protections afforded to patients detained under civil procedure in relation to medical treatment may not be entirely appropriate. In relation to any medication given without consent, the additional opinion of an independent doctor would not be required for two months. The remanded prisoner would not have the benefit of other protections afforded to civil patients, such as the involvement of the mental health officer (MHO) or a second doctor, or the oversight of a care plan by the forum where the detention lasted more than 28 days. While admission to hospital may not be a serious infringement of the rights of a remanded prisoner, (given that the prisoner would otherwise be in prison), compulsory treatment might.
14. We therefore feel that our original proposal (para 6 above) for the involvement of a second doctor with appropriate expertise, was appropriate. We propose that, in addition to the normal protections afforded to detained patients in relation to treatment, there should be a requirement that an independent medical opinion be obtained before medication is administered without consent. This opinion would

be from a medical practitioner approved as having special expertise in the treatment of mental disorder (a so called 'section 20 approved' doctor). There would be an exception for emergency treatment, which could be administered on the same basis, and with the same protections, as treatment administered without consent to a patient subject to emergency detention.

15. Otherwise, the protections available to prisoners detained in hospital on this basis would be the same as for patients detained under civil procedures, as set out in Chapter 10. Thus, for example, should the patient be detained for more than two months, and be in receipt of medication without consent, the approval of an independent doctor authorised by the Mental Welfare Commission would be required.
16. Currently, there is no appeal against a decision of a court to admit an accused person on remand to hospital. We considered whether such an appeal should be introduced and decided that it was not necessary. As we have said, any such person would otherwise be in prison, and so there is not the same issue of deprivation of liberty which applies in other cases of compulsory admission to hospital. Our proposal that the court should authorise continuing detention beyond 28 days would, in our view, provide the appropriate level of independent scrutiny.

Recommendation 25.1

It should continue to be possible for a court to commit an accused person to hospital on the basis of a single medical recommendation.

Recommendation 25.2

Following admission, the responsible medical officer should assess the patient to determine whether the patient meets the criteria for compulsory admission to hospital under the Mental Health Act.

Recommendation 25.3

The responsible medical officer should be required to report to the court, as soon as possible, but no later than 28 days after the admission to hospital as to whether the grounds for compulsory admission to hospital under the Mental Health Act are met. Should the court be satisfied that this is the case, it may authorise continuing detention in hospital. Should it not be so satisfied, it should revoke the order.

Recommendation 25.4

Where a remanded prisoner is admitted to hospital, he or she may be treated compulsorily, subject to the protections contained in the Mental Health Act for treatment of patients subject to compulsion, but it should not be possible to administer medication for mental disorder to such a prisoner, except in an emergency, without first obtaining the consent of the prisoner or a second medical practitioner with experience in the assessment and treatment of mental disorder.

Untried prisoners-transfer for assessment

17. Under s52(2) of the CPSA, it is possible for a court to send a prisoner to hospital to assess whether his or her mental state justifies detention in hospital. This, however, only applies at the stage that the prisoner comes before the court. If a prisoner is already remanded in custody, s70 of the 1984 Act allows Scottish Ministers to ask the sheriff to order that the prisoner be transferred to hospital, if satisfied that the grounds for admission to hospital under Part V of the 1984 Act are met. The sheriff must receive reports from two medical practitioners. We believe that this power should be retained.
18. It appears, however, that there is a gap in the legislation, in that there is no power to transfer to hospital a prisoner who has already been remanded in custody to assess whether the prisoner's mental state warrants detention. In legislative terms, the provisions of s52(2) of the CPSA are not mirrored in s70 of the 1984 Act. We understand that this is not simply a theoretical problem, but has in fact led to difficulties. In a small number of cases, petitions were made to the Court of Session under the *nobile officium*, to allow mentally disordered prisoners to be transferred to hospital for assessment.
19. It is clearly undesirable that this power, which is available to the Court of Session to remedy gaps in the law, should be the basis for such transfers. We proposed in our second Consultation that there should be a statutory mechanism to allow remanded prisoners to be transferred to hospital for assessment of their mental state. This received general support, with the Law Society commenting that the loophole in current legislation should be closed as a matter of urgency. We therefore recommend that procedures which are similar to those for prisoners at the commencement of remand should apply to those whose mental disorder manifests itself later.

Recommendation 25.5

It should be possible for a court to authorise the transfer of a prisoner who is on remand in custody to hospital to assess whether his or her mental state warrants admission to hospital.

Recommendation 25.6

Before authorising such a transfer, the court should be satisfied that a suitable hospital is available for the prisoner's admission, and should receive evidence from a medical practitioner that the prisoner appears to have a mental disorder which may require treatment in hospital.

Recommendation 25.7

When a prisoner is admitted to hospital under this procedure, the same arrangements should apply to those set out in recommendations 25.3-25.4 for prisoners admitted at the initial remand hearing.

Acquitted persons with recommendations for mental health disposals.

20. Section 58 of the CPSA allows a court to impose a hospital order on a patient who has been convicted of an imprisonable offence, if the court is satisfied on the written or oral evidence of two medical practitioners (one of whom is s20 approved) that the grounds set out in s17 of the 1984 Act apply in relation to the offender. If the individual is acquitted (unless it is by reason of insanity), it is of course not possible to make a hospital order.
21. It was pointed out to us that, in recommending a hospital order, two medical practitioners have taken the view that the accused person requires detention. If the patient is acquitted, but still requires to be admitted to hospital, there is no basis for such detention to proceed. Should a doctor be present in court at the time of acquittal, the accused person could be detained on an emergency basis under s24 of the 1984 Act, but it will not always be the case that a doctor is present. Thereafter, the person could be lost to services.
22. In our second Consultation, we put forward the proposal that, in such a situation, the court could reconvene immediately as a civil court to consider an application for long term detention. The recommendations for a hospital order could form the basis for this application. Alternatively, the court could be given a transitional power, based on the recommendations for a hospital order, to detain the person until a hearing for civil admission could proceed.
23. Respondents who considered this issue generally supported the introduction of a mechanism to deal with the problem. However, a number of objections were made to the suggestion that the criminal court reconvene to consider the matter as an application for long term detention. Several respondents, including the Mental Welfare Commission and the Faculty of Advocates, felt that the court would not be well placed to consider the merits of the civil application.

24. On further reflection, we agree with this view. We recommend in Chapter 9 that hearings for long-term compulsion be considered by a tribunal, not by a sheriff sitting alone. It would not then be possible for the sheriff or judge hearing a criminal case simply to 'change hats' to consider the issue of detention under the Mental Health Act.
25. We are attracted to an alternative suggestion, supported by the Royal College of Psychiatrists, amongst others, that the court should have the power to initiate detention, to allow for further psychiatric examination and application for further detention as appropriate. This would be consistent with the powers of doctors and the police to detain for a short period in emergency situations. It would only be possible to exercise this power where the court had received psychiatric evidence to the effect that the person met the criteria for long-term compulsion under the Mental Health Act. It would be desirable if, in making reports recommending hospital orders and related mental health disposals, psychiatrists were to state whether, in the event of the accused person not being convicted, it would be appropriate for the court to exercise this power. We go on to recommend in Chapter 26 that an MHO should also be required to provide a report prior to a mental health disposal, and we would anticipate that this should also address the issue of whether such interim detention would be advisable in the event of acquittal.
26. The Royal College of Psychiatrists' proposal was for detention for up to 72 hours. We are not persuaded such a period of detention is necessary. The purpose of the order is simply to ensure that the patient can be held for long enough for at least one medical practitioner (and, also ideally, an MHO) to be summoned to begin the process of civil detention. Given that the court is sitting in 'office hours', we believe that six hours should be adequate for this purpose.

Recommendation 25.8

Where a court

- ♦ *has received recommendations which would have entitled it to make a hospital order or hospital direction on the conviction of an accused person, and*
- ♦ *that person is acquitted, other than by reason of insanity, and*
- ♦ *it appears to the court that it may be urgently necessary for the person to be detained in hospital to assess whether he or she requires compulsory measures under the Mental Health Act,*

the court should be entitled to order the detention of the person in a place of safety for a period of up to six hours to allow examination by a registered medical practitioner.

CHAPTER 26

CONVICTED OFFENDERS WITH MENTAL DISORDER

Assessment of disposals

1. This chapter discusses the range of disposals available to the Courts in respect of a convicted offender who has a mental disorder. We are of the view that there is, in general, an adequate range of disposals available in respect of mentally disordered offenders, although we did receive evidence that the necessary services to support the range of disposals were not always in place. In particular, there would appear to be a lack of suitable facilities for young people with mental disorders who commit offences, and female offenders who manifest self-harming behaviour. (We make recommendations regarding secure services for children and young people in Chapter 18).
2. There are also problems in ensuring that the appropriate disposal is selected in a particular case. Evidence to the Committee highlighted the tension between the need of the criminal justice system for clear disposals, selected at or shortly after conviction; and the nature of psychiatric diagnoses, which are of necessity often provisional, and subject to change in the light of new evidence.
3. It was also said to us in evidence that courts did not necessarily always have access to all the appropriate information, to assist them in deciding whether or not a particular mental health disposal was appropriate. At present, when a hospital order is under consideration in a criminal case, two medical recommendations are required, and the person must fulfil the normal criteria for detention. A mental health officer (MHO) is not, however, required to give a report³. The same applies for other mental health disposals, including hospital directions.
4. We believe that it is as important to have input from specialist social workers in the case of those mentally disordered persons for whom a hospital order is being considered, as it is for a detention under civil procedures. We therefore recommend that there should always be a report from an MHO where a mental health disposal is being considered in a criminal case.

Recommendation 26.1

For any mental health disposal in a criminal case which currently requires the evidence of two medical practitioners, a court should also be required to receive a report from a mental health officer.

3 Criminal Procedure (Scotland) Act 1995, s.58

5. The State Hospitals Board suggested that courts should be more inclined to call for reports from other disciplines such as psychology to inform disposal decisions, particularly in relation to risk. The British Psychological Society also supported greater use of psychologists in relation to mental health disposals.
6. We do not believe it would be necessary to have a report from a psychologist in every case. However, there are cases where it may be particularly useful, for example, where the offender has a learning disability or mental disorder related to a head injury. As the Act stands, such a report can be considered, but is not required, and cannot substitute for the two medical opinions which must be given. This may tend to devalue a valuable source of expert advice. On the other hand, we would wish to retain the requirement for two medical recommendations, which is consistent with the requirements for long term compulsion under civil proceedings.

Recommendation 26.2

For any mental health disposal in a criminal case which currently requires the written or oral evidence of two medical practitioners, the court should be entitled to require further evidence from a chartered clinical psychologist with appropriate expertise.

7. It was suggested by the Royal College of Psychiatrists and Greater Glasgow Primary Care NHS Trust that greater use of deferred sentencing would provide more opportunity for multi-disciplinary assessment and discussion. We agree that this would, in many cases, be a sensible course of action, which would not appear to require legislative change.
8. Voluntary sector respondents, such as the Scottish Association for Mental Health (SAMH) and ENABLE, felt there was a need for awareness training on mental health and learning disability amongst those working in criminal justice.
9. We discuss the report of the MacLean Committee in the following chapter. However, we note in this context that the MacLean Committee recommended that all agencies operating in the criminal justice system should ensure that professionals who evaluate risk, or make decisions based on risk (including the judiciary) are appropriately trained⁴. We endorse this recommendation, in respect of those who deal with offenders with mental disorders.

Recommendation 26.3

All agencies dealing with offenders with mental disorders should ensure that professionals who evaluate risk, or make decisions based on risk, are appropriately trained.

⁴ Report of the Committee on Serious Violent and Sexual Offenders, (Scottish Executive SE/2000/68) paras 2.50-2.51 and Recommendation 4

Remand for inquiry into mental condition

10. Under s200 of the Criminal Procedure (Scotland) Act 1995 (the CPSA), there is a power to remand a convicted person in custody, or on bail to hospital for enquiry into his or her mental condition before passing sentence. The maximum period of remand is three weeks, but this is renewable by the court. Our main concern about this is the time limit for an appeal against the order, which is currently 24 hours. It was suggested to us, and we agree, that this may be totally unrealistic where a person is possibly suffering from a mental disorder, notwithstanding the relatively short duration of the authorised period of remand. Where a person has been remanded to hospital, we believe that an appeal should be competent at any time during the period of remand.
11. We have discussed in Chapter 25 the issue of compulsory treatment for prisoners remanded under s52 of the Criminal Procedure (Scotland) Act. The same issues arise in relation to s200, and we believe the same provisions should be made to allow treatment on a compulsory basis, subject to the normal Mental Health Act protection for detained patients, and a requirement for consent by either the patient or a second medical practitioner with appropriate expertise.

Recommendation 26.4

It should be possible to appeal against an order for remand of a convicted person to hospital for enquiry into his or her medical condition at any time during the period of remand.

Recommendation 26.5

The provisions for compulsory treatment which apply to untried prisoners remanded to hospital (see recommendation 25.4) should also apply to convicted offenders remanded to hospital for enquiry into their mental condition.

Hospital orders

12. Section 58 of the CPSA provides that where a person is convicted of an offence which is punishable by imprisonment, the court may make a hospital order. (This does not apply where a person is convicted of murder, where the only available sentence is life imprisonment, although it is possible for the prisoner thereafter to be transferred to hospital if appropriate.)
13. The hospital order effectively means that the convicted person is transferred to hospital, and is detained on a similar basis to a patient detained under Part V of the Mental Health (Scotland) Act 1984⁵. Before making such an order, the judge must be satisfied that the grounds set out in s17(1) of the 1984 Act (i.e. the criteria for civil detention) apply to the patient, on the basis of the written or oral evidence

⁵ 1984 Act, s60

of two medical practitioners, one of whom must be approved as having special experience in the diagnosis or treatment of mental disorder. The patient can subsequently be discharged by the responsible medical officer (RMO) or the Mental Welfare Commission, or by the sheriff on appeal. Unlike detention under civil procedures, the nearest relative cannot initiate a discharge. The order requires to be renewed on the same basis as detention under Part V of the 1984 Act, namely after six months, 12 months and annually thereafter.

14. Where a hospital order is made, this may be combined with a restriction order⁶. The effect of this is that the normal provisions regarding renewal of detention orders do not apply, and neither the RMO nor the Mental Welfare Commission can discharge the patient. The control of restricted patients is essentially in the hands of Scottish Ministers, who must authorise any leave of absence or transfer of the patient, and have the power to discharge the patient, either absolutely or subject to conditions. Patients can appeal to the sheriff seeking discharge. We discuss restriction orders in Chapter 27.
15. We propose that, as now, hospital orders without restrictions should operate on the same basis as detention under the civil procedures of the Mental Health Act. The recommendations we make in Chapters 5-11 of this report regarding compulsory treatment would apply, including the criteria for making an order, the protection of the patient during the order, and the role of the tribunal in considering appeals against the continuation of the order.
16. We have given particular consideration to the question of whether a hospital order should continue to be available for offenders with a primary diagnosis of personality disorder.
17. In England the Inquiry into Ashworth Hospital⁷ recommended that hospital orders should not be available for individuals suffering from personality disorder. A number of respondents to our consultations argued that hospital orders were unsuitable for this group. Because the likelihood of a benefit from treatment is doubtful, mental health services might be required to discharge offenders when the level of risk had not reduced, or keep such offenders in hospital, without a clear treatment plan.
18. We take the view that a hospital order should not normally be considered suitable for a person with a primary diagnosis of personality disorder. Where hospital treatment is felt to be appropriate, a hospital direction or transfer direction should be used.
19. We do not, however, recommend that a hospital order be explicitly ruled out for this group. As now, the disposal would depend on medical recommendations, and we note that virtually no offenders with a primary diagnosis of personality disorder have received hospital orders in recent years. We have concluded that the matter should be left to the discretion of the medical and social work professionals, and the courts, to allow for the rare cases where such a disposal may be appropriate.
20. We recommend above that MHOs should have a formal role in the consideration of mental health disposals, including hospital orders. Otherwise, we have received

⁶ See Criminal Procedure (Scotland) Act 1995, s59, and Mental Health (Scotland) Act 1984, ss62 and 68

⁷ *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*, Vol 1 (1999), Cmnd.4194-II, recommendation 7.6-20

little evidence suggesting that substantial revision is required to the legislation concerning hospital orders which do not involve restriction orders.

Interim hospital orders

21. An interim hospital order can be imposed on persons convicted of an imprisonable offence (other than murder). This can be done where the court is satisfied (after considering evidence from two medical practitioners) that the offender is suffering from mental disorder; that it may be appropriate for a hospital order to be made, and that the specified hospital may be the State Hospital. It allows the person to be held in hospital for up to 12 months, although the order must be renewed after 12 weeks and, thereafter, every 28 days⁸.
22. Where a person's mental disorder is thought to be complex, the interim hospital order allows for an extensive period of assessment prior to final disposal. The maximum duration of an interim hospital order was extended from six to 12 months in 1997. The orders appear to have been used more frequently in recent years. Figures from the Mental Welfare Commission Annual Reports show an increase in such orders from 16 in 1994/5 to 49 in 1998/9.
23. In our second Consultation, we set out our provisional view that, for serious offences, interim hospital orders should be recommended in preference to hospital orders, except in cases where the diagnosis is clearly one of an uncomplicated and treatable mental illness. This proposal received general support.
24. The MacLean Committee felt that an interim hospital order was particularly useful for the group of potentially high risk offenders with which it was concerned, and noted that some of the high profile cases concerning serious offenders with personality disorders involved a change to the diagnosis after the imposition of a hospital order. An interim hospital order might avoid this, and would allow for a detailed risk assessment. The Committee therefore recommended that, 'where a psychiatric report in respect of a person convicted of a serious violent or sexual offence recommends the imposition of a hospital order with restrictions, the psychiatrist shall be required to address in the report the question of why an interim hospital order is not appropriate'⁹.
25. An interim hospital order can currently only be imposed when there is reason to suppose that the final disposal might be to the State Hospital- although the interim order need not be to the State Hospital. Presumably this was intended to restrict interim hospital orders to potentially high-risk cases.
26. We accept that there is reason to restrict interim hospital orders to the more difficult and serious cases. The present criteria for an interim hospital order are, in other respects, less stringent than for civil detention, since all that is required are
 - ♦ the presence of mental disorder and
 - ♦ the possibility that this meets the criteria for a hospital order.

8 Criminal Procedure (Scotland) Act 1995, s53

9 *Report of the Committee on Serious Violent and Sexual Offenders* (Scottish Executive SE/2000/68), para 7.20 and recommendation 31

It would be wrong, therefore, to allow interim hospital orders to be available in all cases, since this could lead to a person who did not meet the criteria for civil detention, and whose offence was not serious, being detained in hospital for up to 12 months, prior to a further criminal disposal.

27. Particularly with the proposed development of medium secure services, it could well be the case that people who commit serious offences, and whose cases require thorough assessment, may not be sent to the State Hospital. We therefore propose that the criteria for an interim hospital order be amended to be linked, not to the likelihood of the State Hospital being the final disposal, but to the likelihood that a restriction order be imposed.
28. We also consider that the criteria for the interim order should be amended to reflect the possibility that a hospital direction, rather than a hospital order, be appropriate. It is likely that interim hospital orders will be particularly relevant for the cases where a hospital direction is under consideration. (We deal with hospital directions in paragraphs 30-40 below.)
29. On a practical point, the MacLean Committee felt that the requirement to renew an interim hospital order every 28 days was unnecessarily bureaucratic and burdensome, and recommended that, for high risk offenders, the period should be extended to 90 days¹⁰. The same suggestion was made to us by the Mental Welfare Commission in respect of interim hospital orders generally, and we agree with it.

Recommendation 26.6

An interim hospital order should be possible where-

- ♦ *the offender is suffering from mental disorder, and*
- ♦ *there is reason to suppose that the mental disorder from which the offender is suffering is such that it may be appropriate for a hospital order with restrictions or a hospital direction to be made.*

Recommendation 26.7

Where a psychiatric report recommends the imposition of a hospital order with restrictions, the psychiatrist should be required to address in the report the question of why an interim hospital order is not appropriate.

Recommendation 26.8

The time limit for renewal of an interim hospital order, after the initial 12 week duration, should be increased from every 28 days to every 90 days.

¹⁰ Report of the Committee on Serious Violent and Sexual Offenders, para 7.19 and Recommendation 30

Hospital directions

30. Mental health disposals such as hospital orders are intended to remove a mentally disordered offender from the criminal justice arena, and into the care of mental health services. Other than in cases where 'insanity' is established (see Chapter 29), a mentally disordered offender has been found to be legally responsible for his or her criminal behaviour. Nevertheless, once in the mental health arena, questions of punishment and deterrence are not relevant. This has long been accepted as a humane and justifiable approach. Difficulty arises where the connection between the mental disorder and the crime is not totally clear, or where alleviating the mental disorder may not alleviate the risk that the offender may commit further crimes. Hospital directions are intended to provide a possible solution, by allowing the court both to give an offender a prison sentence and at the same time to ensure that hospital treatment is available.
31. This disposal was introduced in 1997, and is available in relation to offenders convicted on indictment (i.e. more serious cases, heard by the High Court or a sheriff and jury). Section 59A of the 1995 Act provides that, in addition to any sentence of imprisonment a court may impose (including a life sentence for murder), the court may authorise the convicted person's admission to and detention in hospital. Before making a hospital direction, the court must be satisfied that the person meets the criteria for detention under Part V of the 1984 Act, on the same basis as if the court were considering a hospital order.
32. The effect of a hospital direction is that the offender will be transferred to and detained in hospital for so long as the criteria for mental health detention continue to apply¹¹. During the period in hospital, the patient's status is similar to that of a patient subject to a hospital order with restrictions. (We discuss this further in Chapter 27). Should the offender cease to meet detention criteria, for example because he or she has substantially recovered from the mental disorder, he or she is not released, but is transferred to prison to serve out any unexpired portion of the prison sentence (with time spent in hospital counted as time served).
33. Scottish Ministers decide on transfer from hospital back to prison, and on issues such as leave of absence. There is an appeal to the sheriff in relation to decisions by Ministers concerning absolute or conditional discharge¹². Should the sheriff determine that the offender should be absolutely discharged, Ministers must transfer the patient back to prison to serve out the sentence. If the sheriff recommends conditional discharge, Ministers can decide whether hospital or prison is more appropriate.
34. A patient subject to a hospital direction, who continues to be detainable in terms of the Mental Health Act beyond the expiry of his or her prison sentence, may continue to be detained in hospital, effectively on the same basis as a patient detained under civil law. The procedure is for the RMO and another medical practitioner to submit reports to the hospital managers prior to discharge¹³. We make recommendations regarding this process at paragraphs 55-58.

11 1984 Act, s62A

12 1984 Act, s65

13 1984 Act, s74(a)

35. To date, hospital directions have only been ordered in a handful of cases. They were initially controversial, and many psychiatrists and patients groups argued that it was a retrograde step to sentence to prison people who required hospital treatment. However, our consultation, and recent research, suggests that views have changed. There would appear to be a greater acceptance that hospital directions may be of value in certain cases.
36. In responses to our first Consultation, local authorities and health care trusts endorsed the use of hospital directions, and said that they were not used enough. Against that, the Scottish Association for Mental Health said that they opposed the directions in principle, as confusing issues of culpability and treatment. The Law Society felt that their use should be restricted to offenders with personality disorder.
37. We believe that there is a place for hospital directions, particularly in situations where
 - ♦ there is not considered to be a strong association between the offender's mental disorder and the offence, and so punishment for the offence is appropriate, despite the current need for treatment, or
 - ♦ the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.
38. This may not amount to a large number of cases. For offenders who require hospital admission because of a mental illness which is strongly linked to their offending behaviour, and which is likely to respond to treatment, hospital orders would continue to be appropriate. In contrast, for example, those who are found to have an anti-social personality disorder without any other mental disorder, would be likely to continue to receive penal disposals, rather than be placed into the mental health system.
39. One reason which has been cited for the lack of use of hospital directions is the fact that the criteria for recommending a hospital direction are identical to those of a hospital order. Furthermore, the guidance from the Scottish Office states that 'a psychiatrist may not recommend a hospital direction as it is attached to a custodial sentence'¹⁴. The intention is that the psychiatrist should only advise that the offender meets the grounds for detention in hospital. It is for the court to decide whether such admission should be additional to, or instead of, a penal disposal. Yet, without any statutory or other guidance as to what circumstances might justify a hospital direction, or the benefit of expert advice, it is difficult to see how the court can identify when it is the best disposal.
40. We proposed in our second Consultation that the criteria should be clarified, and distinguished from those for hospital orders, and that the current guidance should be revised. These proposals were generally supported, although the Royal College of Psychiatrists and the State Hospitals Board felt it should not be the role of the psychiatrist to recommend something which should lead to a custodial sentence.

¹⁴ Amendments to the Mental Health (Scotland) Act 1984 by the Crime and Punishment (Scotland) Act 1997, NHS MEL (1997) 86, Annex A para 3

We accept this point, and believe that, if the criteria are appropriately clarified, it should be possible for psychiatrists to give evidence which assists the court, without encroaching on the sentencing role.

Recommendation 26.9

The criteria for a hospital direction should be amended to include, in addition to the existing criteria, that either

- ♦ *there is not considered to be a strong association between the offender's mental disorder and the offence, or*
- ♦ *the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.*

Guardianship

41. Under s58 of the CPSA, it is possible for a convicted person to be placed under guardianship, in terms of ss36-52 of the 1984 Act, if the judge is satisfied that the criteria for guardianship in s36 are met. As with hospital orders, two medical reports are required. In addition, an MHO must give evidence, and the court must be satisfied that the local authority or other named guardian is willing to receive the person into guardianship.
42. This power is relatively rarely used. Mental Welfare Commission statistics show that there were five such guardianship orders in the year 1998-1999 and four in 1999-2000. This may be because the powers of the guardian are limited, and enforcement can be difficult if the person subject to guardianship is not prepared to comply with the order. When the relevant parts of the Adults with Incapacity (Scotland) Act 2000 are implemented in April 2002, guardianship under the Mental Health Act will be abolished. Instead, the court will have the options of making an order for welfare guardianship under the Adults with Incapacity Act, with the guardian being the local authority or such other specified person as may be approved by the local authority, or of making an intervention order under that Act¹⁵.
43. We imagine the guardianship order will still only be used to a limited extent in criminal cases. However, it is a useful addition to the range of disposals, which we believe should be retained.

Probation with a condition of treatment

44. For mentally disordered offenders whose situation does not merit imprisonment or detention, it is possible under s230 of the CPSA to impose a probation order with a requirement of treatment. The court must be satisfied, on the evidence of a

¹⁵ Adults with Incapacity (Scotland) Act 2000, Schedule 5, para. 26

medical practitioner approved as having special experience in the diagnosis or treatment of mental disorder, that the offender's mental disorder requires and is susceptible to treatment, but is not such as to warrant a hospital order. Such a probation order includes a requirement that the offender shall submit to treatment by or under the direction of a medical practitioner or chartered psychologist with a view to the improvement of the offender's medical condition. Treatment may be on an in-patient or out-patient basis. Although probation orders generally can last up to three years, the requirement to accept treatment can last no longer than 12 months.

45. If the offender does not comply with the treatment requirement, he or she can be returned to court, and be fined or re-sentenced, or the order can be varied. Refusal to comply with treatment (including refusal to accept medication) will not constitute a failure to comply with the order if the court is of the opinion that the refusal was reasonable, having regard to all the circumstances.
46. Such evidence as we received on probation with a requirement of treatment suggested that it sometimes worked well. It was suggested that it should be possible for the order to extend beyond 12 months, perhaps to three years to tie in with the maximum period of a probation order. This would be consistent with supervision and treatment orders, which can be imposed where the disposal is based on a finding of insanity. We believe that this would be reasonable, and would allow a longer period of sustained intervention, perhaps as a preferable alternative to hospital admission.
47. One forensic service which we visited commented that they were sometimes asked to assist offenders who had been made subject to a probation condition that they attend that service, but who in fact would not be suitable. This is not only unhelpful to the service, but may be unfair to the offender, who may breach the order if unable to meet the conditions of the service.

Recommendation 26.10

It should be possible for conditions of treatment attached to a probation order to last for up to a maximum of three years.

Recommendation 26.11

Before imposing a requirement of treatment specifying that the offender attend a particular service, the court should obtain written or oral evidence from a person who would have responsibility for the delivery of the service, that it is appropriate and available.

Community orders

48. We set out in Chapter 6 our proposals for a new form of community order, which would allow a mentally disordered person to receive treatment on a compulsory basis in the community, rather than being required to be detained in hospital. We believe that such an order may be appropriate for some mentally disordered offenders, and should be an available option. Such a disposal would be based on approval by a tribunal of a plan of care, setting out how the necessary care and treatment will be delivered.
49. We considered whether the criminal court should receive evidence of the proposed plan of care and consider whether a community order is appropriate. However, should our recommendation for a new tribunal be accepted, this would be an area of the law with which the courts would not be directly familiar. We therefore believe that a better solution, should the criminal court consider a community order might be appropriate, would be for the court to remit the case to a mental health tribunal for consideration.
50. The tribunal would consider whether the criteria for such an order were met and whether, in the circumstances, it would be appropriate to make the order. It would then report back to the court, which would decide whether or not to confirm the order, should a community order have been recommended, or to make some other disposal, should the tribunal decide not to recommend a community order, or the court not be satisfied that the recommended order would be appropriate.

Recommendation 26.12

It should be possible for a court to remit a mentally disordered offender to a mental health tribunal, for consideration of a community order.

Recommendation 26.13

In relation to any such referral, the tribunal should consider the appropriateness of such an order, and its nature, and should report back to the court as to whether it recommends a community order.

Recommendation 26.14

On receiving such a report, the court would be entitled to

- ♦ *approve a recommended community order, or*
- ♦ *substitute any other disposal it is entitled to make where the court does not approve a recommendation for a community order, or such an order is not recommended.*

Transfer from prison to hospital

51. It is possible for a person who is already serving a prison sentence to be transferred to hospital, by means of a transfer direction¹⁶. The power to make such a direction is vested in Scottish Ministers, who must be satisfied that the patient meets the detention criteria set out in s17 of the 1984 Act, having received evidence from two medical practitioners, one of whom must be approved as having special experience in the diagnosis and treatment of mental disorder.
52. Ministers can also impose a restriction direction on patients transferred to hospital under a transfer direction. This has a similar effect for a transferred prisoner as a restriction order has on a person given a hospital order. We deal with this further in Chapter 27 (paragraphs 92-94).
53. Prisoners transferred to hospital have a right of appeal to the sheriff against the decision of Scottish Ministers to transfer them¹⁷, but not a decision to refuse a transfer. Under our proposals, the new mental health tribunal would be the appropriate body to consider such an appeal. So far as we can ascertain, Ministers will almost always accede to a transfer request if medical evidence supports it. Nevertheless, they are not obliged to do so. We believe that, where there is medical evidence that a transfer is appropriate, it is wrong that a mentally disordered person should have no right of appeal against a determination by Ministers that he or she must stay in prison rather than be treated in hospital.

Recommendation 26.15

The right of appeal against a transfer direction should be to a mental health tribunal.

Recommendation 26.15

Where a prisoner has been assessed by two medical practitioners as meeting the criteria for admission to hospital under the Mental Health Act, there should be a right of appeal to a mental health tribunal against a decision by Scottish Ministers not to authorise a transfer direction.

54. The time limit for an appeal against the making of a transfer direction is one month. We received evidence from the State Hospital suggesting that people transferred to the State Hospital should have 10 weeks to appeal. Clearly, prisoners being transferred to hospital because they have developed a significant mental disorder are in a vulnerable position, and may well find it difficult to exercise their rights of appeal in the early period of the transfer. We therefore believe that the proposal of the State Hospital should be implemented, and should extend to all transferred prisoners. (We discuss the issues of appeals against placement in the State Hospital further in Chapter 27(paragraphs 79-91)).

16 1984 Act, s71
17 1984 Act, s71

Recommendation 26.17

The time limit for an appeal against a transfer direction, or the refusal to make a transfer direction, should be ten weeks.

55. Where an offender who still has part of the sentence to serve, has been transferred to hospital, but no longer meets the criteria for detention under the Mental Health Act, s71A of the 1984 Act provides that Scottish Ministers may return the offender to prison to complete the sentence. We believe that these arrangements are appropriate.
56. Under s74 (9) and (10) of the 1984 Act, the RMO can continue detention of a transferred prisoner who is subject to a restriction direction, beyond the date at which the prisoner would be due to be released from prison. The procedure is for the RMO to submit two medical reports to the hospital managers and the Mental Welfare Commission. The effect is that the patient is detained beyond the release date as if he or she had been made subject to long term detention under the civil procedures in the 1984 Act, but without there having been any prior approval by the sheriff. The same procedure operates in relation to hospital directions.
57. The Act is not wholly clear as to whether a prisoner subject to a transfer direction without a restriction direction remains subject to detention beyond the expiry of the sentence, on the same basis as a patient detained under civil procedure. On one interpretation, detention continues without any further formalities being observed.
58. We believe it is inappropriate that a person who is no longer subject to a prison sentence should be detained on a long-term basis without the approval of a tribunal.

Recommendation 26.18

It should continue to be possible for Scottish Ministers to return transferred prisoners who no longer require hospital treatment to prison to serve the remainder of their sentence.

Recommendation 26.19

Where a person subject to a transfer direction or hospital direction would be entitled to be released from prison, but the responsible medical officer is satisfied that the prisoner requires continued detention under the Mental Health Act, it should be necessary for the continued detention to be authorised by the normal civil procedures.

Treatment in prison

59. There are significant numbers of offenders in prison who have mental disorders. We took oral evidence on the operation of the arrangements for transfer between prison and hospital from both the Scottish Prison Service and the State Hospital. Both felt the arrangements worked reasonably well for the most part, although the State Hospital commented on a lack of agreement in some cases between the Scottish Executive, prisons and the State Hospital, about whether an offender was ready to be returned to prison.
60. Where a prisoner develops an acute mental illness, we believe that he or she should be transferred to hospital. A question arises, nevertheless, about prisoners whose mental disorder may be kept under reasonable control by medication, but who may not require the degree of specialist care provided in hospital. Should it be possible to require that they accept medication while in prison? At the moment, the prison has no power to compel a prisoner to take medication. If the prisoner refuses to do so, nothing can be done until the prisoner's mental state has deteriorated to the extent that he or she meets the criteria for transfer to hospital.
61. There are also prisoners who, prior to imprisonment, were subject to detention under the Mental Health Act. Section 32 of the Act provides that such prisoners are treated for the first six months as if on unauthorised leave of absence during the time in prison. This means that, within 28 days of release from prison, the offender can be returned to hospital. Where a person is in prison for over six months, the mental health detention falls. During the period of imprisonment, the provisions in Part X of the 1984 Act do not apply, and so the prisoner cannot be required to accept treatment without consent.
62. The Prison Service expressed reservations about the suggestion that prisoners might be compelled to accept medication in prison. They felt that prisons could not provide, and should not try to provide, specialist mental health care, and it was not clear how compulsory treatment would fit with Prison Rules, since it would be inappropriate to punish the prisoner for non-compliance. However, they accepted that, for patients who were subject to a requirement to accept treatment (e.g. under a possible community order), and who were prepared to accept treatment, the situation might be manageable.
63. We accept that any kind of enforced medication in prison would be wrong. As we say in relation to community orders (Chapter 6) forcible treatment should only be carried out in an appropriate clinical setting. We considered whether it should be possible for community orders with conditions of treatment to continue in force during a period of imprisonment. However, on balance, we see little benefit in this. The framework of care within which the community order would be delivered could not be replicated in prison. Furthermore, in the custodial environment, we doubt whether the distinction between compulsory treatment (which is acceptable) and forcible treatment (which is not) could realistically be maintained. We therefore make no recommendations on this point.

64. As with detention at present, we propose that a community order should remain in force on release from prison, where the time spent in custody is less than six months.

Recommendation 26.20

The provisions of s32 of the 1984 Act should continue to apply to persons who are liable to detention in hospital under the Mental Health Act and detained in custody in pursuance of an order of a court.

Recommendation 26.21

Where a person who is subject to a community order is detained in custody in pursuance of an order of a court for less than six months, the community order should continue in operation on the discharge from custody.

CHAPTER 27

HIGH RISK PATIENTS

Introduction

1. In this chapter we deal with two separate, but linked, aspects of the legislation which deals with patients who present a high risk to others: the imposition of restriction orders (and other similar orders) in cases which have come before the criminal courts, and the arrangements for patients to be placed in the State Hospital. We also address the recommendations of the MacLean Committee.

The MacLean Committee

2. The MacLean Committee was established by the UK Government in March 1999. It reported in June of this year¹⁸. The Committee was asked to consider experience in Scotland and elsewhere and to make proposals for the sentencing disposals for, and future management and treatment of 'serious violent and sexual offenders who may present a continuing danger to the public'. The Committee designated this group as 'high risk offenders'. Our own terms of reference require us to have regard to the MacLean Committee's recommendations.
3. The Maclean Committee took the view that, in general, the primary issue of concern in relation to high risk offenders is how best to assess and manage the risk they present. They therefore made a detailed series of recommendations in relation to the risk management of serious violent and sexual offenders, including the creation of a new sentence, the Order for Lifelong Restriction, and a new body, the Risk Management Authority.
4. The Order for Lifelong Restriction (OLR) is intended largely to replace the existing discretionary life sentence, and would be based on a thorough assessment of risk, both prior to and during the operation of the sentence.
5. The Risk Management Authority (RMA) is intended to develop and promote best practice in risk assessment and management in relation to high risk offenders. It would also have an operational role, in overseeing risk assessment and management of individual offenders subject to the OLR.
6. The RMA would agree a risk management plan for each such offender and commission appropriate services to reduce the risk presented. It would supervise the review of this plan on a regular basis, and report progress to the Parole Board. Decisions as to release would be the responsibility of the Parole Board, sitting as a designated life tribunal¹⁹.

¹⁸ *Report of the Committee on Serious Violent and Sexual Offenders*, (Scottish Executive SE/2000/68) (Herein after 'Maclean Report')

¹⁹ Maclean Report Chapter 8

7. Chapter 7 of the Committee's report deals with high risk offenders who have mental disorders. The Committee makes recommendations regarding particular disposals, including hospital directions and interim hospital orders, which we address at the relevant points in our report.
8. In the case of a high risk offender who has been assessed as suitable for an OLR and who also suffers from a mental disorder that meets the criteria for compulsory detention in hospital, the MacLean Committee recommends that the disposal should be an OLR with a hospital direction²⁰ and that this should be a mandatory disposal.
9. The question of OLRs generally is not a matter for this Committee but there is a comment that we would wish to make in relation to this recommendation. The MacLean Committee report points out that those offenders with mental disorder who fall within their designation of high risk offenders are likely to have complex mental disorders, possibly combinations of mental illness, substance abuse disorder, personality disorder, psychosexual disorder and possibly a learning disability²¹. There will be other offenders, however, who have an uncomplicated mental illness, who would undoubtedly present a high risk to the public without treatment, but who are not likely to pose a risk if appropriately treated. We would expect that such offenders should, after careful assessment, continue to be dealt with as now, by means of hospital orders, with restrictions where appropriate.
10. The Committee also makes comments on the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, which we discuss in Chapter 28.
11. Although the recommendations of the MacLean Committee are confined to the group of offenders within its remit, the report suggests that the approach recommended, with its emphasis on risk management, may be relevant to other groups, including patients subject to restriction orders²². We set out below our proposals for restricted patients.
12. In relation to personality disorder, the MacLean Committee is generally of the view that this label is not an appropriate starting point from which to consider the problem of sentencing serious violent and sexual offenders. Many high risk offenders do not attract a diagnosis of personality disorder, and many people with personality disorder are not dangerous. There is still great uncertainty about suitable treatment approaches for personality disorder. The Committee concludes that it has not been able to identify any major clinical development in the management of personality disorder which would justify a change in Scottish practice, namely that the great majority of offenders with a primary diagnosis of personality disorder are dealt with by the criminal justice system.
13. The MacLean Committee considered the possibility of some new form of detention of people with personality disorder who were considered to present a risk to public safety, as proposed for England and Wales by the Home Office²³. They concluded that, in jurisdictions where this had been attempted, the legislation amounted to preventive detention under the guise of mental health

20 Maclean Report Recommendation 27

21 Maclean Report Para 7.3

22 Maclean Report Para. 3.39

23 Maclean Report Paras 12.5-12.14

treatment. The Committee strongly favoured the alternative approach of improving the assessment procedures in the criminal justice system, to deal more effectively with those who present a high risk. We are in agreement with the views of the MacLean Committee on this point.

14. In general, we take the view that the Committee's recommendations in respect of offenders with mental disorders can be accommodated within our proposed framework for a new Mental Health Act.

Restricted patients

Restriction orders-statutory provisions

15. There are special arrangements for people who have been made subject to a mental health disposal by a criminal court, and who are held to present a particularly high risk. Those who are subject to hospital orders may be placed under additional restrictions by way of a restriction order. (These restrictions also apply to offenders made subject to a hospital direction, while they are in hospital.)

16. Section 59 of the Criminal Procedure (Scotland) Act 1995 (CPSA) sets out the criteria for a restriction order. It may be imposed by a criminal court on a person at the time he or she is made subject to a hospital order where it appears to the court:

“having regard to the nature of the offence with which he is charged;

the antecedents of the person; and

the risk that as a result of his mental disorder he would commit offences if set at large, that it is necessary for the protection of the public from serious harm so to do”.

17. Section 62 of the 1984 Act sets out the effect of restriction orders.
18. Firstly, the normal time limits for renewal of detention do not apply. The patient continues to be liable to be detained until absolutely discharged. However, although there is no requirement for detention to be renewed from time to time, there is provision for review. The responsible medical officer (RMO) must examine the patient and report to Ministers at least annually. Furthermore, guidance issued to those involved in the management and care of restricted patients states that, if the RMO considers that the patient's mental condition has changed in such a way that Ministers should be informed, the RMO should take the initiative in making any additional report or recommendation which he or she considers appropriate²⁴.
19. Secondly, any transfer from one hospital to another, or leave of absence, must be approved by Scottish Ministers.
20. Thirdly, the primary power of discharge is vested in Scottish Ministers. Neither the RMO nor the Mental Welfare Commission can discharge the patient, although they can make recommendations to Ministers.

24 *Restricted Patients - Memorandum on Procedure*, Scottish Office Home and Health Department, December 1993

21. There is a right of appeal to the sheriff seeking discharge²⁵. The patient can appeal in a period between six and 12 months from the commencement of the relevant order, and once in any subsequent period of 12 months.
22. The appeal to the sheriff was introduced as a result of the decision of the European Court of Human Rights in the case of *X v UK*²⁶. Such an appeal right was necessary to comply with Articles 5 and 6 of the European Convention on Human Rights. Under the principles enunciated in the earlier *Winterwerp* judgement, there must be periodic review of any detention on the basis of 'unsound mind'. Such detention only continues to be lawful where there is
 - ♦ a true mental disorder established by objective medical expertise;
 - ♦ which disorder is of a nature or degree warranting compulsory confinement; and
 - ♦ which disorder persists at the time of review.

Also, the patient must have the right to have the lawfulness of the continuing detention reviewed by an independent and impartial tribunal.

23. The sheriff must therefore direct the discharge of the patient if the criteria for continuing detention are no longer met.
24. Prior to the passing of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, the criteria for the continued detention of a restricted patient were similar to those for other detained patients. The 1999 Act added a new "public safety" test, which must be fulfilled before either the sheriff or Scottish Ministers may discharge the restricted patient. Discharge must be refused if Ministers or the sheriff are satisfied that the patient is "suffering from a mental disorder, the effect of which is such that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital, whether for medical treatment or not". We deal with the Act generally in Chapter 28²⁷.
25. Ministers or the sheriff can discharge patients either absolutely or subject to conditions. If a patient is discharged subject to conditions, he or she remains liable to be recalled at a future date to hospital.
26. We are advised that there are around 280 patients subject to restriction orders at any one time. Around half of these are in the State Hospital; one-third are in local psychiatric hospitals and the remainder are on conditional discharge.

Ministers' role in relation to restricted patients

The current role of Ministers

27. Scottish Ministers have a significant role in overseeing the management of restricted patients. This includes not only the major decisions in relation to

²⁵ 1984 Act, s63

²⁶ *X v UK*, 1981 4 EHRR 188

²⁷ 1984 Act, s64(A1) and s68(2A)

discharge, but also more day to day management issues. Ministers must approve leave of absence, even at the level of an escorted trip from hospital. They are also responsible for the authorisation of transfers between hospitals and decisions to recall patients from conditional discharge. Decisions by Ministers are based on advice from the responsible medical officer, and internal advice from a psychiatric adviser and officials employed by the Scottish Executive, in some cases supplemented by independent opinions commissioned from elsewhere. In some cases, the decision-making authority is delegated from Ministers to Scottish Executive officials, although Ministers personally approve all decisions to discharge a restricted patient or to transfer a patient from the State Hospital.

28. We considered whether it was still appropriate for Ministers to have this responsibility, particularly in relation to discharge. Originally, it was felt to be right for the responsibility for discharge of restricted patients to be vested in Ministers because of the public safety interest. The Butler Committee, which reviewed forensic provision for patients in England and Wales, took the view that it was acceptable for the Home Office to continue to detain restricted patients whom a tribunal would discharge, because Ministers had a different responsibility from mental health tribunals.
29. This distinction has now largely been eroded. Firstly, the right of appeal to the sheriff has been introduced. Secondly, although the power of Ministers to discharge is worded as a discretion, rather than a duty, it was stated in the case of *Anderson*²⁸ that Scottish Ministers would be legally required to discharge a restricted patient if the criteria for detention were no longer met.
30. Also, the view that it is appropriate for politicians to make decisions concerning continuing detention has changed substantially in respect of prisoners. It is already the case that the power to release prisoners subject to discretionary life sentences and those convicted of murder under the age of 18 has been transferred from Ministers to the Parole Board, sitting as a designated life tribunal. The Scottish Executive has also now announced its intention to introduce legislation which will remove the discretion of Ministers in relation to the release of adult prisoners subject to mandatory life sentences.

Issues raised in consultations

31. In our first Consultation, we asked whether it was right that decisions concerning the discharge of restricted patients should be made by a Minister. Responses were mixed, but several key respondents felt that such an arrangement was no longer appropriate.
32. The Law Society did not advocate change at present, saying that it was appropriate that decisions of this nature are taken by a person who is accountable. However, they felt that, if such decisions were taken out of the hands of the Scottish Executive in the case of prisoners, then the same should apply for restricted patients.

28 *Anderson, Doherty & Reid v Scottish Ministers and Advocate General for Scotland*, Court of Session, 16 June 2000

33. The Royal College of Psychiatrists felt that such decisions should be dealt with by an independent expert panel or tribunal.
34. The State Hospitals Board said that assessments of fitness for transfer to conditions of lower security are fundamentally clinical judgements and should not be influenced inappropriately by political considerations. All such judgements should be made against explicit criteria and through a process that is transparent and publicly accountable. The Board felt that current arrangements fall short of this ideal, and recommended that a new statutory body with clinical expertise, independent of both the State Hospital and the Scottish Executive, be established, with the responsibility to provide consent to discharge for restricted patients against specific criteria.
35. We took oral evidence from the State Hospital on this point. They commented that the current process was somewhat opaque. Advice to Ministers is confidential, so neither the RMO nor the patient is fully aware of the basis on which Ministers' decisions have been made. In principle, they felt that it was wrong that such a decision should be made by a politician.
36. We agree with this view. Whatever the reality in practice, the current system contains the potential for concern that political considerations might influence discharge decisions. We feel that this would be wrong. In our second Consultation, we therefore proposed that an independent body should consider questions of the absolute and conditional discharge, and recall, of restricted patients.
37. Almost all respondents on this point agreed with the proposal, with most believing that the body should have a power of discharge, rather than simply a power to make recommendations. The Mental Welfare Commission reiterated the proposal they made in the Report of their Inquiry into the Care and Treatment of Noel Ruddie²⁹, that an independent body should assume the powers and responsibilities of Ministers in relation to restricted patients. Support for this view was also expressed by the British Association of Social Workers (BASW), the Scottish Association of Mental Health (SAMH), ENABLE, and the Scottish Users Network (SUN).
38. However, there are still two issues to resolve: what should the independent body be, and how should the day to day oversight of restricted patients be managed? In our second Consultation, three options for the independent body were identified: the Parole Board, the Mental Welfare Commission, and a wholly new body.

Our proposals

39. There was little support for the suggestion that this responsibility should rest with the Mental Welfare Commission. It is of course the case that the Commission has the power to discharge non-restricted patients, but this is rarely used, and the primary responsibility rests with the RMO. To give the Commission the central role of

29 *Report of the Inquiry into the Care and Treatment of Noel Ruddie*, (Scottish Parliament, (SP Paper 98, Session 1 (2000)), recommendation 11

deciding whether to discharge restricted patients would compromise its important role as an independent monitoring body. This is, indeed, the view of the Commission itself. We have therefore discounted this option.

40. The Faculty of Advocates and the British Medical Association supported the idea that the Parole Board be constituted in a particular way to carry out responsibilities in relation to restricted patients, but this was opposed by bodies including the Royal College of Psychiatrists and Greater Glasgow Primary Care NHS Trust, on the basis that this was a body which would not be appropriate for people who should be regarded as patients.
41. We think that there is a strong case for a new body. This would ensure appropriate expertise in the needs of the particular patients under consideration. However, we have also considered the option of expanding the role of the Parole Board. We note that, in relation to discretionary life prisoners it has already taken over the responsibility of Ministers for determining the date of release. The MacLean Committee proposals would continue this role, in relation to offenders sentenced to the new OLR.
42. Giving the responsibility to the Parole Board might be administratively simpler than the creation of a completely new body. However, it would significantly increase the Board's workload, and it would be necessary to review the membership of the Board, to ensure it has sufficient expertise in mental health issues. It would also be necessary to ensure that the Board was adequately resourced to discharge its new obligations.
43. Provided this is done, we believe that there would be advantage in the Parole Board taking over responsibility for decisions currently taken by Ministers in relation to discharge and recall of restricted patients, rather than establishing a new body. When carrying out this function, it should be called the Restricted Patients Review Board.
44. However, while Ministers take some decisions personally, others are delegated to officials (although the ultimate responsibility rests with Ministers). If the role of Ministers is removed in relation to discharge, it would be undesirable for the day to day management to remain with them, since decisions in relation to discharge are likely to be affected by what is known about a patient as a result of managing these day to day issues. The Parole Board would not be well placed to carry out this operational responsibility.
45. The MacLean Committee proposes that, for offenders subject to an OLR, the Risk Management Authority should have responsibility for overseeing risk management. A similar role could be played by the RMA for restricted patients. The RMA would take charge of those responsibilities currently delegated by Ministers to officials.
46. As with other patients, restricted patients should have a plan of care. This should also operate as a risk management plan. The RMA would agree the risk

management aspects of the plan with the responsible medical officer. It would then have the power to approve decisions on matters such as leave of absence, on the basis set out in the plan.

47. The RMO would report on the patient's progress to the Restricted Patients Review Board on the same basis as he or she currently reports to Ministers: an annual report supplemented by additional reports in the event of any material change of circumstances.
48. The precise relationship between the Restricted Patients Review Board, the RMA, and the RMO would require to be developed in greater detail. This should be set out in a revised Memorandum on Procedure for Restricted Patients and this Memorandum should be publicly available. It would be particularly important for the Risk Management Authority to liaise closely with local health and social work agencies in carrying out its operational responsibilities.
49. As we have currently already noted, there is a right of appeal to the sheriff for patients seeking discharge. We propose in Chapter 9 that the role of the sheriff in approving and hearing appeals concerning long term compulsion should be given to a new mental health tribunal. Such a tribunal would also consider appeals by restricted patients. Because such appeals may be more complex than those concerning non-restricted patients, and raise issues of public safety, the tribunal in those cases should be chaired by a sheriff. In other respects, the procedure in appeals concerning restricted patients would be essentially the same as for other patients appealing to the tribunal.
50. The provisions regarding the frequency of appeals which could be made would be the same as is currently the case with appeals by restricted patients to the sheriff. As we propose in Chapter 9 there would be an appeal against a decision of the tribunal by either the patient or the Review Board to the Court of Session, on questions of fact and law.

Recommendation 27.1

Scottish Ministers should no longer have responsibility for the management and discharge of restricted patients.

Recommendation 27.2

The Parole Board, sitting as the Restricted Patients Review Board, should take over the responsibility of Ministers for decisions concerning the discharge of restricted patients.

Recommendation 27.3

The Risk Management Authority, if established as proposed by the MacLean Committee, should be given responsibility for those aspects of Ministers' responsibility for restricted patients which are currently delegated to officials, namely the authority to approve leave of absence for restricted patients, transfers between hospitals (other than transfers to lower levels of security, and cross border transfers), and urgent recalls from conditional discharge.

Recommendation 27.4

The responsible medical officer should report on the patient's progress to the Restricted Patients Review Board at least annually, and should furnish additional reports where there is a significant change of circumstances.

Recommendation 27.5

Restricted patients should have a right of appeal to a mental health tribunal once in the period between six and 12 months from the commencement of the relevant order, and once in any subsequent period of 12 months.

Recommendation 27.6

The Memorandum on Procedure regarding Restricted Patients should be revised and made publicly available.

Recommendation 27.7

A tribunal dealing with a restricted patient should be chaired by a sheriff.

Recommendation 27.8

The tribunal and the Restricted Patients Review Board should be under a duty to discharge the patient absolutely if satisfied that the criteria for detention in hospital are no longer met, and it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

Conditional discharge

51. The evidence we have received suggests that, for the most part, the present arrangements for conditional discharge work reasonably well. There are normally between 35-40 patients subject to conditional discharge at any one time. Such patients can be subject to a range of conditions. Where conditional discharge is initiated by Ministers, there are standard conditions that the patient shall subject him or herself to the supervision of such persons as Ministers may approve; shall reside at an approved address; and shall conduct him or herself in a law abiding and orderly manner. Additional conditions may also be imposed as appropriate to the individual case, for example that the person avoid drugs and alcohol³⁰.
52. Supervision of conditionally discharged patients is normally the responsibility of psychiatrists and social workers, and sometimes also community psychiatric nurses. The Care Programme Approach may be employed to aid liaison between agencies. Initially, reports are provided to Ministers on a monthly basis. Should the patient's situation stabilise, this may be reduced to reports every three or, more rarely, six months. If, at any time, the patient's mental state should appear to deteriorate, Ministers may recall the patient to hospital.
53. One concern which has been identified is the apparent lack of a sanction, should a patient breach the conditions of discharge. It would seem that recall is only felt possible where there has been a deterioration in the patient's mental state so as to require detention in hospital and not because, for example, the patient is abusing alcohol or has committed offences. This may seem surprising, but reflects the ruling of the European Court in the case of *Winterwerp*³¹, that detention on the grounds of 'unsound mind' can only be justified where the person has a mental disorder of a nature or degree which justifies detention.
54. We asked in our second Consultation whether there was a case for conditional discharge operating in a manner closer to parole, and whether there should be a process for a formal review of conditional discharge where conditions are breached.
55. Many respondents, particularly from social work, supported the suggestion of a formal review. The State Hospitals Board expressed surprise that this was not currently a requirement and considered that this should be a role for the proposed new supervisory body.
56. However, the Royal College of Psychiatrists felt that a review, in the absence of sanctions, would serve little purpose. It was suggested that a specific offence of breaching conditions should be introduced to allow a court to determine any requirement for further sanctions.
57. Other suggestions were made. The Mental Welfare Commission said that conditions of discharge should be clear, should incorporate a care plan, and be grounded in a robust assessment of risk. The Commission also recommended that it be statutorily required to visit conditionally discharged patients. The British

30 The power to impose conditions is set out in s64(4) and s68(2) of the 1984 Act

31 *Winterwerp v the Netherlands*, 1979, EHRR 387

Association of Social Workers suggested new guidance from the Scottish Executive on the roles and responsibilities of health and local authorities regarding the supervision of this group.

58. We believe that there is a potential problem but it need not be insuperable. It should be borne in mind that any patient subject to conditional discharge must be assumed to have some degree of mental disorder; otherwise the patient would be entitled to absolute discharge. We understand that European case law allows some latitude to States in determining what degree of mental disorder justifies detention, and such detention can be justified by the need to protect others as well as the need for treatment.
59. It would seem therefore to be possible for a patient to be recalled on the basis of a continuing mental disorder together with evidence of increased risk to the public, on the basis of breach of conditions of discharge.
60. While we are not aware of any evidence of serious failures of co-ordination in relation to the management of conditionally discharged patients in Scotland, we feel that our suggestion of a formal review by the Restricted Patients Review Board where conditions are breached may be a useful additional safeguard, to provide additional reassurance to the public.
61. More generally we feel that, under our proposals the Risk Management Authority would be well placed to issue guidance and improve co-ordination between agencies in managing patients subject to conditional discharge.
62. On that basis, we are not convinced that the case for an offence of 'breach of conditions', as suggested by the Royal College of Psychiatrists, is made out. Such an offence would place people subject to a psychiatric disposal into the criminal justice system, which we do not think is desirable.

Recommendation 27.9

If satisfied that the criteria for compulsory care continue to be met, but that the patient does not currently require to be detained in hospital, the tribunal or Restricted Patients Review Board should be under a duty to grant a conditional discharge.

Recommendation 27.10

The Risk Management Authority should have responsibility for ensuring that adequate arrangements are in place in respect of patients subject to conditional discharge, on the basis of a risk management plan.

Recommendation 27.11

The Risk Management Authority should issue guidance on best practice in managing patients subject to conditional discharge.

Recommendation 27.12

Where a patient subject to conditional discharge breaches any of the conditions of discharge, there should be a review of the case by the Restricted Patients Review Board.

Recommendation 27.13

It should be possible to recall patients subject to conditional discharge to hospital on the grounds of continuing mental disorder and evidence of risk of harm to members of the public. Breaches of conditions of discharge could be considered as evidence of increased risk.

Recommendation 27.14

The Mental Welfare Commission should be required to visit patients subject to conditional discharge from time to time.

Delayed discharge after appeals

63. Currently, a sheriff can delay a conditional discharge until appropriate arrangements have been made for the ongoing care of the patient³². However, if the sheriff decides to grant an absolute discharge, there is no equivalent power to defer release. There is concern that this may not allow time for the relevant agencies to put in place arrangements for support or monitoring of the patient. The Mental Welfare Commission proposed, in their Report on the Care and Treatment of Noel Ruddle,³³ an interim procedure or delayed discharge after a successful appeal, which would allow the implementation of community care plans. We sought views on this in our second Consultation.
64. Relatively few respondents dealt with this point. Although there was some support for such a provision, concerns were expressed about its appropriateness in the light of ECHR. It was suggested that good practice would indicate the importance of anticipating a successful appeal and preparing suitable contingency plans.
65. We have sympathy with this point of view. Furthermore, s2 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 amended the legislation so that

³² 1984 Act, s64(7)

³³ *Report of the Inquiry into the Care and Treatment of Noel Ruddle* (Scottish Parliament SP Paper 98, Session 1 (2000) Recommendation 11

the patient does not fall to be released until the expiry of the 14-day appeal period, and is only released then if no appeal has been lodged. This would seem to deal with the concern raised by the Commission, and we believe that to allow a further period of delay would be an unacceptable infringement of the discharged patient's right to liberty. We therefore make no recommendation on this point.

Criteria for admission to the State Hospital

66. Although the State Hospital is often associated in the public mind with mentally disordered patients who have committed serious offences, by no means all of the Hospital's patients fall within this category. The Hospital's Health Improvement Programme shows that, in the period from 1/4/98 to 28/2/99, 26% of patients were admitted from other hospitals, while 43% were sent by the court, and 31% were transferred from prison. As at August 2000, we understand that nearly 40% of the population of the State Hospital were not subject to restriction orders or restriction directions.
67. The Criminal Procedure (Scotland) Act 1995 sets out the basis on which people sent by the Court should be admitted to the State Hospital, namely that the patient 'on account of his dangerous, violent or criminal propensities, requires treatment under conditions of special security, and cannot be suitably cared for in a hospital other than a State Hospital'³⁴. We understand that the State Hospital also operates more specific clinical criteria in determining whether admission in an individual case is appropriate.
68. It is possible, albeit rare, for patients detained under civil procedure to be admitted directly to the State Hospital. The more normal route is by transfer from another hospital. The 1984 Act does not specify directly any specific admission criteria for patients admitted to the State Hospital in these circumstances. However, when a patient is transferred to the State Hospital from another hospital, s29(4) provides a right of appeal to the sheriff. The sheriff must order the return of the patient unless satisfied that the criteria set out in the Criminal Procedure Act apply.
69. In our view, it would be better for the criteria to be set out directly in the Mental Health Act, rather than only to be applicable should the patient choose to appeal.
70. We had some concern that the current criteria were no longer appropriate. We took oral evidence on this point from the State Hospital Board and clinical staff, who did not feel that a change to the criteria was required. In particular, they commented that it would not be appropriate to make the criteria for admission to the State Hospital the same as that for the imposition of a restriction order³⁵, on the basis that many restricted patients were not in the State Hospital, and a significant number of patients in the State Hospital are not restricted patients.
71. Against that, a number of people commented on possible difficulties with the criteria in their responses to our first Consultation. Some local authorities

34 Criminal Procedure (Scotland) Act 1995, s58 (5). See also s59A (4) for hospital directions.

35 Under Criminal Procedure (Scotland) Act 1995, s59, a restriction order may be imposed:

'Where... it appears to the court-

(a) having regard to the nature of the offence with which he is charged;

(b) the antecedents of that person; and

(c) the risk that as a result of his mental disorder he would commit offences if set at large, that it is necessary for the protection of the public to do so'.

commented that the criteria might fall to be revised when the proposed network of medium secure facilities is in place.

72. The Law Society were concerned about the fact that 'dangerous propensities' was sometimes interpreted to include danger to self, meaning that some patients were transferred to the State Hospital when local services could not provide adequate protection against self harm. The Law Society felt that consideration should be given as to whether this was appropriate.
73. In oral evidence, the State Hospital confirmed that people were sometimes admitted when at risk of self-harm, particularly women. This was not encouraged by the Hospital, since the need is really for intensive rather than secure care, but there may be no safe alternative in some cases. Such patients were at risk of becoming entrapped in the State Hospital.
74. The most direct criticism of the current criteria came from the Royal College of Psychiatrists, who said that the term 'dangerous, violent or criminal propensities' was out of date and should be replaced. The essential aspect of any new criteria was that the nature of the patient's mental disorder rendered the patient such a high degree of risk to others that only high security care could ensure the safety of others.
75. We agree that the current terminology is not appropriate. A term such as 'dangerous, violent or criminal propensities' is not only highly stigmatising, but also categorises people in a way which is no longer consistent with clinical practice. It implies that the person is inherently dangerous, rather than requiring high security care at a particular time because of the need for treatment for a mental disorder. The phrase 'criminal propensities' is especially unfortunate, particularly when, as we point out above, a significant number of patients in the State Hospital have been transferred from other hospitals, rather than admitted on the basis of the conviction of a criminal offence.
76. We therefore propose that the statutory criteria should be replaced by criteria which are more consistent with clinical understanding, and other parts of the Mental Health Act.
77. We considered whether the criteria should specify that there must be a risk of serious harm to others, which would exclude people being admitted to the State Hospital on the basis of risk of self-harm. We have sympathy with the argument that patients who present such a high risk of self-harm that they cannot be safely managed in other settings should be in special units, rather than the State Hospital. We believe that, rather than admit such patients inappropriately to a high security establishment, appropriate services offering intensive support should be developed urgently.
78. Should this be done, we believe that the criteria for admission to the State Hospital could appropriately be narrowed. However, we would not wish in the meantime to make it impossible for a person who is at serious risk to be admitted to the State Hospital, if that is the best available option for the patient.

Recommendation 27.15

The Mental Health Act should set out specific criteria for admission to the State Hospital.

Recommendation 27.16

The criteria for admission to the State Hospital should be that the patient suffers from mental disorder of a nature or degree such that

- ♦ *he or she presents a significant risk of harm to self or others, and*
- ♦ *requires treatment under conditions of special security, and*
- ♦ *cannot be suitably cared for in a hospital other than a State Hospital.*

Recommendation 27.17

Urgent consideration should be given to the possible need for appropriate services offering intensive support to prisoners or patients at high risk of self harm, as an alternative to admission to the State Hospital.

Appeals against levels of security

79. Currently, a patient transferred from another hospital to the State Hospital has 28 days to appeal against the transfer³⁶. A person sent to the State Hospital by a court may also appeal against the order on the same basis as any other appeal against sentence³⁷.
80. The State Hospitals Board, in responding to our first Consultation, said that the time scale for appeal against transfer to the State Hospital should be extended from 28 days to 10 weeks. They pointed out that patients transferred to the State Hospital are usually in the throes of an acute mental illness, or have undergone a traumatic life event; and that either of these conditions reduces the ability to make informed decisions about the appropriateness or otherwise of their treatment and its setting.
81. We agree with the views of the State Hospital on this point, and recommend in Chapter 26 that the time limit for an appeal against a transfer direction (including one to the State Hospital) should be extended to 10 weeks. However, we feel that there is a broader issue of concern. It is likely that patients admitted to the State Hospital will meet the admission criteria at the time of transfer. The Hospital faces considerable pressure on resources, and is unlikely to admit patients needlessly. However, the aim of the Hospital is to provide effective treatment, so that patients

36 1984 Act, s29(4)

37 Criminal Procedure (Scotland) Act 1995, s60

may move on to conditions of lower security in due course. The problem is that the patient, should his or her condition improve, has no legal right to move to lower security. The current rights of appeal would only be relevant in the relatively unusual situation that the patient is able successfully to argue for absolute or conditional discharge.

82. We have received evidence from the State Hospital and the Mental Welfare Commission that there are significant numbers of 'entrapped patients'. These are patients who no longer require the level of security afforded by the State Hospital, but for whom appropriate local services are not available. The State Hospitals Board suggested that there is currently little incentive for local health boards and trusts to arrange secure psychiatric services. The local public is unlikely to welcome such services (indeed quite the reverse), and funding arrangements do not create incentives to develop such services. The Board strongly advocated that an explicit statutory duty be placed on health boards to commission local services to address the need for a range of medium and low security services for mentally disordered offenders.
83. We have considerable sympathy with the position of the State Hospital on this point. However, we have decided that, in terms of our core remit of reviewing the Mental Health (Scotland) Act 1984, it would be more appropriate for us to propose another means of addressing this problem, which is more directed at the rights of individual patients. This is that patients should have a continuing right to appeal against the level of security to which they are subjected.
84. It seems to us that to detain a patient unnecessarily in conditions of high security is inconsistent with respect for the patient's rights, and our general principle of *Least restrictive alternative*. Furthermore, the proposed development of medium secure units would seem to make it more likely that such an appeal right would be practicable.
85. We therefore proposed this in our second Consultation. There was general support for this proposal, including from bodies such as the Royal College of Psychiatrists, the Mental Welfare Commission, and the British Association of Social Workers. It was strongly welcomed by the State Hospital.
86. The question arises as to what should happen if the necessary arrangements are not put in place to provide care at a lower level of security. Clearly it would be undesirable that a patient who is still assessed as requiring some degree of secure care should simply be discharged. On the other hand, such a right of appeal is meaningless, unless it is capable of being upheld.
87. A number of suggestions were made as to how such an appeal right might be enforced. The Faculty of Advocates suggested that a failure by a health board to comply with directions following an appeal could amount to contempt of court. However, Greater Glasgow Health Board pointed out that there could be practical difficulties in developing appropriate provisions, which may be outwith the control of the health board.

88. A number of respondents suggested that the body hearing the appeal should be able to set a time limit for provision of the appropriate service. After this period, it should have the right to require health boards, or even Ministers, to appear before it to explain any ongoing failure to meet the needs of the patient.
89. We agree that a staged approach is appropriate. We therefore suggest that, should a patient successfully appeal to a tribunal against the level of security, it should set a time within which the necessary provision should be arranged by the responsible health board. The time limit might be of the order of three months. Should arrangements not be made at the expiry of that period, representatives of the health board should be required to appear before the tribunal to explain the position, and to confirm whether there is a prospect of a placement being found within a reasonable period. The tribunal should be able to extend the time limit for a further period of no more than three months. If, at the end of that period, no provision has been made, the tribunal could order that arrangements must be put in place to accommodate the patient within 14 days.
90. Of course, it would be our hope that such a process would rarely be required. The intention is that the existence of this right would help to ensure that a proper range of provision is in place.
91. Although the current concern relates to patients entrapped in the State Hospital, it is possible that the same difficulties could arise in future in respect of patients in medium secure services, who are not able to move to low security settings. We have addressed this in our recommendations.

Recommendation 27.18

The period during which a patient can appeal against transfer to the State Hospital should be extended from 28 days to 10 weeks.

Recommendation 27.19

Patients should have a right of appeal to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security.

Recommendation 27.20

The procedures and time limits for such appeals should be consistent with the rights of patients to appeal to a tribunal seeking absolute or conditional discharge, as set out in Recommendation 27.5.

Recommendation 27.21

Should the tribunal uphold such an appeal, it could order the relevant health board to make the necessary arrangements for the patient within a specified time, not exceeding three months.

Recommendation 27.22

Should the necessary arrangements not have been made by the end of the specified time, the tribunal would be entitled to require the health board to appear before it. The tribunal would have power to extend the time for arrangements to be made for a further period, not exceeding three months.

Recommendation 27.23

At the expiry of this further period, the tribunal would have the power to order that arrangements be made for the patient within 14 days.

Prisoners transferred to hospital with restriction directions

92. We discuss in Chapter 26 the procedure for transferring a prisoner to hospital, under a transfer direction. Under s72 of the 1984 Act, Ministers can add a restriction direction. This places the transferred prisoner under the same restrictions as a patient subject to a restriction order.
93. We have recommended earlier in this chapter that the responsibility for the management of restricted patients be transferred from Ministers to the Restricted Patients Review Board and the proposed Risk Management Authority. The question arises as to whether prisoners subject to restriction directions should also be subject to the same regime. There would seem to be a strong case for this, given that the Risk Management Authority's original operational role, as proposed by the MacLean Committee, is in respect of prisoners, as of course is the Parole Board's main function. This might also help to ensure co-ordination of risk management interventions between the time a prisoner spends in prison and time in hospital.
94. Against that, the role of the Parole Board in respect of prisoners and, under our proposals, restricted patients, is primarily concerned with issues of discharge into the community, and of management of risks to public safety. These considerations do not arise in the same way in respect of transfers between hospital and prison. Nevertheless, we believe that the balance of the argument supports a consistent approach to offenders in hospital subject to special restrictions, whether by way

of a restriction order or a restriction direction. We therefore propose that the Restricted Patients Review Board and the Risk Management Authority should take responsibility for the management of patients subject to restriction directions, and decisions concerning their return to prison.

Recommendation 27.24

The Restricted Patients Review Board and the Risk Management Authority should take over from Scottish Ministers the oversight of prisoners made subject to restriction directions.

CHAPTER 28

THE MENTAL HEALTH (PUBLIC SAFETY AND APPEALS) (SCOTLAND) ACT 1999

Introduction

1. In August 1999, Noel Ruddle successfully appealed under s64 of the 1984 Act for his absolute discharge from the State Hospital, on the basis that he did not meet the criteria for continued detention under the Mental Health (Scotland) Act.
2. Mr Ruddle had been convicted in 1992 of culpable homicide, with a diagnosis of paranoid schizophrenia, and received a hospital order with restrictions. The diagnosis was subsequently revised, and at the time of the appeal, it was accepted that the only mental disorder from which he suffered was a personality disorder, falling within the legal category of a persistent mental disorder manifested only by abnormally aggressive and seriously irresponsible conduct. Under s17 of the 1984 Act, a person can only be detained with such a disorder if treatment is likely to alleviate or prevent a deterioration in his condition (the so called 'treatability test', discussed in Chapter 5). The House of Lords ruled in the case of *Reid*³⁸ that the same test must be applied in considering whether a patient, at the time of appeal, could continue to be detained.
3. The sheriff in the *Ruddle* case held that Mr Ruddle was not receiving treatment which was likely to alleviate or prevent deterioration in his condition and was not likely to receive such treatment. His detention did not meet the treatability test and he was therefore entitled to be discharged. The question of whether he presented a risk to public safety was immaterial, since detention was only lawful if all the relevant criteria, including the treatability test, were satisfied.
4. This case generated considerable publicity. Following it, the Scottish Executive passed emergency legislation: the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

The provisions of the 1999 Act

5. Most significantly, the Act introduced a new "public safety" test, which requires to be satisfied before a sheriff or Scottish Ministers may discharge a restricted patient. Where the sheriff or Ministers are satisfied that the patient is 'suffering from a mental disorder, the effect of which is such that it is necessary, in order to protect the public from serious harm, that the person continues to be detained in a hospital, whether for medical treatment or not'³⁹, then the patient may not be discharged.

38 *R v Secretary of State for Scotland* 1999 SLT 279

39 Mental Health (Public Safety and Appeals) (Scotland) Act 1999, s1

6. This test is paramount in all cases concerning restricted patients, superseding questions as to whether the patient would benefit from medical treatment. It is only if the patient does not fall foul of the public safety test that the sheriff or Ministers go on to address whether the normal criteria for detention of 'appropriateness', 'necessity' and (where applicable) 'treatability' are met.
7. The Act also introduced a new right of appeal from decisions of the sheriff in relation to restricted patients. This allows both the patient and Scottish Ministers to appeal to the Court of Session on issues of both fact and law, with a further appeal to the House of Lords.
8. Finally, the Act amended the definition of mental illness in s1 of the 1984 Act to include 'personality disorder', placing beyond doubt the question of whether it was lawful to continue to detain people with a primary diagnosis of personality disorder, rather than a mental illness (as it is normally understood) or learning disability.
9. The amendment to the definition of 'mental disorder' is extremely wide in its effect, applying as it does to the 1984 Act in general. In as much as it changes the scope of the Act, this affects the provisions for detention under civil procedure as well as criminal disposals. However, the Scottish Executive stated during the debates on the legislation that it was not its intention to broaden the range of people who might in future be admitted compulsorily to hospital⁴⁰.

Our initial response to the legislation

10. At the time of the legislation, we expressed our concern that the Bill could have undesirable consequences. We wrote to the Justice Minister, stating our view that the scope of the legislation seemed to go beyond a limited response to the particular case, and elevated a necessary regard for public safety above matters of treatment and appropriate care. We felt that this approach was damaging to the way in which society deals with mental health problems, and did nothing to correct the emphasis in public debate on false and misleading stereotypes of 'dangerous psychopaths'. We continue to have these concerns.
11. During the debates on the Bill, the Scottish Executive stressed that it was intended as an interim measure, pending consideration of the reports of this Committee and the MacLean Committee.
12. In our second Consultation⁴¹, we set out some preliminary views on the legislation. We accepted that public safety was an important consideration in decisions regarding the discharge of mentally disordered persons who have offended, but took the view that the aim of mental health services, including forensic services, should be to offer treatment, and not preventive detention. In general, detention on the basis of risk alone should be a matter for criminal law rather than mental health law. Improved assessment procedures, and better use of options such as interim hospital orders and hospital directions, would reduce

40 Scottish Parliament Official Report Vol.2 no.3, (8 September 1999) Iain Gray MSP at columns 247-8.

41 Paragraph 13.46

the risk of high risk offenders being inappropriately made subject to hospital orders.

13. Support for our approach was widespread, including from the Faculty of Advocates, the Scottish Association of Mental Health, the Law Society of Scotland, the State Hospitals Board, and the Royal College of Psychiatrists. In expressing its support, the Scottish Association for Mental Health, amongst others, emphasised its wish that the 1999 Act should be repealed, following consideration of the reports of this Committee and the MacLean Committee.

Who does the Act affect?

14. Against that background, we go on to consider the 1999 Act, particularly the public safety test, in the context of our wider proposals. The first point which arises is who is affected by the Act?
15. The concern which prompted the legislation appears to have been the suggestion that a small number of patients at the State Hospital, who had in the past committed very serious offences, might be released in the wake of the *Ruddle* decision. However the new 'public safety' test applies more widely. It extends to:
 - ♦ patients subject to a hospital order with restrictions
 - ♦ patients who are transferred prisoners with an accompanying restriction direction
 - ♦ patients subject to hospital directions.
16. The test is not confined to patients in the State Hospital but applies to restricted patients in any setting. As we point out in Chapter 27, many restricted patients are not in the State Hospital. Nor is the test restricted to patients with personality disorder. It applies equally to patients with mental illness or learning disability.
17. However, all the patients concerned have this in common: at admission to hospital they were deemed to have met the criteria for detention under the Mental Health Act. In the cases of mental impairment and 'persistent mental disorder manifested only by abnormally aggressive or seriously irresponsible conduct', the criteria included a 'treatability' requirement.

The public safety test

18. The fundamental question is whether it should be the mental health system or the criminal justice system which should deal with offenders who present a risk to public safety, but who would not benefit from treatment delivered under compulsion. In our view, where a person who has offended requires treatment in hospital in order to reduce the risk he or she presents to the public, such treatment should be provided. However, where treatment is not indicated, it should be the criminal justice system which ensures public safety.

19. It is also important that the criminal justice system should seek to make the right disposal at the time of sentencing, after full assessment.
20. So far as the Mental Health Act is concerned we have dealt with our proposed new grounds for compulsion in Chapter 5. In summary, these are
 - ♦ the presence of mental disorder
 - ♦ impaired judgement
 - ♦ risk, including, where appropriate, risk to others, and
 - ♦ likely benefit from treatment.
21. The 'benefit' test is linked to the individual circumstances of the patient and the proposed plan of care, and 'treatment' is broadly defined. The test would supersede the 'treatability' test for personality disorder and mental impairment, and would apply, on admission, to all restricted patients in future. Convicted offenders who did not meet the test would receive a penal disposal.
22. On risk, the presence of 'a significant risk of harm to other persons' is one of the factors we propose in Chapter 5, which may, alongside the other relevant criteria, justify compulsion under the Mental Health Act.
23. We make recommendations in Chapter 26 which are designed to ensure that psychiatrists considering the recommendation of a hospital order with restrictions always consider the possibility of an interim hospital order, to allow time for a full assessment of the offender's mental condition. We also recommend clarification of the circumstances when a hospital direction may be appropriate. The greater use of interim hospital orders, and in appropriate cases, hospital directions, should help avoid a recurrence of the situation which apparently arose in the Ruddle case: an offender being given a mental health disposal, on the basis of a diagnosis which changed, with no mechanism to transfer the offender to a penal setting. Our recommendations on these points are consistent with those of the MacLean Committee.
24. In the case of personality disorder, which is commonly considered to have particular implications for public safety, we have set out our view in Chapter 26 that a hospital order should not normally be considered suitable for offenders with a primary diagnosis of personality disorder, but that, in appropriate cases, a hospital direction should be used. (See Chapter 26 paragraphs 16-19).
25. We should also point out that, in any case, very few patients with a primary diagnosis of personality disorder are detained under the Mental Health Act at the moment and we would expect that to continue to be the case.
26. The Order for Lifelong Restriction, which the MacLean Committee recommends, would be available for those offenders, including those with mental disorders, who are found to present a continuing risk to public safety. Although it is likely only to apply to a small group, the Order is intended, *inter alia*, for the kind of high risk

mentally disordered offender against whom the 1999 Act is apparently directed (notwithstanding that it is in fact wider in its effect).

27. The MacLean Committee has also recommended the creation of a Risk Management Authority (RMA). The RMA would have a function of promoting best practice in risk assessment and risk management. On the issue of responsibility for restricted patients, we have recommended in Chapter 27 that this be vested in a Restricted Patients Review Board, with day to day management issues delegated to the proposed RMA. We believe that this will improve public safety, in helping to ensure that disposals of mentally disordered offenders are based on as robust an assessment of the risk presented by an offender, and the possible treatment needs, as is achievable.
28. We believe that taken as a whole the recommendations of this report, and of the MacLean Committee, provide a framework under which the aim of maintaining the integrity of the mental health system, while providing appropriate protection for public safety, can be achieved.
29. That being so, and in the light of what we have said above, we believe that there is no need for the 'public safety' test, which should be abolished.

Recommendation 28.1

The 'public safety' test provided under s1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should be abolished.

Entry and exit criteria

30. In all of the above, we have assumed that the 'entry' and 'exit' criteria for detention should be the same. In other words, the justification for continuing to detain a patient should reflect the basis on which detention was initiated. This is an important principle which we have emphasised throughout our report: no-one should be detained if they no longer meet the grounds for detention. We wish to maintain this principle in respect of restricted patients. The effect of the public safety test in the 1999 Act is that some restricted patients may be required to remain in hospital when they no longer meet the criteria for admission to hospital.
31. In the case of *Anderson*⁴² the Court of Session did not accept the argument that the fact that the criteria for discharge were different from the criteria for admission necessarily constituted a breach of the European Convention on Human Rights. Be that as it may, we note that European case law, particularly the leading cases of *Winterwerp*⁴³, and *X v UK*,⁴⁴ supports the view that the purpose of review is generally to ensure that the circumstances which justified the initial detention continue to obtain.

42 *Anderson, Doherty and Reid v The Scottish Ministers and the Advocate General for Scotland*, Court of Session 16 June 2000

43 *Winterwerp v the Netherlands*, 1972 2 EHRR 387

44 *X v UK*, 1981 4 EHRR 188

32. Where this is not the case, there is the potential for the role of the hospital to change from therapeutic intervention to containment. This is inconsistent with the approach adopted by psychiatrists in Scotland over many years, and with our principle of *Benefit*, which is one of our recommended criteria for compulsory measures.

Recommendation 28.2

For patients subject to mental health disposals under a new Mental Health Act, including restricted patients, the grounds for discharge from the mental health disposal should be the same as the grounds for admission.

The 1999 Act and prisoners

33. As we have said, the 1999 Act applies not only to patients seeking discharge into the community, but also to prisoners who have been transferred to hospital with a restriction direction, and those subject to hospital directions. The effect of the Act on this group appears to be particularly perverse.
34. The criteria under which a transferred prisoner should be returned from hospital to prison are set out in s71A and s74 of the 1984 Act. Essentially, they provide that a prisoner should be returned to prison when Ministers are satisfied that the person does not meet the criteria for detention under the 1984 Act. However, s1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 provides that a prisoner subject to a restriction direction cannot be returned to prison from hospital when Ministers are satisfied that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in hospital.
35. The implication of this provision is that there may be prisoners who can be more safely managed in the hospital than in prison, even although they are not 'treatable' or otherwise detainable under the normal Mental Health Act criteria. This implication was criticised in the MacLean Committee's Report⁴⁵. The report argued that prisoners should only be detained in health care settings where treatment was appropriate. If this was not the case, and the only issue was how safely to manage the prisoner, that should be a matter for the Scottish Prison Service.
36. We are in agreement with the MacLean Committee on this point. The justification for a prisoner remaining in hospital should be the need for treatment. Where a prisoner no longer requires treatment for a mental disorder, Ministers should make the necessary arrangements for transfer to prison. Of course, these decisions must be taken with sensitivity to recognise the needs of those whose mental state may be variable.

⁴⁵ *Report of the Committee on Serious Violent and Sexual Offenders* (Scottish Executive SE/2000/68), paragraph 7.15 and recommendation 28

Recommendation 28.3

Sections 74(1A) and 74(1B) of the Mental Health (Scotland) Act inserted by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should be repealed.

Other provisions of the 1999 Act

37. We have no difficulty with the new appeal rights in relation to decisions concerning restricted patients. We recommend at Chapter 9 that these be retained under our proposals.
38. The definition of mental disorder is discussed in Chapter 4, including the question of personality disorder. We recommend there that personality disorder should be a separate category of mental disorder, and that its inclusion within the definition of mental illness should be removed.

Those a new Act will not cover

39. Overall, the recommendations we make are intended to supersede the provisions of the 1999 Act, which will then become unnecessary. However, there may be a transitional problem. It appears that there may be a very few patients already subject to hospital orders with restrictions under the current, or even earlier, Mental Health Acts who may present a risk to the public, are not treatable, and cannot lawfully be transferred to prison. Such people might not meet the criteria for continuing detention under our new proposals. We do not know the number of such patients, but it would seem that it may be very few.
40. We note that the MacLean Committee considered this group, and did not feel there was any recommendation they could make which would alter the existing situation for such patients⁴⁶. We have the same difficulty. We considered whether it would be desirable to revert to the assumed position prior to the *Reid* case⁴⁷, that 'treatability' would be a criteria for admission to hospital, but lack of treatability would not be a ground for discharge. However, as we have already indicated, we do not believe that the treatability test, as currently set out, should remain. Also, such a proposal would be subject to similar objections to the 'public safety' test, in that it would result in patients being detained who no longer meet the criteria for hospital admission, effectively for preventive detention rather than treatment.
41. Our proposals regarding the Restricted Patients Review Board and Risk Management Authority would apply to this group. This should, at the least, ensure that there is a full assessment of whether there is, in fact, a serious risk to public safety in individual cases, with a mechanism to consider the most appropriate ways to manage and, if possible, reduce the risk.

⁴⁶ Maclean Report Paragraph 12.3

⁴⁷ *R v Canons Park Mental Health Review Tribunal*, ex parte A, [1995] QB60

42. Nevertheless, that would not resolve the basic question of whether such patients should continue to be detained, in the absence of any other feasible option, under provisions similar to those in the 1999 Act. Ultimately, we have concluded that it is a matter for the Scottish Executive and Parliament to consider whether there is a need for some form of transitional provision which would retain the effect of the 1999 Act for this very limited group of high risk patients admitted to hospital prior to the introduction of reformed legislation. If such a transitional provision were to be introduced, we would recommend that it should be tightly drawn so as to ensure that its effect did not reach beyond this very limited group.
43. There is however one improvement we can recommend. The terms of the 1999 Act mean that it is difficult for patients who do not meet the public safety test to progress to conditions of lower security. This is because, under the legislation as it stands at the moment, it is not possible to grant conditional discharge to a patient who is not treatable. Therefore, patients whose only ground for continuing detention is the public safety test have no mechanism under which they can be tested out in conditions of lesser security, in order to establish that a possible discharge may be appropriate. We believe that the possibility of conditional, as well as absolute discharge should be available for all patients, where this is justified by risk assessment and the plan of care.

Recommendation 28.4

If the Scottish Executive and Parliament judge it to be necessary to retain any of the provisions of section 1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 as a transitional measure to deal with the very limited group of patients detained under the current mental health law who present a high risk to public safety and who would not be detainable under the new Act, the transitional provisions should be drawn in such terms as to ensure that their effect does not reach beyond this group.

Recommendation 28.5

Should the provisions of s1 of the Mental Health (Public Safety and Appeals) Act 1999 be retained in respect of any group of patients, they should be amended to allow such patients to benefit from the possibility of conditional discharge.

CHAPTER 29

INSANITY AND DIMINISHED RESPONSIBILITY

Background

1. The criminal law contains provisions which allow some people with mental disorders to be treated as not fully responsible for their actions: the plea of insanity in bar of trial (or 'unfitness to plead'), the special defence of insanity and, in charges of murder, the plea of diminished responsibility. These are essentially common law provisions, and are not dealt with directly in the Mental Health Act itself. We have given consideration to them, nevertheless, for two reasons. Firstly, the result of a finding of insanity or diminished responsibility is generally that the individual will be detained in hospital under the provisions of the Mental Health Act. Secondly, our consultations suggest a degree of dissatisfaction with the way in which these provisions operate.

Insanity in bar of trial

2. It is fundamental to our system of criminal justice that an accused person must be able to understand and participate in his or her trial. Accordingly, if a person is found to be mentally disordered to such a nature or degree that they cannot understand the trial process or instruct their own defence, no trial can proceed. The person is said to be 'insane in bar of trial' or 'unfit to plead'.

Definition of insanity in bar of trial

3. Insanity is held to operate as a bar to a trial if it 'prevents a man from doing what a truly sane man would do and is entitled to do-maintain in sober sanity his plea of innocence, and instruct those who defend him as a truly sane man would do'⁴⁸. It is possible to be unfit to plead in regard to the particular subject matter of the case, even if sane in ordinary matters⁴⁹. This could presumably apply to a person with mental illness. It appears to be possible to be insane in bar of trial if suffering from a degree of learning disability which would prevent participation in the trial process⁵⁰, although, as we discuss below, there is still doubt as to the law in relation to this. In rare cases, physical disability, such as being mute, might suffice.
4. The most commonly accepted definition of the plea is set out in the case of *Wilson*⁵¹, that it requires:

'a mental alienation of some kind which prevents the accused giving the instruction which a sane man would give for his defence or from following the evidence as a sane man would follow it and instructing his counsel as the case goes, along any point that arises'.

48 Per Lord Justice General Dunedin in *HM Advocate v. Brown* (1907) 5 Adam 312 at p343

49 *HM Advocate v. Sharp* 1927 J.C.66

50 *HM Advocate v. Stewart* 1997 S.C.C.R. 330

51 *HM Advocate v. Wilson* 1942 J.C.75 per Lord Wark at 79

Establishing insanity in bar of trial

5. Before finding an accused person to be insane in bar of trial, the court must have the written or oral evidence of two medical practitioners⁵². It is however, for the court to make the decision, and it is not bound to accept the medical opinion. Research on behalf of the Scottish Office (summarised at Annex 10), established that there were 40 cases involving a plea in bar of trial in the period from 1 April 1996 to August 1998⁵³. The accused was found unfit to plead in 32 of these cases.
6. Under the procedures introduced by the Criminal Procedure (Scotland) Act 1995, a finding of insanity in bar of trial means that a criminal trial cannot proceed. Instead, an 'examination of facts' is held.

The examination of facts

7. The examination of facts (EOF) was introduced to deal with a perceived defect in the legislation prior to 1995: that a finding of insanity in bar of trial automatically led to a hospital disposal, without evidence having been led to establish that the accused person actually committed the wrongful act which formed the basis of the charge.
8. An examination of facts is conducted, as nearly as possible, according to the normal procedures which apply at a criminal trial, although it does not involve a jury⁵⁴. The accused person must be legally represented.
9. The court has to determine whether it is satisfied beyond reasonable doubt that the accused person did the act or made the omission constituting the offence specified in the charge, and, on the balance of probabilities, that there are no grounds for an acquittal. When the court is so satisfied, it makes a finding to that effect. If not so satisfied, the accused person must be acquitted.
10. If acquitted (on either ground), the criminal proceedings come to an end. The accused person cannot be retried, and any detention on mental health grounds would have to be under separate civil detention proceedings. (We discuss the situation of people who might be acquitted but felt to require civil detention in Chapter 25.)
11. There are special provisions where the EOF acquits the accused on the ground that the person was insane at the time of doing the act or making the omission: in other words, where it is found that the accused was insane at the time of the crime, as well as at the time of trial. These are discussed below.
12. If the EOF finds that the accused did the act or made the omission charged, and there are no grounds for acquittal, the accused person will again be liable to one of the range of disposals which can be imposed following a finding of insanity.
13. The research found a total of 30 EOFs during the research period. The facts were held to be established in 22 cases; in three cases the facts were held to be

52 Criminal Procedure (Scotland) Act 1995 s54

53 Burman M. and Connolly C, 1999 *Mentally Disordered Offenders and Criminal Proceedings: The Operation of s54 of the Criminal Procedure (Scotland) Act 1995*; (Stationery Office), Chapter 3

54 Criminal Procedure (Scotland) Act 1995 s55 (6)

established but the accused was found to be insane at the time of the offence, and in five cases the facts were held not to be established.

14. A mental health disposal following an examination of facts is not a 'sentence' for the crime. Arrangements can be made for criminal proceedings to be resumed at a later date, should the accused then be fit to stand trial. It is also possible for people found insane in bar of trial prior to the introduction of the examination of facts in 1995 to be brought to trial on recovery.
15. We understand that it is uncommon for an individual who has been found insane in bar of trial to be retried. However, in respect of restricted patients, the Crown does receive information about progress from time to time, as part of ongoing consideration of whether a new trial would be in the public interest.

Insanity as a special defence

16. The special defence of insanity serves to excuse an accused person from criminal responsibility for his or her actions. The defence can be raised either during an ordinary trial or an examination of facts. If established, it results in an acquittal, but the accused person is still potentially subject to a range of disposals, which we discuss below.
17. The definition of insanity in relation to the special defence is different to the definition in relation to a plea in bar of trial. The test was laid down in the case of *Kidd*⁵⁵, as follows:

‘There must have been an alienation of the reason in relation to the act committed. There must have been some mental defect...by which his reason was overpowered, and he was thereby rendered incapable of exerting his reason to control his conduct and reactions’.
18. The question of insanity is decided by the jury (or the judge in summary cases), in the light of evidence. It is necessary to have regard to medical evidence, but this is not taken as being conclusive. However, it is necessary for there to be a clinically recognised mental disorder before a plea of insanity can be sustained⁵⁶.
19. The test is different from the test in England and Wales, where the so-called *McNaghten* rules apply⁵⁷. Broadly speaking, the English rules require that the person must have been suffering from a disease of the mind with the result that he or she did not know the nature or the quality of the act or, did not know that it was wrong. The effect of the difference is that the Scottish courts consider broader questions as to the severity and effect of a mental illness on reasoning generally, while the English courts focus more narrowly on questions of cognition.
20. In the period April 1996 to August 1998 covered by the research, 15 cases involved an insanity defence, and the plea was upheld in 12 of these.

55 *HM Advocate v. Kidd* 1960 J.C. 61, per Lord Strachan at p70

56 *HM Advocate v Connolly* 1990 S.C.C.R. 505

57 *McNaghten's case*, (1843) [1843-1869] All E.R. Reprints p229

Disposals following a finding of insanity

21. Until 1995, anyone found insane in bar of trial, or insane at the time of the offence, automatically received a hospital order, usually combined with a restriction order. This was criticised as being too inflexible, particularly if the person's mental condition by the time of trial no longer justified detention in hospital. Except in the case of murder, the court can now make the following disposals:
 - ♦ hospital order
 - ♦ hospital order with restrictions
 - ♦ guardianship under the 1984 Act (from April 2002 the Adults with Incapacity (Scotland) Act 2000)
 - ♦ supervision and treatment order
 - ♦ no order.
22. The supervision and treatment order is unique to cases where there has been a finding of insanity. It requires the person to reside in the community under the supervision of a social worker and submit to treatment by or under a registered medical practitioner. The maximum period of the order is three years⁵⁸.
23. There are special rules where the charge is one of murder. If insanity is established, the court must impose a hospital order and restriction order without limit of time⁵⁹.
24. During the period covered by the research, hospital orders were imposed in 26 cases (nine with restriction orders attached), supervision and treatment orders in five cases, a guardianship order in one case, and no order in three cases.

Concerns regarding the insanity provisions

Lack of clinical meaning

25. There is widespread unhappiness with the notion of 'insanity'. This is no longer, if it ever was, a clinically meaningful term, and is not one which mental health professionals would use in any other context.
26. The Scottish Association for Mental Health (SAMH) and the Law Society, amongst others, pointed out that the term 'insanity' is stigmatising and conjures up unhelpful and inaccurate images of mental disorder. The Law Society suggested a term such as 'not responsible by reason of mental disorder' as a more appropriate alternative. However, the problems are deeper than the name of the plea. The Royal College of Psychiatrists described the current definitions as 'outmoded and clinically incomprehensible'.

Difficulties with the legal meaning

27. The research showed a considerable degree of confusion about the way in which the clinical assessment by a psychiatrist should relate to the particular legal tests.

58 Criminal Procedure (Scotland) Act 1995, Schedule 4

59 Criminal Procedure (Scotland) Act 1995, s57(3)

28. The problems with the definition of insanity, both in relation to the special defence, and the plea in bar of trial, are long standing. The Butler Committee, in 1975, reviewed the definition of insanity in England and Wales, and concluded that it should be reformed⁶⁰, but this had not been taken forward. In their response to our first Consultation, the Royal College of Psychiatrists suggested that the Butler recommendations be adopted, namely that the insanity defence be replaced by a finding that the accused is not guilty on evidence of serious mental disorder, with there being a definition of what is meant by serious mental disorder.
29. In approximately a third of the cases concerning a plea of insanity in bar of trial reviewed during the research there were problems concerning the interpretation of the legal tests determining fitness to plead⁶¹. This is not surprising, since the case law appears to give little guidance as to the degree of mental disorder which amounts to unfitness to plead.
30. There appeared to be particular confusion in relation to mental impairment or learning disability, and the researchers noted that 'there was never any real consensus from legal or medical personnel on mental impairment as a reason for unfitness to plead'⁶².

Role of psychologists

31. In evidence to us, the British Psychological Society expressed strong concern about the lack of a formal role for psychologists in determining insanity, particularly in relation to people with learning disabilities. They pointed out that such a case essentially turns on the person's cognitive understanding, and that the assessment of such understanding lay within the competence of psychologists rather than psychiatrists. Although it is not uncommon for psychologists to give evidence, there is no requirement in the legislation that this be done. There is a requirement to have evidence from two psychiatrists, even where a psychiatrist may not be in a position to give the best evidence as to the person's fitness to plead. This point was also highlighted in the research⁶³. In Chapter 26 we recommend that for any mental health disposal in a criminal case, the court should be entitled to take additional evidence from a clinical psychologist. Such evidence might be particularly appropriate in considering the question of fitness to plead.

Practical problems

32. Notwithstanding the problems regarding the way in which insanity is defined and established, the research found general approval of the changes introduced in 1995 for dealing with people found insane. This was also reflected in the evidence submitted to us.
33. We note however some practical problems identified in the research⁶⁴. The researchers comment on problems of delay, including delay in securing legal aid for specialist reports, and in cases coming to court. They also comment that some accused persons had been held for substantial periods of time on remand,

60 *Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244

61 Burman, M. and Connolly, C. (1999) *Mentally Disordered Offenders and Criminal Proceedings: The operation of s54 of the Criminal Procedure (Scotland) Act 1995* (Stationery Office) Chapter 3, part 5

62 Burman and Connolly, Chapter 3, part 6

63 Burman and Connolly, Chapter 3, part 7

64 Burman and Connolly, Chapter 7

with the result being that their mental state deteriorated and they became unfit to plead.

34. There appears to be a particular problem with people with mental impairments, who may not be assessed as suitable for hospital admission pending the determination of the case. Such people would be vulnerable in prison, but may re-offend in the community, and there appear to be difficulties in identifying suitable secure placements while on remand.
35. Although the idea of an examination of facts attracted general support, there was concern that the outcome of an EOF could prejudice a subsequent trial, should the accused recover. There were also difficulties with the trials of co-accused persons running alongside EOFs.
36. In one case, the accused was excused from being present at an EOF, and then acquitted because witnesses were unable to identify him in his absence.
37. So far as we are aware, no action is in train to address any of these perceived problems.

Recommendation 29.1

The Scottish Executive should consider reforms to the procedures for persons who plead insanity, or are found insane, to address the practical difficulties identified in the research into Mentally Disordered Offenders and Criminal Proceedings.

38. There were concerns expressed to us about supervision and treatment orders. It was felt by some people that the lack of sanctions should a person breach a supervision and treatment order, for example by failing to take medication, meant that such orders were of limited value. The research found one case where no action was taken under a supervision and treatment order and the person disappeared.

Insanity in murder cases

39. We were particularly concerned about the implications of the special defence of insanity in relation to a person charged with murder. Unlike in the case of any other offence, such a person must receive a hospital order with restrictions. This seems to us to be a potentially arbitrary outcome. It is possible that the accused person may have partially or wholly recovered from the mental disorder from which he or she was suffering at the time of the offence. A hospital order may be inappropriate, since the person may not require hospital treatment. Indeed, he or she may be able quickly to appeal against the continuance of the order and be discharged.

40. However, while releasing the individual may be acceptable in cases where the mental disorder is unlikely to recur, there may be cases where the individual continues to present a degree of risk, and it would seem wrong that such a person, who has committed a homicide, should be released into the community without supervision.
41. The arbitrariness is emphasised when one considers that a person whose mental disorder at the time of the crime was slightly less severe might be convicted of culpable homicide on the grounds of diminished responsibility, and be eligible for a broader range of disposals, even although the risk and treatment needs in each case may be very similar.
42. A person found insane in bar of trial on a charge of murder is also subject to a compulsory disposal of a hospital order with restrictions. This presents less of a difficulty since the finding implies the presence, at the time of trial, of a severe mental disorder.

Conclusions as to insanity

43. We were satisfied that the criticisms of the definition of insanity, both in relation to the special defence, and as a plea in bar of trial, carried considerable weight. It seems to us wrong that such an important issue as determining the responsibility of an individual for a serious criminal charge should depend on terms and definitions which are largely meaningless to those with the responsibility of giving expert evidence to the court.
44. However, it is clear that reform is not a simple matter. A change in the definition might throw into doubt the effect of existing caselaw, notwithstanding the difficulties psychiatrists have with the current terms. Any new definition would still require medical evidence to be assessed against legal criteria. The question of when mental disorder ceases to make a person responsible for their actions is one of considerable philosophical and practical complexity.
45. In our second Consultation, we proposed that an independent review of the law relating to insanity and diminished responsibility (which we discuss below) be established. This attracted widespread support. However, an alternative approach would be for the matter to be considered by the Scottish Law Commission, who have considerable experience and expertise in reviewing such complex areas of the law.
46. In the meantime, we are persuaded that the requirement that evidence as to insanity be given by doctors is too narrow. In some cases, we agree that psychologists would have an equally valid contribution to make, and we feel there is a strong case that the legislation should recognise this. This would be one issue which should fall to be considered as part of the overall review.
47. In respect of supervision and treatment orders, we believe that the powers of enforcement should be strengthened. It should be possible to stipulate that the

supervised person be required to accept particular treatments, or other interventions designed to reduce or manage risk. Should the person fail to comply, it should be possible in appropriate cases to admit the person to hospital for compulsory treatment, in the same manner as we envisage for community orders.

48. Indeed, if our proposals for community orders are accepted, such orders could be made equally to apply to those receiving a mental health disposal in relation to a criminal case, and could include a wide range of measures designed to ensure the mentally disordered person receives appropriate care and supervision.
49. In relation to people charged with murder, who are acquitted by reason of insanity, we proposed in our second Consultation that such offenders should be eligible for the same range of disposals as other people found insane. Responses were generally in support of this change, although the Royal College of Psychiatrists argued that the legislation in 1995 was based on a view that charges of murder required special treatment, and there was little reason to change this view.
50. We are still of the view that more flexibility should be introduced into the disposal, although we are conscious that this should not be at the expense of public safety. The MacLean Committee argued that the issue of risk should be an important factor in disposing of people found insane under solemn procedure, and recommended a change in the law to allow the court to make an interim hospital order for such people⁶⁵. This would allow both the risk presented by the individual and any appropriate treatment and management strategies to be fully assessed. We endorse this recommendation.

Recommendation 29.2

The Scottish Law Commission should be invited to review the special defence of insanity, and insanity in bar of trial.

Recommendation 29.3

As part of this review, the Scottish Law Commission should consider whether section 54 of the Criminal Procedure (Scotland) Act should be amended to allow evidence as to fitness to plead to be given by chartered clinical psychologists as well as by psychiatrists.

Recommendation 29.4

Supervision and treatment orders should be amended to allow compulsory treatment and other interventions, as specified in the order, with procedures for admission to hospital in appropriate cases in the event of non-compliance.

⁶⁵ Report of the Committee on Serious Violent and Sexual Offenders, (Scottish Executive SE/2000/68) paras 7.21-7.23 and recommendation 32

Recommendation 29.5

The range of disposals available to a court in relation to a person charged with murder and acquitted by reason of insanity should be the same as for persons charged with other offences who are acquitted on that basis.

Diminished responsibility

51. Diminished responsibility is a plea which can only be made in murder cases. If successful, it reduces what would otherwise be a conviction for murder to one of culpable homicide. The practical effect of this is that the convicted person is not bound to receive a life sentence, but can be sentenced to a range of disposals, including a discretionary life sentence, a determinate sentence, or a mental health disposal such as a hospital order.
52. The basis of a plea of diminished responsibility is that, at the time of the crime, the accused had some degree of mental disorder which was not sufficient to absolve him or her totally of culpability, but to some extent reduces his or her responsibility for the crime. It developed as a common law doctrine in Scotland, and was later introduced in England on a statutory basis by the Homicide Act 1957.
53. The classic exposition of the defence was set out by Lord Alness in the case of *Savage*⁶⁶, that:

‘there must be aberration or weakness of mind; that there must be some form of mental unsoundness; that there must be a state of mind which is bordering on, though not amounting to insanity; that there must be a mind so affected that responsibility is diminished from full responsibility to partial responsibility...and I think that there must be some form of mental disease’.
54. Subsequent cases have established that intoxication⁶⁷, psychopathy⁶⁸, or a combination of immaturity and personality difficulty⁶⁹ would not be sufficient to establish diminished responsibility in the absence of a specific mental illness. It seems that learning disability might be sufficient to constitute diminished responsibility, although some cases seem to imply that a mental illness is necessary⁷⁰. There are differences from the caselaw in England and Wales where, for example, personality disorder appears to be a possible foundation for diminished responsibility⁷¹.
55. The main practical criticism directed at the defence of diminished responsibility is that the definition is obscure, and difficult to apply in individual cases. If it is hard to know what ‘insanity’ now means, it is equally problematic to state with confidence what is a state of mind ‘bordering on insanity’. Even if the border can be found, how wide is it, and when can it be said that responsibility is reduced particularly as a result of a mental disorder?

66 *HM Advocate v. Savage* 1923 J.C. 49 at p51

67 *Brennan v. HM Advocate* 1977 J.C. 38

68 *HM Advocate v. Carraher* 1946 J.C. 109

69 *HM Advocate v. Connolly* 1990 S.C.C.R. 505

70 *HM Advocate v. Blake* 1996 S.L.T. 661

71 *R v Byrne* 1960 2 QB 396

56. It is not clear that the defence remains appropriate in its current form. In its origins, it was doubtless a way of preventing people with mental disorders from facing capital punishment, but this need no longer obtains.
57. The defence does not address issues of risk, so it is quite possible for a person who presents a high and continuing risk to be found to have diminished responsibility and receive a determinate sentence, while a person convicted of murder but who presents little continuing risk receives a mandatory life sentence.
58. However, the Law Society took the view that, so long as the mandatory life sentence remained for murder, it would be necessary to have some defence along the lines of diminished responsibility.
59. There is an argument that the mandatory life sentence for murder should be abolished, to allow sentencers to pay proper regard to the circumstances of the crime, the risk presented by an offender, and any mitigating factors, including mental disorder, in passing sentence. This was the approach recommended by the Butler Committee⁷², who felt that the defence of diminished responsibility would then not be required.
60. However, to adopt this approach and its recommendation would have implications well beyond the area of mental health, and is something which we could not consider within the terms of our remit.
61. We believe, nevertheless, that the defence should be reviewed, and that it would be appropriate to do so alongside consideration of the issue of insanity, which we discuss above. The proposal that this be done met with considerable support and little opposition in our second Consultation, and we so recommend.

Recommendation 29.6

The Scottish Law Commission should be invited to review the defence of diminished responsibility.

⁷² Report of the Committee on Mentally Abnormal Offenders (1975) Cmnd. 6244, 19.14-19.16

CHAPTER 30

APPROPRIATE ADULTS

The appropriate adult scheme

1. Where a mentally disordered person comes into contact with the criminal justice system, whether as a witness to a crime, a victim, or a suspect, it is important that his or her particular needs are recognised. We discuss vulnerable witnesses giving evidence in court in Chapter 19, and in this chapter we consider the needs of mentally disordered people being interviewed by the police. In June 1998 a Code of Practice was issued by the Scottish Office, intended to promote the development of 'appropriate adult' schemes⁷³.
2. An appropriate adult is an independent person who is present during a police interview to support and assist a mentally disordered person during the interview (and in some cases afterwards). They are not intended to represent the person in the way that a defence lawyer would do, but to help to make sure that, so far as possible, the person understands the questions the police may ask, and is able to respond.
3. Guidance had been issued to Chief Constables in 1990, recommending that appropriate adults be called on where a mentally disordered person was to be interviewed. However, the earlier guidance gave little advice as to how police officers should identify appropriate adults and arrange for their attendance during the interview. In some areas, notably Fife, appropriate adult schemes were developed as a result of local initiatives by the police, working with health and social work agencies.
4. The 1998 Circular set out the expectation of the Government that appropriate adult schemes should be developed throughout Scotland. It also gave practical guidance on matters such as how the police might identify that a person might require an appropriate adult, and what the role of the adult should be during the interview.
5. The approach in Scotland has been to develop appropriate adult schemes on a non-statutory basis. This contrasts with the position in England, where the provision of an appropriate adult is a statutory requirement under the Police and Criminal Evidence Act 1984. This does not necessarily mean that, in Scotland, the presence or absence of an appropriate adult has no legal effect. It is possible that a court may regard the failure, in an individual case, to provide an appropriate adult as materially affecting the fairness of a police interview, which could lead to evidence being ruled inadmissible.

⁷³ *Interviewing People who are Mentally Disordered: Appropriate Adult Schemes* (SWSG circular 8/98)

6. In June 2000, the Scottish Executive published the 'Towards a Just Conclusion Action Plan'. This set out the Executive's response to the recommendations of a working group considering the needs of vulnerable witnesses, including those with mental disorder. In the Action Plan, the Executive stated that they had confirmed that Appropriate Adult schemes have been established by all Scottish local authorities. It stated an intention to review the operation of the schemes against the terms of the original guidance, and to consider what further guidance may be appropriate in relation to the role of the appropriate adult in court. The review of current schemes is to be achieved by March 2001.
7. We took the view that the provision of support to mentally disordered people being interviewed by the police was extremely important, and considered whether steps could be taken to improve the arrangements, particularly by placing the appropriate adult on a statutory footing.
8. There was a considerable degree of support for this in responses to our second Consultation. Several respondents, including the British Association of Social Workers (BASW) and the Scottish Association for Mental Health (SAMH), commented that the implementation of the current arrangements was patchy. ENABLE commented that it was dealing with a number of cases where the current arrangements had failed people with learning disabilities, and considered that the scheme needed to be formalised on a statutory basis. BASW also commented that there were difficulties in ensuring that people with learning disabilities or mental illnesses were identified when they came into contact with the police, and this raised issues of training and awareness raising for police officers.
9. We heard oral evidence on the current arrangements from the Association of Chief Police Officers (Scotland) (ACPOS). They were generally enthusiastic about the scheme, but felt that there were a number of issues arising in practice which should be clarified. In particular, it was felt that the role of the appropriate adult should be more clearly defined, especially where the adult may go on to participate in a subsequent court hearing; either to support the mentally disordered person, or as a witness. Statutory arrangements might help in providing this clarity.
10. Against that, there was some concern that putting the scheme on a statutory basis could create other problems. It was commented that it would be unclear what effect this would have on the general doctrine of fairness which applies in Scottish courts in determining admissibility of witness statements. The Scottish system is different from the English system in relying more on such broad principles, which can be applied by judges in individual cases, rather than setting out statutory requirements for police interviews. The Law Society supported consideration being given to the scheme being formalised on a statutory basis, but also felt it was necessary to review the categories of people who could be regarded as appropriate adults. The Society considered that this role should only be held by professionally qualified people who knew the adult in a professional capacity. This would be a significant change from the current arrangements.

11. On balance, we have decided that it would be premature to recommend that the appropriate adult arrangements be placed on a statutory footing. We understand that the schemes vary considerably, and there is still considerable debate about questions such as the extent to which the appropriate adult can participate actively in the interview, and the role the appropriate adult should play in subsequent proceedings, up to and including the court hearing. Making the appropriate adult a statutory requirement might provide greater consistency, but could add an element of rigidity, before a consensus has developed on the best way to operate such schemes.
12. Indeed, although the scheme is a legal requirement in England and Wales, we understand that there have been difficulties such as too few people being identified as requiring an appropriate adult, and unsuitable people being asked to carry out the role, purely so that the police can confirm that the statutory requirement has been met.
13. We do, however, believe that more needs to be done to encourage the further development of such schemes, and the identification of best practice. The limited review by the Scottish Executive of existing schemes is a start to this process. In our view, this requires to be supplemented by research into the operation of the existing schemes, an ongoing degree of oversight of local arrangements, and support for networks which can disseminate good practice and share information.
14. We also believe that the option of placing the scheme on a statutory footing should be kept under review.

Recommendation 30.1

Research should be commissioned by the Scottish Executive into the operation of appropriate adults schemes for mentally disordered people who come into contact with the criminal justice system. This should investigate

- ♦ *The extent to which such schemes are operating effectively*
- ♦ *Any difficulties arising from current guidance.*

Recommendation 30.2

The Scottish Executive should make arrangements for the ongoing monitoring of appropriate adult schemes, and the sharing of information between such schemes.

Recommendation 30.3

The Scottish Executive should keep under review the possibility of formalising the appropriate adult scheme on a statutory basis.

Training

15. The issue of better training for police officers is a common thread that runs through both the responsibilities of the police under s118 (removal of a mentally disordered person to a place of safety), which we discuss in Chapter 20, and the arrangements for appropriate adults. In its 1995-1996 Annual Report, the Mental Welfare Commission recommended as follows:

‘As a general issue, the development of community care requires that the training of police be appraised to ensure that there is adequate preparation for recognising mental illness and dealing with members of the public who are mentally ill’⁷⁴.

16. Guidance issued on dealing with potentially violent persons in the community states that national training for police has been reviewed by ACPOS, and police training has been revised in the light of experience of incidents involving mentally disordered persons⁷⁵.
17. The Code of Practice on appropriate adults also emphasises the need for training for police and appropriate adults, and recommends the development of courses approved by local multi-agency working groups.
18. We believe that better training is of crucial importance. Police officers are not, and should not attempt to be, mental health professionals. However, it is important that all police officers dealing directly with the public have a basic understanding of mental illness and learning disability including:
 - ♦ being aware of how to identify that a person may have a mental disorder
 - ♦ knowing how to deal with such a person sympathetically and safely
 - ♦ understanding the relevant legislation and guidance, and
 - ♦ being aware of the appropriate services to call on for assistance if required.

Recommendation 30.4

The Scottish Executive should develop, in consultation with the Association of Chief Police Officers (Scotland) and agencies concerned with mental disorder, a training strategy for police officers on dealing with members of the public who have mental disorder, and the use of the police’s statutory powers under mental health law. This strategy should be published and regularly reviewed.

⁷⁴ Mental Welfare Commission Annual Report 1995-6 page 15

⁷⁵ ‘Roles and responsibilities of general practitioners and police dealing with potentially violent mentally disordered persons in the community’, Community Care Circular 3/99

SECTION 7

INTERNATIONAL AND CROSS BORDER ISSUES

CHAPTER 31

CROSS BORDER ISSUES

1. Part VII of the 1984 Act provides for the transfer of detained patients between Scotland, England and Wales, Northern Ireland, the Channel Islands and the Isle of Man, and the removal of non-UK patients from Scotland. There are parallel provisions in Part VI of the Mental Health Act for England and Wales.
2. We have not received a great deal of evidence on this Part of the Act. It appears, from such evidence as we have, that the procedures for cross-border and international transfer of patients are being operated quite effectively. However, there may be a need to formalise safeguards for the patient.

Transfer within the United Kingdom

Differences between the UK Acts

3. The UK Mental Health Acts are broadly similar, although they differ on some significant issues, such as the definition of mental disorder, and on several practicalities, such as the method of approval of detention. The provisions in the various Acts relating to cross-border transfer are however presently quite similar.
4. It is possible that this will not be the case in the future. In England and Wales, a separate review of the Mental Health Act 1983 is being undertaken by the UK Department of Health, in the light of the report of the Richardson Committee. It is not yet known what the legislative outcomes of that review will be. The same is true as regards any recommendations made in this report.
5. Even if the conclusions reached on cross-border transfer are the same, the timescales for introduction of legislation may differ.
6. There is the possibility, therefore, that the procedures for moving patients within the UK may become more complex. We do not believe that this would be in the best interests of patients, and recommend that there be liaison between the Scottish Executive Health Department, the Department of Health and the Northern Ireland Health and Social Services Department to ensure that, so far as possible, the provisions relating to transfers in the various Acts remain complementary.

Recommendation 31.1

There should be liaison between the Scottish Executive Health Department, the Department of Health and the Northern Ireland Health and Social Services Department to ensure that the provisions on cross-border transfers in the various Mental Health Acts remain complementary.

Consultation and appeals

7. A patient detained in Scotland may be transferred to England, Wales or Northern Ireland if it appears to Scottish Ministers to be in the interests of the patient¹. There are corresponding provisions in the Mental Health Act 1983 in relation to the transfer of patients to Scotland. Arrangements have to be in place to admit the patient to a hospital and, in practice, this means that a doctor is named at the receiving hospital as having agreed to take the patient. It is also possible for patients subject to guardianship to be transferred within the UK, if Ministers are satisfied that the necessary arrangements are made for the person to be taken into guardianship in the receiving jurisdiction. The provisions relating to guardianship will in due course be repealed by the Adults with Incapacity (Scotland) Act 2000.
8. It appears to us to be appropriate that the grounds for transfer are broadly expressed. There are a number of possible reasons why it would be in a patient's interests to be transferred to another jurisdiction. However, we believe that the specific grounds for transfer should be recorded and made available to the Mental Welfare Commission and, where appropriate, the tribunal (see further below).
9. Where a patient is to be transferred from Scotland, s87 of the Act provides that the Mental Welfare Commission and the nearest relative must be given at least seven days advance notice by Scottish Ministers. There is no requirement formally to notify the patient.
10. For patients transferred to Scotland, s88 provides that the receiving responsible medical officer (RMO) must notify the hospital managers within 28 days of the transfer. After such notification, the hospital managers have a further seven days to notify the Mental Welfare Commission. There is no requirement for the receiving hospital to notify the nearest relative
11. In general, we believe that the safeguards for patients in relation to transfers between Scotland and other parts of the UK should build on those which we recommend in Chapter 11 for transfers within Scotland. The requirement for seven days notice prior to leaving Scotland is consistent with these recommendations. We believe it should be retained in a modified form, requiring notice to be given to the patient, the patient's named person and, where appropriate, the primary carer, as well as to the Mental Welfare Commission.

¹ 1984 Act, ss.77 (1) and 80 (1)

12. There could be some situations where the patient very much wants to be transferred as quickly as possible, for example a patient who has experienced an episode of mental illness while in Scotland, but whose home is elsewhere and who wishes to return home. There may also be cases where transfer as quickly as possible is clinically desirable. Currently, there is no power to waive the seven day notice period. We believe it should be possible for the notice to be waived where
- ♦ the patient is able to agree to this and does so agree, or
 - ♦ there are strong clinical reasons for an urgent transfer.
13. So far as transfer to Scotland is concerned, the present notice periods are unnecessarily long, and we recommend that they should be replaced by a provision that both the named person and the Mental Welfare Commission should be notified within seven days of the transfer taking place.

Recommendation 31.2

The grounds for transfer of a patient subject to compulsion from Scotland should continue to be 'the best interests of the patient', not further defined.

Recommendation 31.3

The specific grounds for transfer should be recorded.

Recommendation 31.4

There should be a requirement for Scottish Ministers to notify the patient, the named person and the Mental Welfare Commission of an impending transfer from Scotland. At least seven days advance notice should be given, unless the patient agrees to an earlier transfer, or there are strong clinical reasons for an earlier transfer. Where seven days notice is not given, the reasons for this should be recorded on the notification of the transfer to the Mental Welfare Commission.

Recommendation 31.5

Unless the patient objects, the primary carer (if not also the named person) should also be entitled to notice. The Code of Practice should set out circumstances where the primary carer should be given notice, notwithstanding objections by the patient.

Recommendation 31.6

Details of the transfer of a patient to Scotland should be provided to the Mental Welfare Commission and the named person by the responsible medical officer within seven days of it taking place.

Oversight of transfers

14. Transfers may, at present, only proceed on the authority of Scottish Ministers. We understand that, in practice, officials at the Scottish Executive have delegated authority to give Ministerial approval to transfers of non restricted patients which have already been agreed between the relevant doctors.
15. We have no evidence to suggest that this process disadvantages patients. We understand that officials at the Scottish Executive contact the named doctor in the receiving hospital to confirm that he or she is aware of the transfer and is happy to accept the patient. This seems to us to be an important and necessary protection for the patient.
16. The Scottish Executive's staff are also knowledgeable about the technicalities of transfers under the Act and are able to answer queries from doctors and others on the procedure.
17. However, it may not necessarily be the case that the process of approving a transfer need be a Ministerial responsibility.
18. For non-restricted patients, we gave consideration to whether it could be left to the RMO and a doctor at the receiving institution to discuss the practicalities, as is done for transfer within Scotland under s29 of the Act. Whilst this would have the benefit of simplicity, it might not provide the level of patient protection that we see as appropriate.
19. We therefore propose that Ministers should retain a formal responsibility for authorising transfers of non-restricted detained patients between different parts of the UK. As now, we anticipate that this responsibility would in practice be delegated to officials.
20. In relation to restricted patients, decisions concerning transfer are part of the overall management of the patient. We propose in Chapter 27 that day to day responsibility for this should be transferred to the new Risk Management Authority, subject to the oversight of the Restricted Patients Review Board. It would therefore be appropriate for the Risk Management Authority to be consulted concerning such transfers and for the Restricted Patients Review Board to have the responsibility for approving transfers outwith Scotland.
21. In line with our general approach that compulsory measures of care should be based on consideration of a plan of care, there should be a process for recording the background and circumstances of any transfer.

22. As with transfers within Scotland, a patient being transferred to or from Scotland (or the named person) should have the right to appeal against the transfer. The appeal should be to a mental health tribunal.
23. The precise arrangements would depend on the extent to which the legislation in the other jurisdictions is consistent with our proposals for Scotland. Ideally, the patient should have the opportunity to initiate an appeal prior to the transfer taking place, to a tribunal in the original jurisdiction. Even where the appeal is not heard until after the transfer, it would seem to be desirable that it be heard by the jurisdiction of origin, since that is where the original detention was authorised, and it is where the person would return should the appeal succeed.
24. If this approach were to be followed, any appeal against patients being transferred to Scotland would be a matter for the Mental Health Act of the country of origin. However, a useful safeguard for such patients, in our view, would be for the Mental Welfare Commission to visit them after transfer, to ensure that the arrangements being made for their care were consistent with the requirements of Scottish mental health law.

Recommendation 31.7

Ministers should retain responsibility for approving the transfer of non-restricted patients between Scotland and other parts of the UK.

Recommendation 31.8

The responsibility for approving transfer of restricted patients between Scotland and other parts of the UK should be transferred from Ministers to the Restricted Patients Review Board. The proposed Risk Management Authority should be consulted prior to a transfer of a restricted patient to or from Scotland being arranged.

Recommendation 31.9

Patients being transferred from Scotland should have a right to appeal to a mental health tribunal at any time between notification to the patient and named person and the date of transfer, or within 28 days following the transfer.

Recommendation 31.10

Following a transfer of a patient to Scotland, the Mental Welfare Commission should arrange to visit the patient within three months.

Duration of compulsion following transfer

25. Under the current provisions, upon being transferred to England, Wales or Northern Ireland, the patient is treated as if, on the date of his or her admission to the receiving hospital, he or she has been detained on the basis of an application on that date under the Mental Health Act 1983² or, as appropriate, the relevant Northern Irish legislation. The same applies to transfers from those countries into Scotland.
26. The effect is that the detention 'clock' resets itself. Thus a patient could find that his or her period of compulsion without review or a second opinion on his or her medication lengthens. We do not consider this to be right.
27. We therefore consider that the Act should provide that in all cases the patient should be transferred onto compulsion under the terms of the law of the receiving jurisdiction, but that the compulsion should be deemed to have started on the date that the patient became subject to compulsion under the law of the previous jurisdiction.

Recommendation 31.11

Patients should be transferred onto compulsion under the terms of the law of the receiving country, but that compulsion should be deemed to have started on the date of compulsion under the law of the previous jurisdiction.

State Hospital patients from Northern Ireland

28. Northern Ireland has no secure hospital accommodation. As a result, Scotland receives Northern Irish patients who require to be placed in a secure hospital, including patients detained under civil law, patients committed to a secure hospital by a criminal court and patients given a prison sentence who then become mentally disordered in Northern Ireland and require care under conditions of high security.
29. However, there is no appeal against detention in the State Hospital for patients from Northern Ireland. This is in contrast to s29 (4) of the 1984 Act, which otherwise provides for an appeal by the patient, to the sheriff in the sheriffdom from which he or she was transferred, against being thus detained.
30. Whilst the provisions of the Northern Irish Act are outside our remit, we recommend that consideration be given to ensuring that the rights of Northern Irish patients are equivalent to those of their Scottish counterparts in the State Hospital.
31. There has also been reported to us a difficulty with transferring Northern Irish patients out of the State Hospital, because of a lack of accommodation in

² 1984 Act, ss.77 (2) and 80 (2)

Northern Ireland at appropriate levels of security. As we have said elsewhere, patients should not be detained in conditions of maximum security simply because there are no services available to provide a more appropriate level of security. We therefore recommend that consideration be given by the Northern Ireland Health and Social Services Department to how this problem may best be addressed.

Recommendation 31.12

Consideration should be given by the Northern Ireland Health and Social Services Department as to whether there should be an appeal available to Northern Irish patients against detention in the State Hospital.

Recommendation 31.13

There should also be consideration given to how the difficulties of transferring Northern Irish patients out of the State Hospital may be addressed.

Community orders

32. It would be desirable for there to be arrangements to allow patients subject to community orders to move to other parts of the United Kingdom. At the moment, the UK government has indicated its intention to introduce for England and Wales compulsory orders which could be applicable either in hospital or a community setting³. However, we do not know when such legislation will be introduced, or how it may differ from any Scottish legislation.
33. Section 35K of the 1984 Act makes provision for patients who are subject to after-care under supervision, in terms of the English Mental Health Act, to be made subject to an application for a community care order in Scotland, with regulations setting out the details of the procedure⁴. Section 35K and the regulations made thereunder deal with two equivalent orders, introduced by a single UK Act of Parliament. Should any arrangements for compulsion in the community differ substantially in different parts of the UK, such transfers may be less straightforward. This is a matter which should be dealt with by regulations, following the cross border liaison which we recommend above.

Recommendation 31.14

Should orders similar to our recommended community order be introduced in other parts of the UK, regulations should allow a patient subject to such an order who moves between jurisdictions to be subject to the equivalent order in the receiving jurisdiction.

3 *Reform of the Mental Health Act 1983: Proposals for Consultation* (Dept of Health 1999) Chapter 6

4 Mental Health (Patients in the Community) (Transfer from England and Wales to Scotland) Regulations 1996, (SI No 742)

Overseas patients

34. Section 83 of the Act gives Scottish Ministers the power to remove a patient who is neither a British citizen nor a Commonwealth citizen having the right of abode in the United Kingdom from the country if it is in the interests of the patient to do so. Section 83 applies to both voluntary and detained patients.
35. There is some concern that s83 does not in practice provide the same safeguards, as far as the need to arrange reciprocal healthcare in the receiving country is concerned, as Part VII does for transfers within the UK, even though s83 requires Ministers to be satisfied that proper arrangements have been made for the care and treatment of the patient in the receiving country. There is also no requirement to consult with the patient, and no right of appeal. We believe that patients being transferred overseas are in even greater need of protection than those being transferred within the UK. There should therefore be provision for the patient to be consulted, and to challenge the decision to remove him or her from Scotland.
36. Certain difficulties with the Section have been commented upon. Despite the statement in the Act that Scottish Ministers should arrange “the conveyance of the patient to his destination...” and “his detention in any place or on board any ship or aircraft until his arrival at any specified port or place in any such country or territory”, it is not clear that the detention of the patient legally continues once he or she has left British soil. We discuss this in Chapter 32 in the context of the Hague Convention on the International Protection of Adults, and make a recommendation in that Chapter that compulsion under the Act should last until the patient is handed over to the relevant authorities in his or her home country.

Recommendation 31.15

There should continue to be arrangements to allow Ministers to transfer in-patients receiving treatment for mental illness, who do not have a right of abode in the UK, to countries outside the United Kingdom.

Recommendation 31.16

Such transfers should only take place if Ministers are satisfied that the patient will receive adequate care in the receiving country.

Recommendation 31.17

Unless he or she consents to early removal, a patient should be given at least 28 days notice of the intention to remove him or her from the UK.

Recommendation 31.18

The patient should have the right to appeal to a mental health tribunal against such a decision.

Refugees and asylum seekers

37. We would hope that all non-UK nationals with mental disorders who require to be treated in the UK would have their cases dealt with and decisions about transfer to another country made with sensitivity. However, there are specific issues relating to refugees and asylum seekers whose problems we deal with generally in Chapter 18 (paragraph 48).

Recommendation 31.19

Specialist advocacy should be provided to asylum seekers and refugees with mental disorders to assist them in understanding their legal position and to provide liaison with their legal representatives and/or immigration officials.

The Immigration and Asylum Act 1999

38. The Immigration and Asylum Act 1999 contains provisions which amend the duties of local authorities under the Mental Health Act towards asylum seekers. Broadly, the Act takes asylum seekers out of the normal welfare system, and provides instead a 'safety net' support system administered and funded by the Home Office. Section 120 of the Act amends the duties on local authorities in sections 7 and 8 of the 1984 Act to provide accommodation and aftercare services to persons with mental disorders. Such services may not be provided to persons excluded from benefits under the Immigration and Asylum Seekers Act, if the reason for providing the services is solely because the person is destitute, or because of the anticipated effects of being destitute. The practical effect of this is unclear, since accommodation and after-care services provided under the Mental Health Act are provided because of needs arising from a person's mental disorder, not because the person is destitute.
39. A number of organisations, including the British Association of Social Workers, the Law Society of Scotland, ENABLE and the Scottish Association for Mental Health strongly criticised these proposals (as they were at that stage) in responding to our first Consultation. We are not aware of any difficulties created for local authorities by the existence of these duties in relation to asylum seekers, and we believe that their limitation in this way could create difficulties for a group of very vulnerable people. We therefore believe these restrictions should be removed.

Recommendation 31.20

The amendments to the 1984 Act introduced by the Immigration and Asylum Act 1999 should be repealed.

CHAPTER 32

HAGUE CONVENTION ON THE INTERNATIONAL PROTECTION OF ADULTS

The Convention

1. The Hague Convention on the International Protection of Adults sets out private international law rules governing the protection of incapable adults⁵.
2. The purpose of the Convention is to set out rules among Contracting States for determining which country's courts or administrative authorities have jurisdiction in situations involving incapable adults who have connections with more than one country, which country's law applies, and how the decisions of one country's authorities may be enforced in another country. The Convention is a private international law and judicial co-operation measure and is not concerned with the content of member states' substantive laws relating to the person and property of incapable adults.
3. The Convention provides that, in the usual case, the judicial or administrative authorities of the Contracting State of the habitual residence of the adult have jurisdiction directed to the protection of the adult's person or property⁶. There are, however, various exceptions.
4. In the usual case, the authorities of the Contracting State which has jurisdiction under the terms of the Convention are to apply their own law in exercising it, although again, there are exceptions.
5. The final text of the Convention was agreed at a meeting of the Special Commission of the Hague Conference on Private International Law on 2 October 1999. The United Kingdom signed the Convention in January 2000, but it has not, thus far, been ratified by the UK.
6. The general provisions of the Convention and their applicability to UK law are outside the remit of this Committee. However, it seems reasonable to attempt to ensure that the new Mental Health Act is consistent with the Convention and the internationally accepted rules that it embodies. This will also facilitate the UK's ratification of the Convention, should that be decided upon.

5 Convention on the International Protection of Adults Article 1:

"1. This Convention applies to the protection in international situations of adults who, by reason of an impairment or insufficiency of their personal faculties, are not in a position to protect their interests.

2. Its objects are –

- a) to determine the State whose authorities have jurisdiction to take measures directed to the protection of the person or property of the adult;
- b) to determine which law is to be applied by such authorities in exercising their jurisdiction;
- c) to determine the law applicable to representation of the adult;
- d) to provide for the recognition and enforcement of such measures of protection in all Contracting States;
- e) to establish such co-operation between the authorities of the Contracting States as may be necessary in order to achieve the purposes of this Convention."

6 Article 5

Recommendation 32.1

The new Mental Health Act should, as far as possible, be drafted on the relevant issues in line with the provisions of the Hague Convention on the International Protection of Adults.

Implications of the Convention for mental health law

7. The Scottish Courts Administration, alongside the Lord Chancellor's Department and the Northern Ireland Office of Law Reform, issued a consultation paper on the draft Convention in April 1999, to which the Committee responded. We were pleased to receive in reply a substantive response to our comments and queries from the head of the United Kingdom delegation at the Special Commission of the Hague Conference on Private International Law (which drew up the draft Convention).
8. The main purpose of the Convention is to deal with measures of protection, such as the appointment of a guardian, for incapable adults. It is, therefore, of much more relevance to the Adults with Incapacity (Scotland) Act 2000 than to the present review. It would however, apply to judicial measures taken under mental health law.
9. One important limitation on the scope of the Convention in a mental health context is that it applies only to 'measures of protection' which means in this context only steps with legal effect. Therefore, for example, the treatment of mental illness or making a recommendation or report relating to a person with mental illness are outwith the scope of the Convention. The main implications of the Convention for the Committee, therefore, will surround the legal step of detaining a person habitually resident outside Scotland.
10. Another important limitation is that only 'judicial or administrative authorities' are covered by the provisions of the Convention. The Convention does not, therefore, have any implications for the decisions of individual doctors or social workers (or other individuals), though it does for the courts, for the Mental Welfare Commission, local authorities and probably hospital managers.

Emergency and short term detentions under the 1984 Act

11. The Convention gives powers which allow for judicial or administrative authorities to detain people not habitually resident in the State, on an emergency or short term basis.
12. Article 10 (1) of the Convention states:

"In all cases of urgency, the authorities of any Contracting State in whose territory the adult or property belonging to the adult is present have jurisdiction to take any necessary measures of protection".

13. This power lapses as soon as the State which would normally have jurisdiction takes over.
14. Article 11 allows the authorities of a Contracting State within which the adult is present to “take measures of a temporary character... which have a territorial effect limited to the State in question” to protect the adult, until the authority with jurisdiction takes over.
15. In Scotland, there is a question as to whether it is, in fact, a ‘judicial or administrative authority’ that places the person on emergency or short term detention. The doctor does not constitute an authority within the meaning of the Convention. However, the doctor technically makes a ‘recommendation’ for detention, but it is not clear whether this recommendation is, in fact, to a judicial or administrative authority, with whom the responsibility for the legal step finally lies. The 1984 Act does not appear to spell out to whom the recommendation is actually made, although we assume that, as with long term detention, it is implied that the recommendation is to hospital managers.
16. We believe that it is probably rare that a person not habitually resident in Scotland requires emergency or short term detention. However, should this occur, we suggest that it would be desirable if such a case fell within the provisions of the Convention. For this to be the case, his or her detention would have to be undertaken by a ‘judicial or administrative authority’.
17. This could be achieved by two means: either by clarifying the sections relating to emergency and short term detentions so that they state that the recommendation of the doctor (and the mental health officer (MHO)) is to an authority within the meaning of the Convention, or by having separate detention provisions in place for patients habitually resident outside Scotland.
18. The former seems the simpler method, and consistent with the general approach of the Act. We therefore believe that the Act should make it clear that recommendations by doctors and consent from the MHO (if obtained) should be made to the hospital managers, whose responsibility it will be to detain the person.

Recommendation 32.2

The Mental Health Act should make clear that emergency and short term detentions are on the basis of recommendations to the hospital managers.

Long term detentions and community orders

19. For long term detention, jurisdiction would probably derive from a detained patient’s ‘habitual residence’ rather than any other criterion. We therefore imagine that, in the usual case, patients habitually resident outside Scotland would be

returned to the country of their habitual residence instead of being given long term detention orders.

20. However, there will be situations when this will not be appropriate. There may be a need to detain a person from abroad for more than the 28 days allowed for short term detention, to investigate the person's circumstances and determine the best course of action. The Convention would seem to allow for this. The review of long term compulsory measures by an independent tribunal would bring these within the scope of the convention.
21. It is unlikely to be appropriate to give a community order to someone habitually resident outside Scotland.

Inter-country transfers

22. It may prove to be difficult to transfer a detained patient from one country (e.g. the country of temporary detention) to another (e.g. the country of the habitual residence) without the patient at some stage losing the status of being subject to detention. At present the 1984 Act simply gives Scottish Ministers the right to deport non-UK patients⁷.
23. Article 33 of the Convention provides for the recognition of orders made in one country for placements in another country, provided there has been proper consultation and no objection by the receiving country.
24. Therefore, we propose that, taking advantage of this provision in the Convention, there should be a specific provision in the Act which states that detentions continue to apply during the period of transfer to a country with jurisdiction over the patient, and until such time as the patient is transferred to the control of the judicial or administrative authorities in the new host country.
25. The actual length of detentions should not normally be any longer than would be the case if the patient remained in Scotland.

Recommendation 32.3

There should be a specific provision attached to detention orders for patients not habitually resident in Scotland, which states that these orders may apply during the period of transfer to a country with jurisdiction over the patient.

Recommendation 32.4

The orders should apply until the patient has been transferred to the control of the judicial or administrative authorities in the country with jurisdiction, or until the end of the period of detention, whichever is the earlier.

⁷ 1984 Act, s.83

CHAPTER 33

EUROPEAN CONVENTION ON HUMAN RIGHTS AND THE COUNCIL OF EUROPE WHITE PAPER ON PSYCHIATRY

The European Convention on Human Rights

1. The European Convention on Human Rights (ECHR) was drawn up in 1950 and ratified by the United Kingdom in 1951.
2. The Convention rights are binding on the Scottish Parliament and the Scottish Executive under the Scotland Act, and on public authorities throughout the UK since the Human Rights Act came into force on 2 October 2000.
3. The Convention rights which apply under the Scotland Act and the Human Rights Act can be summarised as follows:
 - ♦ The right to life (Article 2)
 - ♦ Freedom from torture and inhuman or degrading treatment or punishment (Article 3)
 - ♦ Freedom from slavery and forced or compulsory labour (Article 4)
 - ♦ The right to liberty and security of person (Article 5)
 - ♦ The right to a fair and public trial within a reasonable time (Article 6)
 - ♦ Freedom from retrospective criminal penalties and no punishment without law (Article 7)
 - ♦ The right to respect for private and family life, home and correspondence (Article 8)
 - ♦ Freedom of thought, conscience and religion (Article 9)
 - ♦ Freedom of expression (Article 10)
 - ♦ Freedom of assembly and association (Article 11)
 - ♦ The right to marry and found a family (Article 12)
 - ♦ Prohibition of discrimination in the enjoyment of Convention rights (Article 14)
 - ♦ The right to peaceful enjoyment of possessions (Article 1, Protocol 1)
 - ♦ The right to education (Article 2, Protocol 1)
 - ♦ The right to free elections (Article 3, Protocol 1)
 - ♦ The right not to be subjected to the death penalty (Protocol 6)
4. Most of these rights are not absolute. The Convention permits limitations to be placed on many of the rights to enable States to secure important objectives such as national security; the prevention of disorder or crime; the protection of health or morals and the protection of the rights and freedoms of others.

Enforcement of the ECHR

5. Since 1966, British citizens have had the right to take a case to the European Court of Human Rights in Strasbourg if they feel that their rights under the Convention have been infringed by the State. Where the Court finds a State to be in breach of the Convention, it may be required to change its law to rectify the breach.
6. However, the Scotland Act 1998 has brought the ECHR into the mainstream of Scots lawmaking and practice. Under the Act it is outwith the competence of the Scottish Parliament and the Scottish Executive to pass any legislation or do any other act which is incompatible with the Convention⁸.
7. Every piece of legislation or act of the Parliament and Executive is potentially challengeable in the courts on ECHR grounds and, if found to be in breach, the courts can strike down the legal provision or act.
8. We note that there have been a large number of legal challenges on ECHR grounds since July 1999, but that only a small proportion of these has been successful. Most of these have been on low-profile matters, but there have been a handful of highly publicised judgements, for example, relating to the appointment of temporary sheriffs.
9. The Human Rights Act 1998 came into force throughout the UK on 2 October 2000. It has important implications for the Westminster Parliament. However, the most significant effect of this piece of legislation in Scotland is that acts of 'public authorities' must now be compliant with the Convention. Acts of public authorities are challengeable in the courts, and a person may rely on Convention rights in proceedings brought against him or her by a public authority. 'Public authority' is a broad term, encompassing all persons or bodies acting in a public capacity, and the Human Rights Act thus extends ECHR rights beyond the provisions of the Scotland Act.
10. In September 2000, the Scottish Executive announced its intention to introduce a Bill dealing with ECHR issues. We understand this Bill primarily deals with criminal justice matters, and does not contain significant proposals in relation to mental health law.

The Convention and the Mental Health (Scotland) Act 1984

11. It is, of course, the case that much of the Mental Health (Scotland) Act 1984 is concerned with compulsory measures, which in many cases will affect rights under the Convention. However, as has already been stated, these rights are not for the most part absolute. The Convention, and judicial interpretation of it, has always recognised that there is a balance to be struck between the general interests of society and the protection of the individual's rights.
12. The most relevant article of the Convention to detention in hospital is Article 5, the right to liberty and security of person. It is Article 5 (1) (e) of the Convention which

8 Scotland Act 1998, s. 29 and s. 57 (2)

permits States to undertake detention on mental health grounds. It provides as follows:

“1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants”

13. Other Articles which are of key concern in relation to mental health include Article 6 (the right to a fair trial), Article 8 (the right to respect for private and family life), and Article 14 (prohibition of discrimination in enjoyment of Convention rights), although others will of course be appropriate from time to time.

14. Article 6 states that:

“In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.”

15. This applies to decisions in relation to mental health detention, as well as a range of other decisions which may affect a person’s civil rights. It does not mean that a court, as the term is applied in Scotland, is required to review every such case, but it does require that decisions must either be made, or can be appealed to, a body which has key features of a court, including independence, and the power to make a decision which is binding on the affected parties.

16. Article 8 states that:

“Everyone has the right to respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

17. This is relevant to a range of issues, including sexual relationships (see Chapter 21) and control of patients’ correspondence (see Chapter 11).

18. Article 14 states that :

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

19. Although mental disorder is not specifically mentioned, the general nature of Article 14 should ensure that people's Convention rights are not unjustifiably affected because of the existence of a mental disorder. The principles of equality and respect for diversity which we propose in Chapter 3 are in line with Article 14.
20. There is a significant body of European case law concerned with mental health. For example, the case of *Winterwerp*⁹ established criteria under which ongoing liability to detention on the grounds of 'unsound mind' must be justified, namely
 - ♦ the existence of a true mental disorder established by objective medical expertise
 - ♦ which disorder is of a nature or degree warranting compulsory confinement, and
 - ♦ which disorder persists at the time of review.
21. It was the decision of the European Court in the case of *X v UK*¹⁰ which led to the Government changing the law in the Mental Health (Scotland) Act 1983 to give a right of appeal to the sheriff against the refusal of Ministers to discharge a restricted patient.
22. The recent challenge to the Mental Health (Public Safety and Appeals) (Scotland) Act was based on ECHR arguments¹¹. Although unsuccessful, we understand it is subject to appeal, and it seems likely that this could presage further challenges to aspects of the 1984 Act.
23. The Committee began its work before the relevant provisions of the Scotland Act or the Human Rights Act came into force. However, it has been aware from the outset of the importance that the ECHR would increasingly have in Scotland.
24. We have therefore kept the ECHR very much in mind. We state on occasion throughout this report when our consideration of the Mental Health (Scotland) Act 1984 has been particularly influenced by questions of Convention rights. However, even when we have not said as much, our recommendations have generally been influenced by recognition of the rights of the individual, including under the Convention.
25. However, detailed scrutiny of the compatibility of our recommendations with the European Convention on Human Rights, is not a matter which lies within the remit or responsibilities of the Committee. We asked in our second Consultation whether respondents wished to make comment on the impact of the ECHR on mental health law. There were few responses on this point, which suggests to us that many people working in the field of mental health are not yet sure what the implications of the ECHR are for mental health law.
26. We believe that the general approach which we have taken in this report reflects the general principles of the Convention, and, if implemented, may help to remove doubts about the compatibility of the Mental Health Act with the Convention.

9 *Winterwerp v the Netherlands*, 1979 2 EHRR 387

10 *X v UK* 1981 4 EHRR 188

11 *Anderson, Doherty and Reid v the Scottish Ministers and the Advocate General for Scotland*, Court of Session 16 June 2000

Insofar as our proposals are accepted, it will of course be for the Scottish Executive and Scottish Parliament to translate them into legislation, and to ensure that the detailed legislative proposals meet the requirements of the Convention. Caselaw concerning the Convention has made it clear that it should not be interpreted narrowly, but in accordance with developing human rights norms. We anticipate, therefore, that the Scottish Executive and Parliament will wish to ensure that any new mental health act applies the general spirit of the Convention, as well as being compliant with the current case law.

Council of Europe White Paper on Psychiatry and Human Rights

27. We are also aware of the Council of Europe White Paper on Psychiatry and Human Rights, which was published on 3 January 2000 for public consultation purposes. It was drawn up by the Working Party on Psychiatry and Human Rights of the Council of Europe's Steering Committee on Bioethics. The terms of reference of the Working Party require it:

"to draw up guidelines to be included in a new legal instrument of the Council of Europe. These guidelines should aim to ensure protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients, including their right to appropriate treatment."

28. It would seem likely that any such instrument will not be finalised, or ratified by the UK government, for some time. The Government will no doubt wish to take account of any developments in mental health law which follow this report, in its dealings with the Council of Europe concerning the proposed new legal instrument.

SECTION 8

OTHER MATTERS

CHAPTER 34

REGULATIONS, RESEARCH AND OTHER ISSUES

Regulations

1. There are relatively few regulations or statutory instruments made under the 1984 Act. The most significant are probably the regulations setting out treatments which are specified under part X of the Act as requiring additional protection¹, and the Act of Sederunt setting out certain rules for mental health hearings in the sheriff court². As we point out in Chapter 10, the specified treatments have not been reviewed since the Act was introduced. In relation to the Act of Sederunt, the Mental Welfare Commission advised us of its concern that its provisions, for example as to when a *curator ad litem* should be appointed, are often not well understood or applied.
2. Should a new Act be introduced, no doubt a new series of regulations will require to be introduced. We hope that the Scottish Parliament will ensure that these are openly debated. It will also be important that the Scottish Executive ensure that professionals, service users and carers are aware of the regulations, particularly through training, and by including appropriate references in the Code of Practice.

Statistics and research

3. We were concerned by the lack of adequate statistical information concerning the operation of the Act. The Mental Welfare Commission holds some information, as a by-product of its statutory responsibility to be notified of various matters, and in recent years it has developed its information technology to make better use of this information. We recommend in Chapter 23 that the Commission should be under a duty to collect and publish statistical information, which may help to ensure that this role is carried out systematically.
4. However, there are significant gaps in the information available to the Commission. It does not hear, for example, of applications for detention which are initiated, but not proceeded with. Nor is it able to guarantee that those who are legally required to submit information always do so, and it has expressed concern that the Act is not being fully complied with in relation to the submission of statutory forms.
5. There is little or no monitoring of how the Act affects particular groups, for example, minority ethnic communities.
6. There is also a dearth of proper research. In order to gather even basic information for the Committee about how the procedures for detention operated in the sheriff

1 The Mental Health (Specified Treatments, Guardianship Duties etc.) (Scotland) Regulations 1984 (SI No 1494)

2 Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc Rules) 1999 (SI No 2929)

courts, it was necessary to commission research- which appears to be the only systematic study of the subject which has taken place in the lifetime of the Act. (See Annex 7)

7. The authors of the literature review which we commissioned (see Annex 8) commented:

‘This review exercise has highlighted the lack of research or audit on the use of mental health law in Scotland either in terms of process or outcomes...The lack of research and data is unfortunate since the size of Scotland means it is well placed to carry out good national studies on total populations of patients affected by mental health law. Good monitoring of the new law would seem particularly important since in a number of the studies ...expectations were not met in reality.’

8. The Accounts Commission report ‘A Shared Approach’ pointed to a lack of valid and reliable information on the cost, quality and efficiency of services, the extent to which they meet identified need, and the outcomes achieved for individuals. The report recommended that the various initiatives to provide information on mental health services be co-ordinated.
9. The introduction of a new Act would be an ideal opportunity to look at the present arrangements for the collection of statistics and to begin a co-ordinated programme of information collection, and targeted research, which should help to show how the new legislation was working and whether its aims were being met.

Recommendation 34.1

The Scottish Executive should initiate a co-ordinated programme of statistical and other information gathering and of research relating to the new Mental Health Act.

Forms

10. The procedures for compulsory care under the 1984 Act involve a considerable number of forms. The content of many of these forms is set out in regulations³. These forms are used to provide important information such as the basis of the medical recommendations for detention under s18 of the Act. Other forms are non-statutory, such as the form which records the grounds for an emergency admission to hospital under s24.
11. These forms are important because they are not simply records of decisions, but in many cases are the basis for a decision. The research into the operation of detention in the sheriff courts showed that many s18 applications are determined without hearing oral evidence. The evidence on which the decision of the court is taken is, in effect, the forms submitted to the court.

³ The Mental Health (Prescribed Forms) (Scotland) Regulations 1996 (SI No 743)

12. That being so, the content and design of the forms is of considerable importance. For example, the form which sets out the medical recommendation for admission to hospital contains six closely spaced lines, taking up just over an inch of the form, to set out the basis of the patient's mental disorder and how it meets the criteria for detention. There are seven lines, taking up one and a half inches, to set out the basis for the opinion that it is necessary for the patient to be treated in hospital and that treatment cannot be provided unless the patient is detained. The form indicates that this space should also be used to indicate whether other methods of care and treatment are available and if so why they are not appropriate, and why informal admission is not appropriate.
13. Given the design of the form, it is not surprising that the research found that many medical recommendations are extremely terse, and in some cases, regrettably, illegible.
14. Other forms, for example Form 10, under which an independent doctor certifies under Part X of the Act that treatment should be given to a non-consenting detained patient, do no more than set out the statutory formula for the decision, and a brief description of the treatment in question, without any space to record any factors which may be material to the decision.
15. Our proposals for compulsory procedures involve a more detailed consideration of the circumstances of the individual patient. That being so, it will be important for thought to be given to the appropriate design of the new forms that will be necessary.
16. Such forms are also, potentially, an important source of statistical information, by which practice can be audited and improved. For this information to be collected to best advantage, it will be important that the forms are designed to take account of the approach to information gathering which we recommend in paragraph 9 above.
17. In saying this, we are conscious of the pleas of professionals, that time spent filling forms is time not spent helping clients. Nevertheless, proper recording of information is the cornerstone of good medical and social work practice. It should therefore be possible to translate this good practice into compliance with the statutory requirements, without adding unduly to the workload of professionals. The developing use of information technology may assist in integrating the recording of information for the purposes of delivery of care and compliance with statutory requirements.

Recommendation 34.2

The statutory forms which support procedures under the Act should be drafted to ensure that

- ♦ *they provide adequate information for the relevant purpose*
- ♦ *they assist the process of information gathering and research into the use of the Act, and*
- ♦ *they can be used efficiently and effectively by professionals.*

18. The Criminal Procedure (Scotland) Act 1995, unlike the 1984 Act, does not prescribe statutory forms to support procedures under the Act, for example, recommendations for a hospital order. This means that professionals who only occasionally give such reports have no guidance as to their content. We heard evidence that, as a consequence, reports do not always provide all the appropriate information, and might even omit aspects of the relevant statutory criteria for the recommendation which is being made.
19. We believe that this is an unfortunate omission, and that there should be statutory forms for mental health disposals by the criminal courts, as well as for civil measures of compulsion. On the other hand, we would not want to see a largely pre-printed report, where a doctor or mental health officer simply filled in blanks and signed the form. A reasonable compromise would be standard forms, which included explanatory notes and a column for text.

Recommendation 34.3

There should be statutory forms to support mental health disposals in cases before the criminal courts.

Training

20. We make recommendations throughout this Report which reflect the importance we attach to the training of health and social care professionals, and other groups such as the police, particularly in the law relating to mental health.
21. The introduction of a new Act will require a comprehensive programme of training for all those who will have to operate its provisions. This is a considerable challenge, but may also present an opportunity to improve the awareness of mental health law.
22. The responsibility for ensuring that there is adequate training in place will be shared amongst employers and professional bodies, but the Scottish Executive will have a key role. It should both set clear expectations, particularly of the NHS and local authorities, and help to co-ordinate activities, to avoid duplication of effort and promote inter-disciplinary working. It may be appropriate for some of this work to be contracted out to a suitable organisation or consortium. The precise arrangements are not a matter for us, but we feel it is important to highlight the need for early consideration to be given to a co-ordinated strategy for training in the new Act.

Recommendation 34.4

The Scottish Executive should develop a strategy to ensure that all who have to operate the new Mental Health Act are appropriately trained.

CHAPTER 35

THE STATE HOSPITAL

Statutory basis for provision and management of the State Hospital

1. The 1984 Act originally contained provision, in Part VIII, for the State Hospital. It imposed a duty on the Secretary of State to provide such hospitals as appeared to him to be necessary for persons subject to detention, who required treatment 'under conditions of security on account of their dangerous, violent or criminal propensities'. The only hospital so provided was the State Hospital at Carstairs. The Act provided for a Management Committee to manage the hospital, on behalf of, and subject to direction by, the Secretary of State.
2. Much of Part VIII of the 1984 Act was repealed by the State Hospitals (Scotland) Act 1994. This transferred the duty of the Secretary of State to provide high security hospitals from the Mental Health (Scotland) Act to the National Health Service (Scotland) Act 1978, which is the general statutory provision governing the provision of the NHS in Scotland. It also provided that the management of such a hospital could be devolved to a health board. Arrangements were then made to establish a Special Health Board which, from 1 April 1995, took over the management of the State Hospital from the State Hospital Management Committee⁴.
3. We understand that this change was prompted by a desire that the State Hospital operate on a similar footing to other parts of the NHS (although it is unusual for a health board in directly providing health care, rather than contracting with NHS Trusts to do so). We endorse this aim, and we were not made aware of any concern about the general statutory position of the State Hospital.
4. In 2000, the Scottish Health Advisory Service reviewed mental health services at the State Hospital. Their report raised a number of concerns about the culture within the hospital and took the view that the Hospital was not yet fully integrated within a national network of local hospital and community services, so as to ensure that a person has appropriate safe care at all stages of the rehabilitation process. The report also highlighted a number of positive developments, and pointed out that some of these difficulties were not within the power of the State Hospital to correct. The recommendations of the report did not identify any changes to the statutory basis of the State Hospital as being desirable⁵.
5. Some of the provisions in s91 of the Act in relation to the State Hospital Management Committee have not been repealed. We assume that these were retained for transitional purposes only, since that Committee now has no ongoing

4 State Hospitals Board for Scotland Order 1995 (SI No 574) and Mental Health (State Hospital Management Committee, State Hospital, Carstairs) (Scotland) Transfer and Dissolution Order 1995 (SI No 575)

5 Scottish Health Advisory Service (June 2000) *Review of Mental Health Services in the State Hospital*

role. It would seem that, in a new Mental Health Act, these provisions would be unnecessary.

Recommendation 35.1

Part VIII of the 1984 Act should be repealed.

The Medical Sub-Committee

6. One issue which arose in the *Ruddle*⁶ case was the role of the Medical Sub-Committee at the State Hospital. This was originally constituted as a sub-committee of the State Hospital Management Committee, and carried out an expert advisory role within the Hospital, including reviewing the appropriateness of continued detention and treatment of State patients. The legislative basis for the committee disappeared when the Management Committee was replaced by the State Hospitals Board for Scotland, but the Medical Sub-Committee continued to perform an advisory role. In that capacity, it was influential in relation to decisions concerning Noel Ruddle, in the period prior to his successful appeal against detention.
7. The Mental Welfare Commission enquiry into the care and treatment of Noel Ruddle⁷ considered the role and responsibilities of the Medical Sub-Committee. It expressed some concern that its role in relation to restricted patients was unclear in some respects⁸, and recommended that the purpose and procedures of the Medical Sub-Committee should be reviewed, so that there is clarity as to the purpose and effect of its clinical, managerial and statutory involvement with patients⁹.
8. We understand that the State Hospitals Board and the Scottish Executive are reviewing the arrangements in the light of this report. Since the Medical Sub-Committee or any future replacement would appear not to need any specific statutory reference, we do not feel it is necessary for us to make any recommendations in this regard.

⁶ *Noel Ruddle v Secretary of State for Scotland*, Lanark Sheriff Court, 2 August 1999

⁷ *Report of the Inquiry into the Care and Treatment of Noel Ruddle*, (Scottish Parliament, SP Paper 98 Session 1 (2000))

⁸ paragraphs 2.10.5 and 7.5

⁹ Recommendation 7, page 68

CHAPTER 36

CODE OF PRACTICE

1. Section 119 of the 1984 Act requires Scottish Ministers to prepare a Code of Practice. We are in favour of the retention of such a Code of Practice, but in a strengthened and extended form. This accords with the consultation responses that we received on this matter.

The existing Code of Practice

2. The Act specifies that the Code will have two principal functions:
 - ♦ to give guidance on detention and discharge under the Act and
 - ♦ to give guidance on medical best practice.
3. The existing Code of Practice¹⁰ was published in 1990. It sets out its aims as follows:

“The code offers advice on what is generally agreed to be good professional practice in relation to the procedures laid down in the Act, in the expectation that this will enable members of different professional groups to work together on practical issues that may straddle professional boundaries”¹¹.
4. There is no legal duty in the Act to comply with the guidance given in the Code. However, the Code itself states¹² that, as the Code is a statutory document, failure to observe its terms could have legal consequences.

The retention of a Code of Practice

5. There are several reasons why we favour the retention of a Code of Practice, in an updated form.
6. We think that the new Code could be given the role of promoting the Principles of the Act (see Chapter 3). It could give detailed guidance on the practical implementation of the Principles, whilst the Code itself would also be based upon those Principles. This would help to ensure that the Principles would become the fundamental basis upon which treatment and care under the Act would be based.
7. It is in keeping with our recommendations in other parts of the Report that users and carers should be given better information about care and treatment under the

10 *Mental Health (Scotland) Act 1984 – Code of Practice*, (Stationery Office) Scottish Home and Health Department (1990)

11 Paragraph 2

12 Paragraph 3

terms of the Act. The new Code could perform the role of a “guide” to the Act for users and carers. If it were made readily available it could become a key reference document for those users and carers who seek to understand the legal underpinning of mental health services.

8. The new Code would have the aim of offering practical guidance on best professional practice and guidance as to procedure under the new Act to professionals working in the field of mental health. If it were kept up-to-date, guidance from the Code on how the Act should operate in practice could be of great help to those charged with operating the provisions of the Act.
9. The Adults with Incapacity (Scotland) Act 2000 requires, at s13, that Codes of Practice be prepared for those carrying out functions under the Act. As we indicated in Chapter 2, we are of the view that the provisions of the Mental Health Act should, wherever practical, be complementary to those of the 2000 Act. The retention of a Mental Health Act Code of Practice would assist in this aim.
10. Respondents to our consultation were in favour of the retention of a Code. When we asked in our first Consultation whether there should be a Code of Practice in future, all but one of the 40 organisations and individuals which responded on this question said that there should be. We also asked whether respondents found the present Code useful: a clear majority of respondents agreed that they did. However, respondents to both questions also pointed towards serious problems with the way the Code is currently drafted and used.
11. In our second Consultation, we invited comment on the areas covered by the Code. There was a common view that the Code required to be extended and strengthened. In particular, respondents expressed a wish that the Code provide
 - ♦ a means of addressing practice issues that emerge over time from the work of bodies such as the Mental Welfare Commission and Scottish Health Advisory Service.
 - ♦ a means of linking with relevant provisions in other legislation.
 - ♦ a guide to evidence based practice in critical areas such as special treatments

A new Code of Practice

The Principles of the Act

12. We believe the Code should act as an aid for all parties in operating the Act according to the Principles set out in the Act.
13. If, as we suggest in Chapter 23, the Mental Welfare Commission is given the formal role of being the “guardian” of the Principles of the Act, the Code of Practice would reinforce the Commission’s role in being guided by, promoting and advancing the Principles.

A guide to best professional practice

14. The Code of Practice should seek to promote inter-agency working and best practice. We believe that its guidance should be more detailed than at present and should cover all elements of the new Act. The Code would therefore give guidance on compulsory care and treatment, both in hospital and in community settings. The Code should also give guidance on elements of service provision which are not linked to compulsion, such as advocacy. The Code should take account of, and refer to, other guidance as appropriate.
15. In providing guidance on best professional practice, the Code will be influenced by the standards set by other bodies such as the Clinical Standards Board for Scotland, Scottish Health Advisory Service and The Scottish Commission for the Regulation of Care. There should be a statutory requirement for consultation with these bodies in drafting the Code.
16. There could also be broader guidance, for example on the implications of the requirement, arising from the Principles, to take account of specific needs arising for example, from age, gender or culture in providing services.

A guide for users and carers

17. We heard evidence from users and carers that they find mental health law impenetrable. It was neither easy for them to understand the legal basis for treatment nor to be certain of their rights.
18. If the Code is to operate in future as a guide to users and carers it must be drafted wherever practicable in a less technical and more accessible way.
19. However, the Code will inevitably be a lengthy document, covering a range of issues, some of them of great complexity. Particular individuals or groups will have interests in specific parts of the Code, and there will be issues of its accessibility to people whose first language is not English. We therefore believe that, alongside the production of the Code, there will be a need to promote awareness of its contents.

Recommendation 36.1

The Act should require Scottish Ministers to prepare a Code of Practice.

Recommendation 36.2

The Code should operate as follows:

- ♦ *It should be a guide to the Principles of the Act and their implications for care and treatment.*
- ♦ *It should be a practical guide for service-providing agencies and medical and other professional staff on the provisions of the legislation.*
- ♦ *It should give advice on best professional practice in relation to the Act.*
- ♦ *It should, wherever practicable, be written in straightforward non-legal language, that users and carers and other non-specialists may refer to.*

Recommendation 36.3

The Scottish Executive should develop and implement a strategy to promote awareness of the Code amongst all those with an interest .

Legal force of the Code

20. We asked consultees what legal force they thought the Code of Practice should have. There were a variety of views expressed. The British Association of Social Workers (BASW) considered that there should be a legal duty to comply with the Code, as did many of the voluntary sector respondents. The Law Society took the view that the code should be for guidance, but in proceedings, non-compliance would require justification. Others said the Code should have no legal force but should be to inform and encourage practitioners.
21. We take the view that there should continue to be no legal duty imposed by the Act to comply with the Code. However, we agree with the Law Society's view that non-compliance with the Code's provisions would have to be justifiable if challenged in legal proceedings.

Recommendation 36.4

The Code of Practice should not be legally binding, but a failure to apply the Code should require to be justified if challenged in legal proceedings.

Training on the Code

22. We heard evidence that professionals receive little training in the present Code. We believe that the Code should have a greater impact than is currently the case. Ongoing training for professionals who operate the Act should include appropriate reference to the provisions of the Code of Practice.

Scope of the Code

23. We note that s119 did not originally include any reference to guardianship nor community care orders (the latter were introduced after the 1984 Act was brought into force). Neither of these therefore feature in the current Code of Practice, and while both these areas are now provided for in s119¹³, the Code has not been updated to follow suit.
24. We make recommendations about the need for regular updating of the Code below. Clearly, we would not wish to see the Code failing to keep pace with changes in care because the wording of the relevant Section of the Act was restrictive. The wording of the statutory provision which will replace s119 should therefore be broad and flexible. This will allow it to reflect the Code's new broader functions, as outlined above, and also to be amenable to any future changes in the Code's specific subject areas.

Publication of the Code

25. It was six years after the 1984 Act became law that its Code of Practice was published. This delay, although at least partly caused by the statutory requirement to consult widely with interested parties, meant that there was for several years a lack of guidance on the most appropriate implementation of a new, complex piece of legislation.
26. The Code of Practice should be an important element of people's understanding of the provisions of the Act and their implications. This role will be particularly important when a new Act is introduced, as it will differ in many key respects from the 1984 Act.
27. There should be, as at present, a requirement for consultation with relevant groups before the Code is published. Our proposed implementation group (see Chapter 37) should have a key role in relation to the drafting of the Code.
28. However these considerations are no excuse for unnecessary delay. We take the view therefore that the Code of Practice should be developed in tandem with the new legislation and placed before the Scottish Parliament not later than one year after the Act receives Royal Assent.

Revisions of the Code

29. There is a requirement under s119 that Scottish Ministers should "from time to time revise"¹⁴ the Code. However, the Code was published in 1990 and is now some ten years old (although we are aware that a revision of the Code is currently being undertaken). In the decade since the Code was published, there have been many changes in mental health care. These are not reflected in the Code.
30. We recommend that regular updates of the Code should be undertaken by the Scottish Executive. These updates should reflect, amongst other things,

¹³ Amended by Mental Health (Patients in the Community) Act 1995, s4(2) and Sched. 2, para 9

¹⁴ 1984 Act, s119(1)

guidance and advice issued by the Mental Welfare Commission as well as professional bodies. We heard evidence that guidance from the Commission is extremely useful, but that it can be difficult for professionals to be aware of it and clear about its status.

31. We also recommend that apart from the regular updates a full revision of the Code should be undertaken every five years. We suggest that the Mental Welfare Commission, in collaboration with the Implementation Group, should take the lead on making recommendations to the Scottish Executive of the main changes required to the Code. The requirement for consultation on the draft Code with all relevant groups would also remain in force.

Recommendation 36.5

It should be a requirement of the Act that the Code of Practice should be published within a year of the Act receiving Royal Assent and should be drafted in consultation with relevant parties.

Recommendation 36.6

Updates of the Code should be undertaken on a regular basis.

Recommendation 36.7

There should be a five-year maximum period within which a full revision of the Code must be undertaken, in consultation with relevant parties.

The Notes on the Act

32. In addition to the Code of Practice, further guidance on the provisions of the 1984 Act exists in the form of the Notes on the Act¹⁵, which is a reference guide which was produced by the Scottish Office at the time the 1984 Act was published. The Notes have not been updated in line with changes to the Act itself.
33. The Notes are a Section-by-Section guide to the contents of the Act. They are aimed at all those who are given a role in the Act as well as those other professionals (e.g. court officials and records officers) who may have to undertake roles relating to the Act's provisions.
34. The Notes are explanatory in nature and neither have any statutory function nor are they an authoritative guide to how the Act or its Regulations are to be used and interpreted.

¹⁵ *Mental Health (Scotland) Act 1984 – Notes on the Act*, Scottish Home and Health Department (1984)

35. The Notes overlap in some respects with the Code of Practice. However, they have a separate function and we recommend that they continue to be a separate reference document for professionals and others concerned with the Act.
36. It is of course essential, if the Notes are to be in use as a reference document, that any changes to the Act itself are reflected in published updates to the Notes.

Recommendation 36.8

Notes on the new Mental Health Act should be published by the Scottish Executive, and any changes to the Act should be reflected in changes to the Notes on the Act.

Technological improvements

37. We note that in future technological improvements are likely to improve the flow of information about the Act.
38. We would hope that versions of the Code would be placed in searchable electronic form on the internet, and that the Code would be electronically linked to the Notes on the Act and to the Act itself. We would also hope that at appropriate places in the electronic Code there would be links, for professionals, to the relevant pieces of guidance from professional bodies, standards-setting bodies such as the Clinical Standards Board for Scotland and the Mental Welfare Commission. For the benefit of users and carers the Code should also give links to voluntary bodies, health education sites and other sources of useful information.

CHAPTER 37

IMPLEMENTATION AND MONITORING OF THE NEW ACT

Implementation and Monitoring Group

1. We are aware that a great deal of work will be needed to ensure that the Mental Health Act is implemented in a way that is in keeping with its underlying principles. The primary responsibility for ensuring that this is carried through will lie with the Scottish Executive. We have ourselves tried in our work to involve all those with an interest in mental health law, and we believe this approach should also be adopted by the Executive. This could be done through a group of representative individuals, with an advisory and overseeing role.
2. We recommend therefore that there should be an Implementation and Monitoring Group. This group should comprise representatives of user, carer, professional, service provider and voluntary sector interests. The group would be appointed by the Scottish Executive, after consultation with the relevant interests. Its Terms of Reference would be published.

Role of the group

Implementation

3. During the implementation stages, we believe that there would be three key roles for the Implementation and Monitoring Group.
4. Firstly, the Group would be charged with having oversight of all the practical work that is required to take the Act from its Royal Assent to its provisions coming into force. It would provide practical advice and support to the Scottish Executive on any Regulations and Guidance which will require to be introduced to implement the Act.
5. Secondly, the Group would provide a means of liaison between the Executive and outside bodies. This would be facilitated by the members of the Group being representative of those interests involved in implementing the Act.
6. Thirdly, the Group would have a key influence over the drafting of the new Code of Practice, in collaboration with the Executive and other bodies such as the Mental Welfare Commission. This would help to ensure that the Code is drafted in such a way as to be of maximum value to service users, carers and professionals.

Monitoring

7. We also feel that there could be an ongoing role for the Implementation and Monitoring Group once the provisions of the Act have been brought into effect, in overseeing the ongoing use of the Act. In this it would work closely with the Mental Welfare Commission, which would continue to have its own role of ensuring that the provisions of the Act are being used appropriately.
8. The Implementation and Monitoring Group would be free to decide its own methods of working. In its monitoring role, it could, among other things
 - ♦ make recommendations to the Scottish Executive regarding the updates and revisions of the Code of Practice and be involved in the drafting of these updates and revisions, and
 - ♦ recommend to the Executive areas of research which it believes should have attention.

Other groups currently in place

The National Implementation Steering Group

9. A National Implementation Steering Group has been put in place to oversee the implementation of the Adults with Incapacity Act. The Steering Group consists of representatives of many of the interests involved with the Act, including user and carer interests.

The Mental Health and Well Being Support Group

10. We also note that the Mental Health and Well Being Support Group is undertaking an ongoing monitoring role in mental health service development. It developed from the Mental Health Reference Group, which advised on the development of the Framework for Mental Health Services in Scotland, and is charged with monitoring the implementation of the Framework and advising the Scottish Executive on best practice. This Group, made up of Scottish Executive professional staff and outside experts, has recently begun a programme of visits to all health board areas to discuss the progress being made on the implementation of the Framework and offer advice. The Group co-opts expertise as needs dictate.
11. It will of course be important for the various groups to liaise closely on areas of mutual interest.

Recommendation 37.1

A Mental Health Act Implementation and Monitoring Group should be set up to oversee the implementation of the new Act and any associated Regulations and Guidance.

Recommendation 37.2

The Mental Health Act Implementation and Monitoring Group should represent user, carer, voluntary sector, service provider and professional interests.

Recommendation 37.3

The Mental Health Act Implementation and Monitoring Group should have an ongoing monitoring role relating to the Act.

ANNEXES



ANNEX 1

Summary of the Mental Health (Scotland) Act 1984, its History and Comparison with England and Wales.

Nature of the Mental Health (Scotland) Act 1984

1. The 1984 Act is commonly thought of as the legislation which provides for the compulsory detention and treatment of mentally disordered people. However, the Act contains a number of other important provisions. We summarise the provisions of the Act in paragraphs 20 to 45 below.
2. On the other hand, the 1984 Act is not a comprehensive statutory code covering all aspects of the care and treatment of mentally disordered persons. Most of the legislation relating to the duties of public authorities can be found in other Acts, such as the Social Work (Scotland) Act 1968, and the National Health Service (Scotland) Act 1978.
3. The 1984 Act contains provisions regarding people subject to mental health disposals by order of the criminal courts. These interact closely with provisions of the Criminal Procedure (Scotland) Act 1995.
4. A number of provisions in the 1984 Act have been replaced by provisions in the Adults with Incapacity (Scotland) Act 2000.

History of the 1984 Act

5. The 1984 Act introduced no new law. It was a consolidating Act, re-enacting the 1960 Act with all subsequent amendments up to and including those in the Mental Health (Amendment) (Scotland) Act 1983.

The 1960 Act

6. The last comprehensive reform of mental health law was in 1960. Until then the relevant law was contained in the Lunacy (Scotland) Acts, 1857 to 1913 and the Mental Deficiency (Scotland) Acts 1913 and 1940.
7. The Percy Commission (1954-57), followed in Scotland by the Dunlop Committee, led to fairly sweeping reform in the Mental Health (Scotland) Act 1960. The 1960 Act was concerned primarily with detention, and was a liberalising measure. It sought to ensure that people with mental disorders were not automatically subject to legal controls, and to protect the rights of those who were detained against their will.

1983 Amendments

8. In 1983, the Act was amended substantially. The debate in the early 1980s focussed on tightening legal safeguards for patients, and defining more precisely the compulsory powers which could be exercised over them. Safeguards over treatment, not just detention, were extended. This was consistent with the general growth of concern for patients' rights.
9. The 1983 amendments
 - ◆ sought to shift the role of guardianship from 'detention and restriction' to 'protection';
 - ◆ introduced additional safeguards for treatment given to detained patients (Part X of the present Act);
 - ◆ introduced the present s9 with its requirements for qualifications, experience and competence for mental health officers (MHOs) who, until these amendments, were simply whoever was appointed as such by local authorities;
 - ◆ introduced enhanced roles in procedures, for example in the 28 day review of detention cases;
 - ◆ forbade successive use of emergency and short-term detention procedures;
 - ◆ introduced emergency detention by a nurse for a period of up to two hours;
 - ◆ introduced the right of appeal to the sheriff against detention under a hospital order with restrictions.
10. Other amendments included provisions in relation to patients' correspondence and patients absent without leave, and the requirement under s110 to give information to detained patients and nearest relatives.

Major amendments to mental health law since 1984

The Mental Health (Detention) (Scotland) Act 1991

11. This was introduced following a court decision¹ that a person could not be detained under common law powers by medical staff if the detention was not specifically authorised by the Act. The particular problem concerned a patient whose condition unexpectedly deteriorated towards the end of a 28 day period of detention under s26 - too late for the procedures to detain under s18 (up to six months) to be completed. The 1991 Act allowed for extensions to 28 day detentions to allow court processes to be completed.

The Criminal Procedure (Scotland) Act 1995

12. This consolidated changes to criminal procedure since 1975.
13. Part VI of the Act reformed the procedure for people accused of crimes who are found to have been 'insane' at the time of the alleged offence or at trial. In the past,

¹ Black v Forsey 1989 SLT 572

such people were automatically transferred to hospital, whether or not this was the most appropriate disposal, and without any formal hearing to establish that they had carried out the alleged criminal act. The 1995 Act introduced a new 'examination of facts' to test the evidence against an accused person found insane in bar of trial, and provided that a person found insane could be subject to a range of disposals, including a new community based order: the 'supervision and treatment order'.

The Mental Health (Patients in the Community Act) 1995

14. This Act, which covered both Scotland and England and Wales, was introduced after several high profile English cases of severely mentally ill people in the community harming themselves and others. It introduced the community care order in Scotland. This is available for patients who have been detained in hospital, and are to be discharged into the community. The order contains a range of conditions with which the patient is expected to comply, tailored to that patient's situation. The order has been criticised by psychiatrists as lacking any effective means of enforcement.
15. The Act also restricted the period under which a patient could be discharged from hospital under 'leave of absence' (which makes the patient liable to recall at any time) to 12 months. Prior to this, the duration of leave of absence was potentially unlimited.

The Crime and Punishment (Scotland) Act 1997

16. Following the report of the Reed working group into psychopathic disorder², a new criminal disposal was introduced: the hospital direction. The direction allows a court to impose a prison term for an offence, but in addition to direct that the person be sent in the first instance to hospital. If the person recovers, or is found to be not mentally disordered or to be untreatable, they can be transferred to prison to serve out the rest of their term. If the offender continues to be mentally disordered, beyond the expiry of the prison sentence, he or she can continue to be detained in hospital under civil procedure.

The Mental Health (Amendment)(Scotland) Act 1999

17. This Act authorised hospital managers to continue to hold, expend and dispose of the property of patients discharged from hospital to whom s94(1) of the Mental Health (Scotland) Act 1984 no longer applied.

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

18. This Act was introduced in Scotland to add public safety to the grounds for not discharging certain detained patients. The Act amends the 1984 Act by providing that a restricted patient can continue to be detained, whether or not he or she is receiving treatment, if detention is necessary to protect the public from serious harm. It also amends the definition of mental disorder to include personality

² Report of the Department of Health and Home Office Working Group on psychopathic disorder Reed, London; Department of Health(1994)

disorder, and introduces a new appeal against a decision of a sheriff in relation to the discharge of a restricted patient.

The Adults with Incapacity (Scotland) Act 2000

19. This introduced a new legal framework in relation to financial, personal and medical decision-making for adults who are unable to act on their own behalf. It replaces the provisions concerning guardianship and management of patients' funds in the 1984 Act. The provisions are due to come into effect in the period from April 2001 to April 2002.

Provisions of the 1984 Act

Part I

20. Section 1 contains the key definitions setting out who is included in the Act, particularly the definition of 'mental disorder'.

Part II

21. Section 2 regulates the Mental Welfare Commission for Scotland. Sections 3-6 provide for the functions and duties of the Commission to exercise protective functions over people with a mental disorder who are unable to protect themselves. Their powers include the power to visit detained patients and persons subject to guardianship, to hear complaints and to carry out enquiries where there may be ill treatment, lack of care or improper detention.

Part III

22. Sections 7-11 impose duties on local authorities to provide after-care services and to appoint mental health officers (MHOs). Section 11 provides for the training and occupation of people with mental handicaps. This is in the context of broader duties to provide community care services under the Social Work (Scotland) Act 1968.

Part IV

23. Sections 12-16 impose controls on private hospitals for mental disorder and provide for their registration.

Part V

24. This is one of the major parts of the Act. Sections 17-35 deal with compulsory detention in hospital, setting out the conditions which must apply before a person can be compulsorily detained (s17) and providing for the means of application for admission (s18) and those eligible to make the application to the sheriff (s19). Section 20 details the requirement for examination by two doctors.

25. Emergency detention (up to 72hours) is dealt with in s24 and s25. Section 26 deals with subsequent periods of short-term detention (up to 28 days).
26. Section 27 provides for leave of absence from hospital for up to 12 months. Section 28 deals with the return and re-admission of patients who leave hospital without permission, fail to return after an authorised absence, or fail to live where they are required to under leave of absence.
27. Provisions for the transfer of detained patients to another hospital or into guardianship are dealt with in s29.
28. Sections 30–34 provide for the duration of the authority under the Act for the detention of patients in hospital and for discharge, and make provision for patients who are absent without leave, in custody, or sentenced to imprisonment.
29. Section 35 deals with appeals against detention.
30. Sections 35 (A) to (K) set out the provisions for community care orders.
31. Sections 36-52 deal with the general provisions on application for guardianship and will be superseded by the Adults with Incapacity (Scotland) Act 2000.
32. Sections 53-57 set out the procedures to establish who is the patient's nearest relative.
33. Section 58 allows for regulations to be prescribed and s59 defines the meaning of 'responsible medical officer', 'local authority', 'absent without leave' and 'court holidays' within Part V of the Act.

Part VI

34. Sections 60-76 are concerned with the transfer to hospital of persons with a mental disorder convicted of criminal offences or otherwise in contact with the criminal justice system.

Part VII

35. Sections 77-89 deal with the transfer of detained patients between Scotland and England, Wales, Northern Ireland, the Channel Islands and the Isle of Man.

Part VIII

36. Section 91 makes certain administrative arrangements regarding the State Hospital.

Part IX

37. Sections 92-95 impose duties on local authorities and the Mental Welfare Commission to take steps to ensure that people's property is protected while they are in hospital. Section 94 will be replaced by the Adults with Incapacity (Scotland) Act 2000 when the provisions of that Act come into effect.

Part X

38. The consent to treatment rules for detained patients are dealt with in ss96-103.

Part XI

39. Offences under the Act are addressed in ss104-109. Sections 106 and 107 are intended to protect people against inappropriate sexual relationships.
40. Sections 110-113 cover the rights of patients to receive information, to express their views at a court hearing and to have respect shown for their religious beliefs.
41. Sections 114-116 relate to patients in hospital, authorising the giving of an allowance for personal expenses to patients and setting out the circumstances in which a detained patient's correspondence can be intercepted.
42. A mental health officer (MHO) or Medical Commissioner of the Mental Welfare Commission is given the right to enter private premises under s.117, if a mentally disordered person is thought to be there and at risk. Section 118 gives the police the power to take to a place of safety a mentally disordered person found in a public place who appears to be at risk.
43. Section 119 imposes a duty on the Scottish Ministers to produce a Code of Practice for the guidance of doctors, hospital staff and mental health officers (MHOs), governing the detention and care of patients detained under the Act and to revise it as necessary.
44. Sections 120-121 deal with the transfer of patients to hospital or the place they should live under guardianship and gives powers to retake patients absent without leave.
45. Section 123 gives Scottish Ministers the power to hold an inquiry into any matter arising under the Act.

Comparison with mental health law in England and Wales

46. Scottish mental health legislation has, in recent years, tended to develop in parallel with English law, although there are significant differences between the 1984 Act and its counterpart in England and Wales, the Mental Health Act 1983.
47. Such differences include:
- ◆ the English Act has four categories of mental disorder: mental illness, mental impairment, severe mental impairment and psychopathic disorder, while the Scottish Act has only two: mental illness and mental handicap;
 - ◆ it is possible to be detained for a period of assessment of up to 28 days in England, without having first been subject to emergency detention;

- ◆ all long-term detentions in Scotland (lasting up to six months before renewal and renewable thereafter) require the prior approval of the sheriff. In England and Wales the Tribunal need not consider a case until the end of the first six month period, if the patient has not appealed;
 - ◆ in England and Wales, the appeal route is to specialised Mental Health Review Tribunals, while in Scotland it is the Sheriff Court;
 - ◆ the Mental Health Act in England and Wales contains the main provisions concerning management of the property and assets of mentally disabled people. In Scotland this is now contained in the Adults with Incapacity (Scotland) Act 2000; and
 - ◆ the Mental Welfare Commission for Scotland has a wider remit than the English Mental Health Act Commission, which is only concerned with detained patients.
48. Following a review by the Richardson Committee³, the Department of Health in England has issued a green paper discussing reforms to the 1983 Act⁴. In some respects, the proposals, if implemented, would make English law more similar to Scottish law, for example by introducing quasi-judicial oversight at the commencement of long term detention. The English review, although less comprehensive than ours, covers a number of issues which we also address, particularly the question of compulsory treatment in the community.

³ *Review of the Mental Health Act 1983: Report of the Expert Committee* (Department of Health, 1999)

⁴ *Reform of the Mental Health Act 1983 – Proposals for Consultation* (Department of Health, 2000)

ANNEX 2

ORGANISATIONS AND INDIVIDUALS FROM WHOM CONSULTATION RESPONSES WERE RECEIVED

The following organisations responded to the 1st Consultation paper:

Aberdeen City Council Social Work Department
 Aberdeenshire Council Social Work Department
 Aberdeen Council of Voluntary Organisations
 Advocacy 2000
 Advocacy Service Aberdeen
 Alzheimer Scotland - Action on Dementia
 Angus Council Social Work Department
 Argyll & Clyde Health Board
 Argyll & Clyde Local Health Council
 Association of Chief Police Officers in Scotland
 Association of Directors of Social Work
 Ayrshire & Arran Health Board
 Badenoch & Strathspey Association for Mental Health
 Barnados Scotland
 Borders Local Health Council
 Borders Health Board
 British Association of Social Workers (Scotland)
 British Geriatrics Society (Scottish Branch)
 British Medical Association (Scottish Office)
 British Psychological Society
 Central Council for Education and Training in Social Work
 Children in Scotland
 Church of Scotland Board of Social Responsibility
 City of Edinburgh Council, Social Work Services Department
 Clackmannanshire Council, Housing and Social Services
 College of Occupational Therapists
 Commissioner for Local Administration in Scotland
 Common Services Agency for the NHS in Scotland
 Community Psychiatric Nurses' Association
 Consultation and Advocacy Promotion Service
 Crown Office and Procurator Fiscal Service
 Dumfries & Galloway Council, Legal Services Department
 Dumfries & Galloway Council, Social Services Department and Health Board (Joint response)
 Dundee City Council Social Work Department
 East Ayrshire Council
 East Dunbartonshire Council Social Work Department

East Lothian Council Social Work Division
 Easter Ross Community Mental Health Team (Joint response from four Community Mental Health teams in the Highlands)
 ENABLE
 Falkirk Users' Network
 Fife Advocacy Project (Collection of individual opinions of advocates)
 Fife Council Social Work Service
 Fife Primary Care NHS Trust, Mental Health Occupational Therapy, Queen Margaret Hospital
 Friendset (Collection of individuals comments)
 Garvald Centre, Edinburgh
 General Assembly of the Church of Scotland, Committee on Church and Nation
 General Medical Council
 Glasgow Association for Mental Health
 Glasgow City Council Social Work Services
 Grampian Health Board
 Grampian Primary Care NHS Trust, Psychiatrists Medical Advisory Committee, Royal Cornhill Hospital
 Greater Glasgow Primary Care NHS Trust, Florence Street Resource Centre, (Joint response from Occupational Therapists, Professions Allied to Medicine and the National Paramedic Advisory Committee)
 Greater Glasgow Primary Care NHS Trust, Gartnavel Royal Hospital
 Guardianship Board, Kowloon, Hong Kong
 Hamilton/East Kilbride Mental Health Forum
 Headway House (Dumfries & Galloway) Association Limited
 Health & Social Services Councils, Northern Ireland
 Highland Council, Social Work Services and Highland Community Mental Health Teams (Joint response)
 Highland Primary Care NHS Trust, Mental Health Division, Craig Dunain Hospital
 Highland Users Group
 Independent Federation of Nursing in Scotland
 Inverclyde Community Care Forum
 KEY Housing Association Limited
 Lanarkshire Health Council
 Law Society of Scotland (Memorandum of comments by the Mental Health and Disability Committee)
 Lothian Primary Care NHS Trust, Learning Disability Services, William Fraser Centre (Comments from consultants in psychiatry of learning disability)
 Lothian Primary Care NHS Trust, Psychiatric Services, Royal Edinburgh Hospital (Comments of lead clinicians in psychiatric services)
 Lothian University Hospitals NHS Trust, Royal Hospital for Sick Children, Community Child Health Services
 Lothian University Hospitals Trust, Royal Infirmary of Edinburgh, Department of Psychological Medicine
 Manic Depression Fellowship Scotland (Collection of individual responses)
 Mental After Care Association
 Mental Health Aberdeen
 Mental Health Foundation (Glasgow Office)

Mental Welfare Commission for Scotland
 Midlothian Council
 Napier University, Department of Child Health, Mental Health and Learning
 Disabilities and Faculty of Health Studies
 National Board for Nursing, Midwifery and Health Visiting for Scotland
 National Health Service Confederation in Scotland
 National Nursing, Midwifery and Health Visiting Advisory Committee
 National Schizophrenia Fellowship Carelinkline Service (Comments from service
 users)
 National Schizophrenia Fellowship (Scotland)
 New Horizons Borders
 North Ayrshire Council, Social Services (Summarisation of comments from staff)
 North Lanarkshire Council
 North of Scotland Consortium for Mental Health Officer Training
 Orkney Housing Association Limited
 Orkney Islands Council (Comments from Mental Health Officers and operational staff
 involved with dementia, mental disorder, criminal law and children)
 Patients Advocacy Service, The State Hospital (Response from Management
 Committee and Advocacy Service itself)
 People First (Scotland)
 Perth & Kinross Council Legal and Social Work Services
 Pillar, Aberdeen (Responses from two individuals)
 Princess Royal Trust, Borders Carers Centre (Comments from carers who are
 members of the Mental Health Carers Group and supported by Borders Carers
 Centre)
 Profound & Multiple Impairment Service, White Top Research Unit, University of
 Dundee
 Renfrewshire Council Social Work Department
 Renfrewshire & Inverclyde Primary Care NHS Trust, Community Mental Health
 Resource Team (Outline of comments raised at Inverclyde's Mental Health Officer
 meeting)
 Richmond Fellowship Scotland (Summarisation of comments from different parts of
 the organisation)
 Roman Catholic Church, Archdiocese of Glasgow
 Royal College of General Practitioners (Scotland)
 Royal College of Nursing (Scottish Board)
 Royal College of Physicians (Comments from two expert Fellows)
 Royal College of Psychiatrists (Scottish Division)
 Royal College of Surgeons of Edinburgh
 Scottish Association of Health Councils
 Scottish Association of Law Centres
 Scottish Association for Mental Health
 Scottish Borders Council (MHO's and Medical Staff at Dingleton Hospital,
 incorporating GP views)
 Scottish Consumer Council
 Scottish Council for Single Homeless
 Scottish Council on Human Bioethics
 Scottish Users' Network

SENSE (Scotland)
Sheriffs' Association
Shetland Islands Council Social Work Department
South Ayrshire Council, Community Services Department
South Lanarkshire Council Social Work Resources
St. Aubin's Project
State Hospitals Board for Scotland
Stirling Council Housing and Social Services (Responses from mental health officers,
the mental health team and legal services)
Sutherland & Co. (Solicitors and Notaries)
Tayside Primary Care NHS Trust, Adult Directorate, Angus Community Mental Health
Department, Forfar Infirmary (Individual responses from staff)
United Kingdom Central Council for Nursing, Midwifery, and Health Visiting
University of Edinburgh, Department of Psychiatry
University of Glasgow, Department of Public Health
Values into Action
Volunteer Development Scotland
West Lothian Healthcare NHS Trust
Western Isles Association for Mental Health
Western Isles Mental Health Partnership

Individual responses

Ms Allison Alexander

Dr Derek Ball

Ms Maureen Beaton

Mrs Norma Bennie

Mr A.R. Brown

Mrs & Mrs C. Bruce

Dr Isobel H. Campbell

Dr Peter J. Connelly

Dr F. Coulter

Dr John Crichton

Dr William E. Dickson

Mr George Gourlay

Dr Martin Humphreys

Dr Alan Jacques

Mr Tom Keenan

Dr Jane Larner

Mr Michael Lowit

Ms Chris McGregor

Dr A.V.P. MacKay

Dr Ian C. Matson

Professor Eric Matthews

Dr Rhona Morrison

Ms Patricia Price

Dr D.A. Primrose

Dr Andrew H. Reid

Dr Karen W. Richard

Mr David S. Sutherland

Dr Lindsay Thomson

Ms Marion Ulas

Dr Stephen C. Young

The following organisations responded to the 2nd Consultation paper:

Aberdeenshire Council Housing and Social Work Service
 Advocacy 2000
 Advocacy Service, Aberdeen
 Alzheimer Scotland – Action on Dementia
 Angus Council Social Work Department
 Argyll & Bute Council
 Argyll & Clyde Local Health Council
 Association of Directors of Social Work
 Ayrshire & Arran Health Board
 Ayrshire and Arran Primary Health Care Trust, Ailsa Hospital (Comments from staff within the mental health service)
 Ayrshire and Arran Primary Care NHS Trust, Arrol Park Resource Centre
 British Association of Social Workers (Scotland)
 British Association of Social Workers (Mental Health Officers National Forum)
 British Medical Association (Scottish Office)
 Borders Health Board
 British Geriatrics Society (Scottish Branch)
 British Psychological Society
 Central Council for Education and Training in Social Work (Scottish Committee)
 Children in Scotland
 Church of Scotland Board of Social Responsibility
 Citizens Commission on Human Rights
 City of Edinburgh Council Social Work Department
 Clackmannanshire Council Social Services
 Clinical Standards Board for Scotland
 Common Services Agency for the National Health Service in Scotland (Central Legal Office)
 Community Psychiatric Nurses' Association
 Council on Tribunals Scottish Committee
 Craig Dunain Hospital (Mental Health Services)
 Deafblind UK
 Dumfries & Galloway Health Board and Dumfries & Galloway Social Services Department
 Dundee City Council Social Work Department
 Dr Grays Hospital, Elgin (Response from Psychiatric Consultants and Staff Grade Doctors)
 East Ayrshire Council Social Work Services Department
 East Lothian Council
 Edinburgh & East of Scotland Deaf Society
 ELCAP
 ENABLE
 Faculty of Advocates
 Falkirk Council Social Work Services
 Falkirk Users' Network
 Fife Advocacy Project
 Fife Council Social Work Service
 Fife Health Board

Fife Primary Care NHS Trust, Cameron House
 Forth Valley Primary Care NHS Trust, Larbert
 General Assembly of the Church of Scotland, Committee on Church and Nation
 Glasgow City Council Social Work Services
 Grampian Primary Care NHS Trust, Mental Health Clinical Governance Group, Royal Cornhill Hospital
 Grampian University Hospitals, Royal Aberdeen Children's Hospital, Department of Child and Family Psychiatry
 Greater Glasgow Health Board
 Greater Glasgow Primary Care NHS Trust – Occupational Therapists & National Paramedic Advisory Committee, Florence Street Resource Centre
 Greater Glasgow Primary Care NHS Trust, Gartnavel Royal Hospital
 Guardianship Board, Kowloon, Hong Kong
 Hamilton/East Kilbride Mental Health Issues Group
 Highland Council Social Work Services
 Highland Users' Group
 Highland Users' Group, Wester Ross Branch
 Huntlyburn Acute Admission Unit (Comments from Nursing Staff)
 Independent Federation of Nursing in Scotland
 Independent Healthcare Association (in conjunction with the Scottish Independent Hospitals Association)
 Inverclyde Council (Mental Health Officers)
 KEY Housing Association Ltd.
 Lanarkshire Health Council
 Lanarkshire Primary Care NHS Trust
 Law Society of Scotland (Memorandum of comments by the Mental Health and Disability Committee)
 Learning Disability Alliance Scotland
 Lothian Health Council
 Lothian Primary Care NHS Trust, Community Mental Health Team, Craigroyston Clinic
 Lothian Primary Care NHS Trust, Learning Disabilities Service
 Manic Depression Fellowship Aberdeen
 Manic Depression Fellowship (Scotland)
 Mental Health Aberdeen
 Mental Health Consumer Group
 Mental Health Foundation
 Mental Health Services, Nursing Home, Craig Dunain Hospital, Inverness
 Mental Welfare Commission for Scotland
 Midlothian Council Social Services
 Moray Association for Mental Health
 National Board for Nursing, Midwifery and Health Visiting for Scotland
 New Horizons Borders
 North Ayrshire Council, Social Services (Summarisation of comments from staff)
 North Lanarkshire Council Department of Social Work
 North of Scotland Consortium for Education and Training in Social Work
 National Schizophrenic Fellowship (Scotland) Carelinkline Service (Summarisation of comments from callers)
 National Schizophrenic Fellowship (Scotland)
 Orkney Islands Council Department of Community Social Services

People First (Scotland)
 Perth & Kinross Council Housing and Social Work Services
 Pillar (Aberdeen)
 Psychologists' Special Interest Group Working with Older People
 Renfrewshire Autism and Asperger Group
 Renfrewshire and Inverclyde Primary Care NHS Trust, Mental Health Directorate (Inverclyde), Ravenscraig Hospital
 Renfrewshire Council Social Work Department
 Royal College of General Practitioners (Scotland)
 Royal College of Nursing (Scottish Board)
 Royal College of Psychiatrists (Scottish Division)
 Royal College of Psychiatrists (Scottish Division), Liaison Psychiatry Section
 Royal College of Physicians of Edinburgh
 Schizophrenia and Bi-Polar disorder Carers' Reference Group
 Scottish Association of Health Councils
 Scottish Association for Mental Health
 Scottish Consumer Council
 Scottish Council on Deafness
 Scottish Borders Council (Minutes of meeting between Mental Health Service Medical and Mental Health Officer staff)
 Scottish Borders Council, Social Work Mental Health Team
 Scottish Council on Human Bioethics
 Scottish Head Injury Forum
 Scottish Health Advisory Service
 Scottish Human Services Trust
 Scottish Users' Network
 SENSE (Scotland)
 Sheriffs' Association
 South Ayrshire Council
 South Lanarkshire Council Social Work Resources
 St. Aubin's Project
 Stirling Council Mental Health Services
 Stirling Council Criminal Justice Services
 Tayside Forensic Voices Carers Support Group
 Tayside Health Board
 Tayside Primary Care NHS Trust, Ashludie Hospital (Responses from staff in Psychiatry and Primary Care)
 Tayside University Hospitals NHS Trust
 United Kingdom Central Council for Nursing, Midwifery & Health Visiting
 University of Aberdeen, Department of Mental Health
 University of Edinburgh Second Year Medical Students
 University of Glasgow, Department of Public Health
 University of Glasgow, School of Law, Centre for Research into Law Reform
 Values into Action
 Volunteer Development Scotland
 West Dunbartonshire Council Department of Social Work and Housing
 West Lothian Healthcare NHS Trust
 Yorkhill NHS Trust (incorporates the Royal Hospital for Sick Children including the Department of Child and Family Psychiatry)

Individual responses

Ms Jermaine Allison	Dr Walter Muir
Dr J.A. Baird	Ms Mary F. Murchison
Dr Derek Ball	Dr Paul Myatt
Ms Val Blair	Dr Robert J. R. McCabe
Dr. John Boyd	Dr Sheila McDonald
Ms Elizabeth Burtney	Ms Chris McGregor
Dr Isobel H. Campbell	Ms Brenda McIntosh
Ms Rosemary A. Carter	Professor Tom M. McMillan
Ms Adrienne Sinclair Chalmers	Dr Ronnie McVicker
Ms Jane Coll	Dr Steven Novosel
Mr William C. Cowling	Mr Colin O'Docherty
Dr John Crichton	Mr Joe Pearson
Dr Alistair Deering	Dr D.A. Primrose
Ms Alice Docherty	Reverend Lorna Rattray
Mr Alex Doherty	Mr Johnathan Rees
Dr Grace Fergusson	Dr Andrew H. Reid
Mrs Christine Fulton	Dr A. Riley
Dr Robert Gibb	Mr Tom Reilly
Mr Michael Hagan	Dr E. B. Ritson
Ms Maggie Harper	Dr Alexander M. Robertson
Dr Audrey Hillman	Dr Pauline Robertson
Ms Emma Hogg	Ms Helen Gunn-Russell
Dr Martin Humphreys	Dr Neill Simpson
Dr Alan Jacques	Dr Ken Slatford
Dr H.E. Kirk	Mr Harry Smith
Ms Charlotte Lee	Mr David S. Sutherland
Ms Anke Maas-Lowit	Mr Chris Turner
Mr Michael Lowit	Ms Marion Ulas
Dr A.V.P. Mackay	Dr Nicholas Walker
Dr John R. Martin	Mr W. Hunter Watson
Professor Eric Matthews	Dr J. Webster
Dr Paul Matthews	Ms Greta Young
Dr Paul Morris	Dr Stephen C. Young

ANNEX 3

NOTE OF PLACES VISTED

The Committee visited the following services and facilities:

Advocacy and mutual support groups

Advocacy Service, Aberdeen
Visited on 12 October 1999

Highland Users' Group, Inverness
Visited on 1 September 1999

Legal Services Agency Mental Health Legal Representation Project, Glasgow
Visited on 14 September 1999

Forensic and secure mental health services

Douglas Inch Centre, Glasgow
Visited on 6 October 1999

Gardner Unit, Salford (Adolescent Forensic Service)
Visited on 28 October 1999

Scott Clinic, Rainhall, Merseyside (Medium Secure Unit)
Visited on 29 October 1999

State Hospital, Carstairs
Visited on 19 October 1999

Wards 5 and 6, Leverndale Hospital, Glasgow
Visited on 6 October 1999

Learning disability facilities

Royal Edinburgh Hospital Learning Disability Services
Visited on 24 September 1999

Strathmartine Hospital, Dundee
Visited on 6 August 1999

Community based mental health services

Ferryfield House Nursing Home, Edinburgh
Visited on 5 August 1999

Florence Street Resource Centre, Glasgow
Visited on 6 October 1999

Glasgow Association for Mental Health
Visited on 13 August 1999

National Schizophrenia Fellowship (Scotland) Drop-In Project, Dundee
Visited on 23 July 1999

National Schizophrenia Fellowship (Scotland) "Rendezvous" Drop-In Project, Dumfries
Visited on 2 August 1999

Penumbra Housing Association, Edinburgh
Visited on 31 August 1999

Penumbra Respite Facility, Aberdeen
Visited on 12 October 1999

St Triduana's medical practice, Edinburgh
Visited on 31 August 1999

South-West Edinburgh Assertive Outreach Team
Visited on 5 August 1999

42nd Street, Manchester
Visited on 28 October 1999

Prison

HMP Barlinnie, Glasgow
Visited on 20 August 1999

Psychiatric hospitals

Ashludie Day Hospital Dundee, Ward 5
Visited on 23 July 1999

Argyll and Bute Hospital, Lochgilphead
Visited on 5 October 1999

Crichton Royal Hospital, Dumfries
Visited on 2 August 1999

Craig Dunain Hospital
Visited on 1 September 1999

Gartnavel Royal Hospital - Intensive Psychiatric Care Unit
Visited on 26 August 1999

Parkhead Hospital
Visited on 20 August 1999

Royal Cornhill Hospital
Visited on 1 November 1999

Royal Edinburgh Hospital
Visited on 9 September 1999

Others

Falkirk Sheriff Court- Section 18 hearings
Visited on 27 June and 26 July 2000

Glasgow Sheriff Court- Section 18 hearing
Visited on 27 July 2000

Mental Health Review Tribunals in England:

- ◆ Ashworth Hospital
Visited on 11 May 2000
- ◆ Rathbone Hospital, Liverpool
Visited on 11 May 2000
- ◆ Stockton Hall Hospital, York
Visited on 12 May 2000
- ◆ St Nicholas Hospital, Newcastle
Visited on 12 May 2000

Mental Welfare Commission for Scotland
Visited on 13 September 1999 and 4 October 1999

St. Mary's School, Kenmure (Secure school)
Visited on 26 August 1999

ANNEX 4

ORGANISATIONS AND INDIVIDUALS FROM WHOM ORAL EVIDENCE WAS TAKEN

The following organisations gave oral evidence to the Committee at the Oral Evidence sessions held in February 2000:

Advocacy 2000:

Ms Marcia Ramsay, Project Director

Association of Chief Police Officers (Scotland):

Mr Ian Gordon, Assistant Chief Constable, Tayside Police
Superintendent Robert Main, Tayside Police

Association of Directors of Social Work:

Mr Duncan Macaulay, Head of Operations, City of Edinburgh Council
Ms Christina Naismith, Principal Planning and Commissioning Officer (Mental Health),
City of Edinburgh Council

British Association of Occupational Therapists (BAOT):

Mrs Jenny Carr, Chair,
Dr Maggie Nicol, Senior Lecturer, Queen Margaret University College

British Association of Social Workers:

Mr Peter Clarke, Mental Health Officer
Ms Ruth Stark, Professional Officer

British Medical Association:

Dr John Garner, GP and Chairman of the Scottish Council
Dr Peter Bennie, Consultant Psychiatrist and Member of the Scottish Council

British Psychological Society (BPS):

Mr Michael Carlin, Forensic Psychologist and Solicitor
Ms Alison McMullan, Consultant Clinical Psychologist, Hartwood Hospital
Dr Sally Cheseldine, Consultant Clinical Psychologist, Kirklands Hospital, Bothwell

Community Psychiatric Nurses Association:

Ms Lena Collins, Scottish Chair
Mr Ian Dow, UK Chair

Crown Office:

Ms Shona Barrie, Policy Group
Mrs Janet Cameron, Policy Group

The Law Society of Scotland:

Mr Adrian Ward, Solicitor, Convener, Mental Health and Disability Committee
Ms Anne Keenan, Deputy Director

Manic Depression Fellowship (Scotland):

Ms Mary-Lou McDermott, Convener

Mental Welfare Commission:

Mrs Norma Bennie, Vice-Chair
Mrs Faith Cotter, Part-Time Commissioner
Mr George Kappler, Social Work Officer

National Schizophrenia Fellowship (Scotland):

Dr Janette Gardner, President
Mrs Mary Fawdry, Board of Management

Royal College of Nursing:

Mr Alex McMahon, Head of Policy
Mrs Christine Brown, Team Leader, Ayrshire and Arran Primary Care Trust

Royal College of Psychiatrists (Scottish Division):

Dr Harry Miller, General Psychiatry, Aberdeen
Dr Pauline Robertson, Learning Disability, Edinburgh
Dr Michael Morton, Child and Adolescent Psychiatry, Glasgow
Dr Colin Gray, Forensic Psychiatry, Carstairs
Dr David J. Hall, General Psychiatry, Dumfries
Dr Donald Lyons, Old Age Psychiatry, Glasgow

Scottish Association for Mental Health (SAMH):

Mr Richard Norris, Head of Policy and Information
Ms May Dunsmuir, Legal and Parliamentary Officer

Scottish Health Board General Managers Group:

Mr John Jackson, Assistant Director of Commissioning – Priority Services, Greater Glasgow Health Board

Scottish Health Advisory Service:

Dr Sandra Grant, Director
Dr Margaret Whoriskey, Adviser for Disability
Ms Lesley Wilkes, Adviser for Mental Health

Scottish Prison Service:

Dr Alan Mitchell, Medical Adviser
Mr Tony Leslie, Nursing Adviser

Scottish Users Network:

Mr George H. Ronald, Director
Mrs Sharon Ronald, Secretary

Sheriffs Association:

Sheriff Daniel Convery

State Hospital Board and Clinical staff:

Mr Dick Manson, General Manager
Dr William Dickson, Medical Director
Dr Tom White, Consultant Forensic Psychiatrist
Mr Doug Irwin, Director of Security (Acting)
Dr Andrew Zealley, Non-Executive Board member
Dr Barbara Ballinger, Non-Executive Board member

The following gave oral evidence on ethnic minority issues to the Committee in June 2000:

Ms Shaben Begum, Advocacy Co-ordinator, State Hospital
Ms Lesley Boyd, Manager, Health Inequality, Lothian Primary Care Trust
Dr Shainool Jiwa, Mental Welfare Commissioner
Mr Colin Lee, Project Leader, Men in Mind, Edinburgh Association for Mental Health
Ms Naina Minhas, Project Co-ordinator, Nari Kallyan Shango (Women's Welfare Group)
Ms Sadiea Nawaz, Health Information Worker, Nari Kallyan Shango (Women's Welfare Group)
Ms Rashpal Nottay, Development/Advocacy worker, Minority Ethnic Communities Mental Health Project, Royal Edinburgh Hospital
Ms Sana Sadollah, Arabic/Refugee Linkworker Advocate, Mental Health Inclusion Project, Lothian Primary Care NHS Trust

The following gave oral presentations at meetings of the Committee:

Speaker	Subject
Mr John Aldridge) Developments in mental health
Head of Health Care Policy Division) services and implications for
Scottish Executive) mental health law
)
Mr Tom Leckie)
Inspector)
Community Care Team))
Social Work Services Inspectorate)
Scottish Executive)

Mr Adrian Ward Convener of Law Society of Scotland Mental Health and Disability Committee	Principles of mental health law reform and international comparisons
Dr Sue Warner Principal Research Officer Scottish Executive Central Research Unit))))
Ms Alison Bean Research Officer Scottish Executive Central Research Unit)) Research into Courts))
Ms Suzi Macpherson Consultant Scottish Executive Central Research Unit)))
Ms Julia White Consultant Scottish Development Centre for Mental Health Services)))) Analysis of Users and Carers) Consultation Leaflet))
Ms Dorothy Buglass Consultant Scottish Development Centre for Mental Health Services))))
Dr Allyson McCollam Deputy Director Scottish Development Centre for Mental Health Services	Analysis of Committee Consultation papers
Ms Alana Atkinson Senior Development Consultant Scottish Development Centre for Mental Health Services	Analysis of User and Carer Consultation Events
Dr Jacqueline Atkinson Senior Lecturer in Behavioural Science Department of Public Health University of Glasgow	Literature Review
Professor Warren Brookbanks (by video link) Associate Professor School of Law University of Auckland New Zealand	New Zealand's incapacity legislation

ANNEX 5

CONSULTATION WITH USERS AND INFORMAL CARERS

1. The Committee consulted users of mental health services, and informal carers, by means of three consultation events and the publication of two consultation leaflets, one of which was specifically aimed at people with learning disabilities. References to 'carers' in this Annex should be taken to mean informal carers.

Consultation events

2. A series of three consultation events was organised by the Scottish Development Centre for Mental Health Services (SDC) on behalf of the Committee, and what follows are the key points taken from the report which the SDC made to the Committee.
3. The events held in Aberdeen, Edinburgh and Glasgow were organised in partnership with local mental health organisations (Aberdeen Mental Health Services Consumer Group, Consultation and Advocacy Promotion Service and Glasgow Association for Mental Health). The Committee was represented at each of the events.
4. Each event began with comments from the local organisation on the issues raised by the local users and carers they had consulted regarding the current Mental Health Act and the changes they wished to see in place. These sessions were followed by group discussions, aided by a facilitator. The delegates met at the end of the day to feed back key issues and to make further comments and raise questions.
5. Attendance at the events was as follows:-

Venue	Service Users	Carers
Glasgow	13	7
Edinburgh	27	13
Aberdeen	16	8
Total	56	28

6. There were a number of themes that came through very strongly at all three events for both service users and carers. These were:
 - ◆ rights of the individual (as a service user or carer);
 - ◆ information;
 - ◆ access to services;
 - ◆ accountability; and
 - ◆ treatment.

7. Users and carers described experiences where their rights under the present Mental Health Act had not been upheld and felt there was little in place to safeguard them. There was a general view that the current Act gave too much power to psychiatrists, who seemed accountable to no-one for their actions and treatment of patients. Both service users and carers considered this unsatisfactory. The issues raised are summarised below.

Stigma

8. Concern was expressed about the stigma society attaches to mental illness and there was recognition that the wider issues of stigma and discrimination need to be considered, particularly in relation to social exclusion and the desire for a more socially inclusive Scotland.

Compulsory treatment and safeguards

9. There was general agreement amongst service users and carers that there was a need for some kind of legislation to ensure the safety of individuals who are mentally ill, and the general public. There was recognition that sometimes people need to be detained for their own safety and care, or for the safety of those around them.
10. Both service users and carers expressed a desire to see something in the Mental Health Act that limits and controls decisions concerning treatment. They want to see advance statements developed and implemented and greater protection for invasive procedures. Service users felt patients should have more choice about treatments, and medication should only be enforced when people are a danger to themselves or others. Carers felt there was too much reliance on medication, and felt that alternatives, such as counselling and cognitive therapy and life and social skills, should be more widely used.
11. Service users and carers felt that people should be involved more in decisions affecting them, and that communication between professionals and users and carers needs to be improved. If compulsory treatment is the only option to safeguard someone's life, then it needs to be administered in a humane way. Clearer national guidelines, which service users have contributed to, should be drawn up for staff in these circumstances; for example, wherever possible, staff of the same sex as the service user should administer medication.

Forum for reviews/appeals

12. Both service users and carers felt the present system was too formal and unsympathetic and they wanted to see more done to raise awareness about mental ill health with sheriffs and other professionals involved in the process.
13. Service users felt a tribunal system would be a more humane approach and that service users should be part of any such system. They also felt that any new system should allow for an appeal for all powers of detention under the Act.

Carers felt that their views should be taken more seriously by mental health officers (MHOs) when they are considering detaining someone under the Act.

14. Service users and carers want to have a less formal and intimidating procedure when people are being detained.

Rights of service users and carers

15. The rights of service users and carers were key issues at all events. Both service users and carers recounted experiences which they felt demonstrated that the current Mental Health Act does not support or protect their rights. It was said that existing procedures are not being followed and there seems to be little in place to safeguard the rights and interests of these groups.
16. Service users want an act to state clearly what their rights are and what they can do to appeal against decisions. They would like information on the provision of independent support, for example from a contract of care setting out standards to be expected.
17. Carers also felt that any mental health act should be explicit about the rights of carers. Carers should have a right to more information and carers' views should be recorded. Carers felt that relationships within families are often damaged when they are asked to agree detention for the person they are caring for. They were of the view that they should not be required to make such decisions.
18. The information needs of service users and carers need to be addressed and radically improved. Information has to be available at all stages and in an accessible format. Service users felt they needed more information about mental illness from GPs and also need more information on discharge from hospital.
19. Service users and carers felt that advocacy should be more comprehensively developed across Scotland, using resources currently deployed in mental health services. Independent advocacy needs to be legitimised and its role in mediation acknowledged.
20. Access to services in the community needs to be more consistent. Many examples were given of people in the same city receiving different services, or being denied access because they did not live within a certain catchment area. The level of service a person receives should not be determined by where they live. More needs to be done to prevent hospitalisation when people are becoming unwell, and services should be available in the community, 24 hours a day, seven days a week. The view was expressed that clearer standards for services need to be developed.

Safeguards for voluntary patients

21. There seems to be a lack of clarity about the rights of voluntary patients that needs to be addressed. Examples were given of voluntary patients being threatened with

detention if they did not agree to treatment. Voluntary patients currently have little protection under the Act.

Protection from abuse and exploitation

22. Delegates felt that more action was required to protect people who commit offences when mentally ill. The court system needs to be less formal in these circumstances and there should be protection from the media. Delegates agreed that the work being undertaken in the Review of the Health and Social Work and Related Services for Mentally Disordered Offenders, launched in January 1999, should address this in more detail.

Mental Welfare Commission

23. There was a general view that the Mental Welfare Commission does not have enough resources to fulfil its current role. People are frustrated that the Commission often acts only in an advisory capacity and would like to see the Commission playing a more active role in safeguarding service users' rights and interests. Both service users and carers feel the Mental Welfare Commission should have powers to play this more active role.

Promoting good practice

24. Users and carers expressed the view that psychiatrists need to be openly accountable for their practice and their practice of detaining people under the Act should be under greater scrutiny. Service users felt they should be actively involved in assessing the quality of hospital and community services and in an education programme for all professionals dealing with mental health on how to work with service users and carers.

General issues

25. Delegates raised the following issues in addition to those already discussed:
 - ◆ the new Act needs to be laid out in a more accessible language, as the present format is confusing and complex for service users and carers;
 - ◆ the law should protect someone who is under the Mental Health Act from eviction, with reviews in place to assess the person's needs;
 - ◆ service users and carers believe that people on long-term medication should receive free prescriptions;
 - ◆ service users would like to see more done in schools to educate young people and children about mental health issues to raise awareness and reduce stigma;
 - ◆ more needs to be done to educate employers and the general public about mental health issues. In particular employers and the benefits system need to be more flexible to enable people to return to work in a supportive way.

Consultation leaflet

1. A leaflet directed to users of mental health services and informal carers was issued in June 1999. Over 11,000 copies of the leaflet were distributed via health boards, local authorities and voluntary organisations. By early January 2000, 202 responses were received.
2. The responses were analysed by the SDC who submitted a report to the Committee. What follows is a summary of points made from their report.
3. This consultation provided a channel for the people most directly affected by mental health law to give their views. There was an opportunity on the consultation leaflet to indicate whether the response came from a user, a carer, a worker or some other group. Of the responses received, 99 were from service users, 39 from carers, 60 from workers and four from groups. The wide range of responses indicated that many respondents had had direct experience of the workings of the current legislation. The responses included a number of specific suggestions about how existing arrangements under the legislation might be improved.
4. The general themes to emerge from the wide range of views expressed were:
 - ◆ recognition that compulsory measures, both treatment and detention, are required, in certain circumstances, principally where risk is a serious factor;
 - ◆ the importance of ensuring that the criteria for such measures are clearly defined;
 - ◆ formal procedures, service ethos and professional practice, are influential in determining the way in which these measures are enforced;
 - ◆ effective interagency and interprofessional working are crucial in implementing the law and ensuring that people receive a co-ordinated response to their needs;
 - ◆ professional practices should be driven by a clear set of principles that uphold the individual's rights to respect and dignity and to exercise control as far as possible over what happens to him or her; and
 - ◆ the importance of strengthening the rights and safeguards of service users and carers, within any legislative framework proposed, and of recognising the particular vulnerabilities of specific groups.
5. A summary of respondents' views is given below.

Experiences of detention

6. There were several common elements to the experiences described by respondents in relation to detention and the features users and carers perceived as important in relation to compulsory detention were:
 - ◆ being treated with respect and sensitivity;
 - ◆ having access to information and advocacy;

- ◆ addressing the stigma and negative connotations associated with detention that often remain with the individual long after the event;
- ◆ ensuring that access to assessment and treatment can be more readily available and that there is greater flexibility in the provision of the law to accommodate individual needs and changes in needs; and
- ◆ balancing provision for intervention in emergencies with the necessary checks and safeguards to ensure consultation with those concerned.

Compulsory medical treatment

7. There was a common recognition among users and carers that compulsory treatment was required under certain circumstances to prevent deterioration in the individual's mental health and/or to avoid harm. It was considered that, as far as possible, any such intervention should be discussed and negotiated with the individual and where relevant the carers involved. Loss of control and autonomy was a major concern amongst users.
8. There was general opposition from both users and carers to the use of ECT without consent. This was partly a result of the damaging effects that were perceived to be associated with ECT.

Compulsory treatment in the community

9. A majority of users and carers agreed that compulsory treatment in the community should be an option. From those who objected to this, objections raised ranged from the ethical, relating to human rights, to the pragmatic, relating to the practicalities of enforcement and ensuring compliance.

Service users' contact with police or court

10. Overall, many people thought that the Sheriff Court was not the appropriate place to hear appeals or to arrange detentions. Both service users and carers found it intimidating. It often felt as if people were being treated as criminals. To a large extent workers supported these views. Access to independent lay advocacy and to legal representation were regarded as important elements in improving access to justice.

Service users' rights

11. The rights of service users were linked to access to advocacy and to an acceptable standard of services. The principle of *Reciprocity* was inherent in many of the views expressed; expecting people to accept compulsory measures brought with it an obligation to put in place the services and supports needed to ensure that treatment was effective.

Rights and protection of voluntary patients

12. The potential vulnerability of voluntary patients was an underlying theme to many of the experiences described. This indicated the importance of providing

protection to safeguard individual rights and well-being. This was considered to be particularly important, as respondents questioned the significance attached to distinctions between voluntary and compulsory patients. In some instances, subtle ways of persuading patients to comply appeared tantamount to compulsion and yet the individual was assured less protection in the law.

Carers' rights

13. The comments of users and carers reflected different perspectives on issues of information sharing, confidentiality and carer involvement in care planning. While users were more likely to have reservations about the role of carers, some were interested in ways of working which allowed the user and potentially the carers to make their wishes known in advance. Carers were frustrated and angry at being marginalised and overlooked by professionals. The absence of respite services was symptomatic of the lack of recognition of the significant role they played in supporting their relative or friend.

Protection from abuse and exploitation

14. Respondents looked to mental health law to protect the interests of those who were vulnerable from exploitation or abuse. They were often critical of the ability of current provisions to achieve this end. Concerns raised ranged from poor standards of care to acts of deliberate abuse. A common theme was that users and carers found it difficult to complain or to have a complaint followed through, to ensure that the behaviour did not occur again.

Advocacy

15. Users, carers and workers agreed that advocates could assist in many situations, including at time of detention or appeal, creating understanding between users and carers and between users and professionals. Details of advocacy were rarely given but the general perception seemed to be of someone independent of hospital and social work services who could interpret the user's needs to professionals. Advocacy was sometimes seen as a pathway to other services, such as after-care or legal representation.

The Mental Welfare Commission

16. Respondents had mixed experiences and held very different perceptions of the Mental Welfare Commission. In some instances users and carers regarded the Commission as inaccessible and had concerns about its capacity to challenge professional opinion.

Issues brought forward by workers

17. Workers raised a broad range of issues relating directly to their professional concerns, in implementing the Act, covering the following points:
 - ◆ the tensions inherent in interprofessional working and their potential impact on the way in which the provisions of the law are enforced;

- ◆ the importance of clarity about roles and responsibilities and pleas from some professional groups to reconsider how they are cast in the law; and
- ◆ the importance of taking account of the geographical diversity of Scotland and the very different pressures that operate in a remote or rural area.

Agencies providing services

18. Users' comments drew attention to a lack of integration in service responses and the need for greater continuity of care across agencies, localities and settings. Respondents wished to be assured that users would receive the same standard of care and protection from abuse, whether they were receiving a health or social service, were in a hospital, a residential facility or in the community.

Guardianship

19. There was some interest in the extension and simplification of guardianship as a means of protecting people from abuse and exploitation.

Personality disorder

20. The responses indicated concerns that the label of "Personality Disorder" is not helpful. One of the main consequences described was that people so labelled were less likely to receive an adequate response from health and social services.

Advance directives and nomination rights

21. Advance directives afforded an opportunity for the individual to exercise more control by making provision for eventualities should they become unwell. This included the facility to specify the individual whom they would wish as a nearest relative in the eyes of the law.

Special needs of women, children, and people with learning disabilities

22. Respondents were keen to see flexibility in the provision of the law to acknowledge and respond to individual needs, expectations and vulnerability. For women this meant recognising possible childcare responsibilities and preferences for single sex facilities, for children and adolescents it involved responding in age appropriate ways, without compounding distress. Finally the law was considered as an important protection for people with learning disabilities who might be at risk of abuse.

Have your say consultation with people with learning disabilities

1. In December 1999 the Committee issued a consultation leaflet entitled *Have Your Say* to people with learning disabilities. Five hundred and eighty leaflets were issued and 101 were returned. This consultation focused on those aspects of the legislation with most salience for people with learning disabilities, seeking their views on detention, compulsory treatment, the rights of individuals and their families, and protection. The leaflet was distributed through health boards, local authorities and voluntary sector agencies.
2. Responses were analysed by Scottish Human Services, and what follows is a summary of their analysis.
3. The findings of the consultation gave a useful insight into users' views and gave powerful messages about people's life experiences.
4. Thirty-one of the 101 respondents had had personal experience of detention. Only four people reported that this had been a good experience, whereas 18 had described detention as a bad experience. The positive reports about detention centred on helpful staff, having a chance to talk and sort out problems. The negative comments concerned:
 - ◆ being assaulted;
 - ◆ being treated in a disrespectful way by staff;
 - ◆ being threatened with punitive measures;
 - ◆ lack of information about what was happening;
 - ◆ feeling shut in and having a life sentence;
 - ◆ a sense of powerlessness; and
 - ◆ feeling frightened, vulnerable and unsafe.
5. Most respondents felt there were times when it would be acceptable to make people take their medicine - when the person was ill, on medical advice or if there was a risk of danger to the individual or to others. Eight respondents said people should never be forced to take their medication. However, it was a different picture when the same question was asked about people at home. It was seen as less acceptable, and less practicable, to force them to take their medicine. forty-three respondents thought this should never happen; 39 thought it would be acceptable in some circumstances.
6. Most respondents believed that people should never be made to take treatments they did not want. Treatments which people thought should never be given without an individual's consent included ECT, some drugs and injections, aversion therapy and sterilisation.
7. About a fifth of the sample thought it was sometimes acceptable for some treatments to be given without consent; if the person was dangerous, on medical

advice and in emergencies. However, respondents thought people should always be told what the treatment was and why it was necessary.

8. The most popular options for people being told about rights when going into hospital were by an advocate and by family members. The importance of accessible information was stressed; written information should include illustrations. People wanted to be told what was wrong with them and what was going to happen to them.
9. Just over half the respondents reported that, given help, they would use a lawyer, while just under a third would approach the Mental Welfare Commission. A significant proportion of the sample had never heard of the Mental Welfare Commission.
10. When asked what rights to services they should have, 27 people identified community nursing and 22 advocates. Other services identified included assessment, information, treatment at home, health care, and transport.
11. There were a number of underlying principles which people thought were important, namely:
 - ◆ the right to have whatever support was needed;
 - ◆ to exercise choice;
 - ◆ to have a say in important decisions;
 - ◆ to have access to the same services as the rest of the population;
 - ◆ to feel safe and comfortable;
 - ◆ to be included; and
 - ◆ to have a good quality support and the right to appeal or seek a second opinion.
12. In relation to sexual rights, 75 respondents thought there was a need for protection for some adults with learning disabilities. The best ways to ensure people only had sex when they wanted included an understanding of rights, opportunities to talk things over and sex education. The importance of stringent staff checks and training were also noted. Some respondents opted for more active risk limitation strategies, such as consent laws, constant chaperoning and surveillance techniques.
13. Views about carers' rights to information and decision-making were varied and fairly evenly spread. Some thought families should have no rights, others thought they should be able to make decisions on behalf of the individual, while others thought families should be involved but not have the final say. Fifty-nine people objected to families being given information about their care without their agreement and 23 thought this was acceptable.
14. Forty-two respondents did not believe they had adequate legal protection from ill treatment. Some had personal experience of bullying and harassment. Several respondents thought the police could do considerably more to help them,

for example by responding more quickly when called for and investigating allegations of ill treatment more thoroughly. In addition some respondents had experience of the police not taking their complaints seriously and being unpleasant to them.

15. The responses to this consultation were very similar to responses from the consultation with service users and carers and the consultation events as described above. In particular the views were very similar in relation to:

- ◆ negative experiences of detention;
- ◆ objections to compulsory treatment;
- ◆ lack of information;
- ◆ wanting more choice and control over their own lives; and
- ◆ the need for independent advocacy.

16. The recurring themes underlying the responses were:

- ◆ people want more choice in their lives and more involvement in the decisions affecting them;
- ◆ they want clear information, given in an accessible manner by someone known to them, and they should have a right to independent advocacy; and
- ◆ people want to be recognised as adults and treated with respect and fairness.

ANNEX 6

SPECIAL EVENTS

1. The Committee's process of evidence-gathering included three one-day seminars on issues of specific interest: learning disability, dementia and children's issues.

Learning disability seminar 10 December 1999

2. ENABLE organised a one-day round table seminar to look at how the Act affects people with learning disabilities.

Delegates

Jackie Bain	People First
Keith Bowden	Gartnavel Royal Hospital
Victor Chlebowski	City of Edinburgh Social Work Dept
Anna Cooper	University of Glasgow
John Dalrymple	Support for Ordinary Living
Alison Di Rollo	Crown Office
Michael Doyle	Fife Primary Health Care NHS Trust
Caroline Greenwood	Mental Welfare Commission
James Hogg	University of Dundee
George Kappler	Mental Welfare Commission
W. Bruce Kidd	Royal Cornhill Hospital
Bill Lindsay	University of Abertay
Kirsty Lowe	The State Hospital
Ros Lyall	Lothian Primary Care NHS Trust
Ewan Davidson	Turning Point
Gary McIntyre	Key Housing Association
Jimmy McNab	People First
Andy Miller	Dunfermline Advocacy Initiative
Pauline Robertson	Lothian Primary Care NHS Trust
Norman Sutton-Hibbert	East Renfrewshire Social Work Dept
Rob Warren	Royal Edinburgh Hospital Patients' Council
Margaret Whoriskey	Scottish Health Advisory Service

ENABLE

Pat Christie	
Elizabeth Craigmyle	
Norman Dunning	
Lena Gillies	
Morris Howatt	Speak Out Advocacy Project
Linda Kerr	
Bill Learmonth	

Millan Committee

Bruce Millan	Chairman
Jim Dyer	
Linda Headland	(ELCAP)
Jim Kiddie	
Roger Maxwell	
Malcolm McEwan	
Colin McKay	Secretary

3. The aims of the day were :

- ◆ to identify issues of particular significance for people with learning disabilities in the context of the review of the Mental Health (Scotland) Act 1984;
- ◆ to inform the Committee by exploring key issues in round-table discussions;
- ◆ to highlight areas of good practice which should be maintained and disseminated further or to identify bad practice/procedures which need to be changed; and
- ◆ to draw together conclusions.

4. Discussions were held in six sessions covering five key themes, which are summarised below.

Part 1: Why have learning disability in the Act?

5. Linda Headland presented views, from a rights perspective, on the positive and negative things about the Act for people with a learning disability. She considered further action was needed to:

- ◆ conduct an exercise to review different experiences from countries where there is not a comparable Act;
- ◆ seek experiences of people with learning disabilities who have been detained, analyse this, their treatment, how they went in, length of stay, outcomes;
- ◆ work on appropriate alternatives to include people with learning disabilities in a reviewed Mental Health Act – there is at the moment no consensus just confusion and polarised views;
- ◆ commission a specific piece of work on what might happen if people with learning disabilities were not included in the Mental Health (Scotland) Act.

6. Pauline Robertson presented views from a clinical perspective. She considered that the Act should include people with learning disabilities, and that those who had been subject to the present Act had not been disadvantaged by its provisions. Around 180 people with learning disabilities are currently detained. Arguments for inclusion in the Act included:

- ◆ Possible need for in patient assessment to clarify diagnosis.
- ◆ Broad scope of treatment in the Act.

- ◆ Need to deal with people with both mental illness and learning disability.
 - ◆ Need to provide for long-term supervision and treatment for those who offend/ are at risk of offending.
7. There was no consensus among delegates about whether learning disabilities should be excluded from the Mental Health (Scotland) Act although it was recognised that specific provisions for people with learning disabilities (e.g. rights to day services and protection for vulnerable women) could be contained within other legislation.

Part 2: Learning disability and offending behaviour

8. Keith Bowden discussed how and why people get into trouble. He said there is still a public attitude that people with learning disabilities are potential offenders. There are no figures available to detail the extent to which offending is a problem within this group, and the majority of those who do come into contact with the criminal justice system are young men with mild to borderline learning disabilities.
9. Alison di Rollo presented a prosecutor's perspective on how the Criminal justice system can meet the needs of people with learning disabilities. She said a key question was how we balance the interests of a learning disabled accused person, who enjoys a presumption of innocence and the right to a fair trial, with the interests of the victims of crime, in particular, and society in general. The criminal justice system is not designed or equipped to "meet the needs" of the learning disabled or indeed any other accused, at least not exclusively. Its objective is to ensure, so far as possible, the fair and effective administration of justice, taking into account all of the various interests at play. Prosecution may be so incompatible with the needs of an individual learning disabled offender that criminal proceedings will not in fact be taken, even where there is sufficient evidence that the accused committed an offence. However, where the offence is serious, for example, sexual offending, offences against children, serious assault and homicide, the interests of the victim and the community will usually outweigh those of the accused, so that criminal proceedings will be justifiable in the public interest.
10. Delegates concluded that there are too few alternative disposals to meet the needs of people with learning disabilities who offend. It would be useful to be able to remit serious cases to a non-criminal tribunal for advice.

Part 3: Vulnerability and abuse (first session)

11. George Kappler gave a brief report on a Deficiency in Care and Treatment Inquiry carried out by the Mental Welfare Commission. The Inquiry concluded that: the adult concerned did not receive adequate supervision and protection during the period under review; the Housing Department were to be commended for their efforts in trying to secure appropriate care and protection for her; several agencies involved in her care, treatment and protection did not respond adequately and timeously to the majority of the assaults against her, which came within the scope

of the Inquiry; poor communication between and within agencies resulted in an inadequate assessment of her mental disorder and level of vulnerability and contributed to unnecessary delays in the decision to use the powers of the Mental Health (Scotland) Act to protect her; this vulnerable person experienced deficiency in care throughout the entire period under review by the Inquiry.

12. Several recommendations were made as a result of the Inquiry, including one that the Millan Committee be made aware of the findings and recommendations of this Inquiry report.
13. Bill Lindsay gave a presentation on *Sexual abuse – how can we meet the needs of the perpetrator?* He said historical attitudes existed that men with intellectual disability/mental impairment have a higher rate of offending and sexual offending, and sex offenders with intellectual disability/mental impairment are likely to re-offend. Possible reasons for a higher rate of sex offending are: less well developed social/sexual identity; less opportunity for sexual relationships; less clarity on societal norms/taboo; greater chance of detection and more likelihood of confessing. Professor Lindsay considered that there were erroneous assumptions that this group had poor self-control or a higher sexual drive. There is some supporting evidence of a higher rate of sexual offending and evidence suggests that 40-70% of men, with and without learning disabilities, will re-offend.
14. In conclusion, Professor Lindsay said individuals can, and should be encouraged, to take responsibility for their actions. People should be assessed on their ability to understand taboos of society and the criminal justice system. The criminal justice system needs to change to deal appropriately with people with learning disabilities who are charged, and there must be appropriate treatment and management.
15. Pat Christie presented a paper discussing the sexual rights of people with learning disabilities. She said that while it is important that the law should protect people with learning disabilities where they are vulnerable, we must also be willing to uphold their rights to experience a range of adult relationships of any kind within the law. As the law stands at present, it seems very difficult to accept that people with profound disabilities also have sexual feelings and rights. She also stressed that the protection of women afforded by the present s106 is valuable and necessary and that it could also be extended to men. However, the interpretation of the level of competence or understanding of the person with learning disability could be disputed. There is a need to address how the law could be adapted to be clear about abuse, and yet flexible. A further issue raised was the need for some legal protection of care staff who are genuinely trying to provide a normal sexual life to people with learning difficulties.
16. Delegates concluded that:
 - ◆ There needs to be a better balance between protecting people and accepting normal sexual behaviour.

- ◆ People should not be denied the right to a sexual relationship just because they are in hospital or residential care.
- ◆ Section 106 should provide protection for both women and men.
- ◆ There is a lack of robust national guidance or a code of conduct for service providers which encompasses sexual rights and staff responsibilities for protection.

Part 4: Vulnerability and abuse (second session)

17. Colin McKay gave a presentation on protecting compliant voluntary patients. He said although very few learning disabled people were detained under the Act, there is no formal protection when, arguably, people with learning disabilities are less able to protect their own interests. Some options which have been put forward to offer protection included advocacy, complaints procedures, assessment and review of community care, and detention with clearer guidelines. Because these are people who are unlikely to be able to complain, there may need to be modifications to statutory complaints procedures in place for them which work. There may be a need for a minimum standard of care to prevent young people with learning disabilities being placed inappropriately in hospital.
18. Delegates agreed that there is a need for national standards in the use of restraint techniques.

Part 5: The rights of people with learning disability

19. Rob Warren presented a paper discussing the question 'can we make procedural rights meaningful to people with learning disabilities?' He said he believed the current legislation serves people with learning disabilities poorly and that the specific needs of people with learning disabilities are not addressed. Interventions in the lives of people with learning disabilities, and the consequent loss of personal freedom or loss of ability to choose and effect change, extends beyond the Mental Health (Scotland) Act and includes those affected by the Criminal Procedure (Scotland) Act 1995. At present there are insufficient safeguards within legislation for people with learning disabilities.
20. Mr Warren concluded that there needs to be:
 - ◆ a specific recognition of the needs of people with learning disabilities and legislation to address this;
 - ◆ a strong emphasis placed on seeking out and taking account of the views of those affected by interventions;
 - ◆ a stronger and more positive emphasis placed on personal development and potential for change;
 - ◆ processes and rights which are more clearly defined, rigorously applied and made more accessible;
 - ◆ a far greater scrutiny of interventions and the way these affect people with learning disabilities;

- ◆ automatic and mandatory access to an individual advocate and provision made for this;
- ◆ an established right to collective advocacy and provision made for this.

21. Delegates agreed that there needs to be much greater provision of advocacy. There is a need to define when someone should have a right to an advocate. Advocacy should be mandatory in certain situations, e.g. when someone is subject to certain legal situations or treatments. Advocacy is also important for vulnerable groups of people including those with limited communication.

Part 6: The role and rights of carers

22. Linda Kerr presented a carer's experience of the system, on behalf of a carer with a son who has a mild learning disability, and schizophrenia. She described the experiences in coming into contact with mental health services. The issues raised by the carer included: she had to repeat the whole history every time she met a new psychologist, social worker, or doctor; her son's assessments stated he should have stability yet he had been in 12 different places in five years; no financial support was offered until the advocate stepped in after four years. However, the carer did feel very well informed in relation to her and her son's rights. Each time he had been sectioned the mental health officer (MHO) had explained what was happening and what they could do. What was lacking was practical support and adequate services.
23. Delegates stated that there should be a link between detention and a care plan to ensure that people receive adequate after-care services.

Dementia seminar 21 January 2000

1. The seminar which was organised by Alzheimer Scotland -Action on Dementia, aimed to address what the law should do, in relation to people with dementia and their carers, and how best to recognise their particular needs.

Delegates

Kate Allan	Dementia Services Development Centre
Simon Backett	St John's Hospital, Livingston
Liz Baikie	Royal Victoria Hospital, Edinburgh
Sheena Bailey	Stratheden Hospital, Fife
Martin Bird	Scottish Borders Council Social Work Department
Tricia Campbell	City of Edinburgh Social Work Department
Charlotte Clarke	University of Northumberland
Colin Cowie	Scottish Care, Craigard House Nursing Home, Ballater
Andrew Dunning	Older People's Advocacy Alliance; Cabinet Office
Ronald Franks	Legal Services Agency
Kevin Hurst	West Lothian Council
Jamie Malcolm	Nursing Commissioner, Mental Welfare Commission Scotland
Jacqueline McDonald	Lothian Local Medical Committee (GP)
Anne Mason	Stirling University
David Nichols	Scottish Law Commission
Elsbeth Stirling	Dundee Liff Hospital
Lynn Welsh	Paisley Law Centre
Heather Wilkinson	Stirling University

Alzheimer Scotland – Action on Dementia

Gill Boardman	Rights and Legal Protection Committee; Community Psychiatric Nurse, Murray Royal Hospital, Perth
Noni Cobban	Council Member; Director, Croft Home Care, Edinburgh
Jim Davie	Rights and Legal Protection Committee; Consultant Physician, Department of Medicine for the Elderly, Stobhill Hospital, Glasgow
Maureen Dewar	Carer, Edinburgh Branch
Caroline Elliott	Administrative Secretary - Public Policy
Jim Jackson	Chief Executive
Alan Jacques	Convener
Jan Killeen	Public Policy Director
Donald Lyons	Council Member; Clinical Director, Greater Glasgow Primary Care NHS Trust
David McClements	Council Member and Rights and Legal Protection Committee; Solicitor, Russell & Aitken
Una Martin	Carer; Edinburgh Branch
Dorothy Sutherland	Chairperson, Stirling and District Branch
Hunter Watson	Rights and Legal Protection Committee, Former Carer

Millan Committee

Bruce Millan	Chairman
James Connechen	
Malcolm McEwan	
Hilary Patrick	
Colin McKay	Secretary
Bette Francis	Secretariat
Luke McGarty	Secretariat

2. Discussion centred around a series of eight sessions, which are summarised below.

Session 1 : Policy context in relation to the Adults with incapacity Bill

3. Hilary Patrick explained the legislative background to the Committee's review and the interaction between the Adults with Incapacity (Scotland) Act 2000 and mental health legislation. Ms Patrick asked delegates to consider how incapacity might be included in a new Act, perhaps by the inclusion of a capacity test as the primary ground for intervention.

Session 2 : Assessing capacity for people with dementia

4. Dr Alan Jacques described the effects of dementia on decision-making, and the causes of variability in capacity. He explained how variability in the condition results in difficulty in assessing capacity. A highly skilled assessment process is needed, with multi-disciplinary input, geared for each individual person with dementia.

Session 3 : Assessing risk

5. Dr Charlotte Clarke gave a presentation detailing how people with dementia are assessed in terms of the risk they present to themselves and others. She presented case studies raising a variety of questions about how we consider risk and how we deal with it. Dr Clarke suggested a number of features which should be considered as central to the assessment of risk in dementia care:
 - ◆ A framework should have trans-cultural credibility, and accommodate temporal dimensions of fluctuating levels of cognitive ability and progressive deterioration.
 - ◆ A framework of risk assessment should identify both a conventional 'problem' orientation and an assessment of the strengths and competencies of the individual and their care environment.
 - ◆ A framework should accommodate the service users' perspective of risk.
 - ◆ Risk taking should be recognised as a component of practice – zero risk is not an option in therapeutic care.

Session 4 : Treatment and compulsion

6. Dr Donald Lyons addressed the issues of treatment and compulsion. He described four cases, the first of which illustrated the difficulty of trying to distinguish between a patient passively accepting treatment and actively resisting treatment. He suggested that a new Mental Health Act could usefully include a principle of 'minimum necessary intervention', as does the Adults with Incapacity (Scotland) Act. The second example related to a patient who passively accepted being in a nursing home. Several delegates noted that such examples were widespread but it was difficult to reach a definitive answer on whether or not admitting and treating such patients without formal consent/approval was proper or appropriate.
7. In discussing the third and fourth examples, many delegates confirmed that the use of disguised sedatives was widespread in practice. Arguments put forward to justify this might include that informing the person is pointless if he or she is incapable of processing that information, and that doing so is a less restrictive alternative to detention and forcible medication.
8. Dr Lyons observed that one of the biggest challenges for any new mental health legislation would be balancing the protection of the individual against introducing an unworkable bureaucratic system.

Session 5 : The status of carers in consultation and decision making about compulsory interventions.

9. Mr Hunter Watson described his experiences as a carer. He made the following recommendations in relation to incapacitated adults:
 - ◆ Where practicable, healthcare professionals should consult with at least one carer prior to any welfare intervention.
 - ◆ No-one should be denied recognition as a carer simply because he/she is not a relative, welfare attorney or guardian.
 - ◆ Carers should have a right to all relevant information before discussing any welfare decision, and should be allowed the time to reflect on that information.
 - ◆ Each incapacitated adult should have a care manager, who is not an employee of a care home in which the adult lives.
 - ◆ Such adults should not be removed from a care home against their or their carers' wishes, without recourse to a court or tribunal.
 - ◆ A new appeals procedure should reduce the need to go to court.
 - ◆ Legislation for care homes should permit certain forms of treatment under the mental health act. Surreptitious medication should be illegal. Inspectors should monitor observation of legislation.

Session 6 : The role of independent advocates

10. Andrew Dunning gave a presentation on the role of independent advocates. He explained that there is no advocacy legislation in the U.K. although there is a considerable amount of policy guidance. Over a hundred schemes are now in place for older people, up from a dozen in 1993.
11. Mr Dunning detailed the reasons for advocacy with older people, especially at key points of transition to different environments. Protection is required from abuse and also from over-protection. Advocacy helps avoid depersonalisation, discrimination and encourages participation. Currently the shape of advocacy is determined by those who commission services – there is a need for the advocacy movement to shape the goals and outcomes.
12. He concluded that there is a need for a formal role for advocates in mental health law. To achieve this, professionals will have to look at conflicts of interest, ensuring rights and wishes are respected. Sufficient resources will be required to back quality standards and training.

Session 7 : Removal from home to hospital or other facility

13. John Armstrong discussed the difficulties encountered when removing someone from their home because of mental incapacity. In relation to the question on the justifications for compulsorily removing a person from home, Mr. Armstrong said legislation should identify the criterion –that the person needs treatment -and that treatment is for a general medical condition. It should be justifiable to remove someone suffering neglect, physical, sexual or financial abuse if there are no other means of prevention. He recognised that a move to a hospital was not always appropriate as would be required under the present Mental Health Act.
14. He gave a summary of proposals:
 - ◆ It should be clear there is a right to gain admission to the person's home when necessary.
 - ◆ The right thing has to be done when admission gained.
 - ◆ It should be possible to get a warrant if admission is refused. The Vulnerable Adults Report contained a framework which would meet the needs.

Session 8: The use of physical restraints, including locked doors

15. Mr Jamie Malcolm discussed the use of physical restraints, saying that the key question for this session was "Does the law need to have special safeguards to cover the use of restraint?"
16. Mr Malcolm described many forms of restraint, saying it can be both explicit and intentional, or subtle and incidental to other care activities: e.g. catheterisation could, in some circumstances have the effect of restraining an individual. He said

restraint should be seen as a significant intervention. It could, in some situations, be considered to constitute an assault. It is stigmatising, and carries a risk of harm to the person being restrained. It can increase the symptoms of dementia. Pressures on care staff because of limited training, poor resources and poor design of the care environment can lower the threshold for the use of restraint as can unrealistic expectations of the creation of an entirely risk free environment. External influences, such as inspection, audit and advocacy are necessary to counter this. Restraint should only be used after a full assessment, consideration of alternatives, and should be the minimum necessary for the minimum time.

17. Mr. Malcolm concluded by asking if restraint issues should be addressed purely by guidance, inspection etc, or whether there needed to be minimum safeguards in the law to minimise the risk of improper restraint, which interferes unduly with the personal freedom of the person involved and may actually increase risk of harm for that person.

Summary

18. The day's events were summarised with some proposals and some questions which delegates asked the Committee to consider:
 - ◆ Should there be a distinction between treatment for mental and for physical disorder?
 - ◆ Is resistance to treatment versus passive acceptance of treatment the dividing line for the Mental Health Act? What status should advance directives have?
 - ◆ The Vulnerable Adults Report should be implemented.
 - ◆ The discussion on *Incapacity* and *Risk* as basic principles raised the question of how far they are separate from each other and how much they interact.
 - ◆ How far should access to services be part of mental health legislation?
 - ◆ Who should do assessment? – it is important to have the views of relatives and carers.
 - ◆ With regards to courts and hearings, there is agreement that the sheriff court as it stands is not the right place.
 - ◆ There are lay and professional concepts of risk.
 - ◆ There is a distinction between “minimum necessary” and “least intrusive” intervention.
 - ◆ Should issues of treatment be divorced from the locus of treatment?
 - ◆ Consultation with carers should be at least yearly.
 - ◆ Should advocacy be a legally based right, and how should people who are mentally incapable have access to advocacy?
 - ◆ There will be financial restraints, but hopefully this should not determine the law.
 - ◆ Is restraint a form of treatment?
 - ◆ Access to information for carers is essential.

Children's event 19 November 1999

- 1 Children in Scotland organised a one-day seminar to raise issues of particular significance concerning children and young people. A report from the seminar has been published by Children in Scotland. Chaired by the vice-convenor of Children in Scotland, Professor Lorraine Waterhouse of the University of Edinburgh, a collection of evidence was heard from a wide range of sources including professionals, practitioners and young people (see delegate list). The seminar aimed:
 - ◆ to identify issues of particular significance for children and young people in the context of the review,
 - ◆ to inform the Committee on areas of debate by exploring key issues under discussion,
 - ◆ to emphasise areas of good practice and innovation relevant to mental health legislation.

Delegates

Robyn Bray	Penumbra Youth Project
Linda Brown	Yorkhill NHS Trust
Holly Calder	Penumbra Youth Project
Nicola Cogan	Glasgow University
Liz Craigmyle	ENABLE
Sandra de Munoz	Royal Infirmary of Edinburgh NHS Trust
Christina Del Priore	Royal Hospital for Sick Children
Nigel Duerdoth	The Mental Health Foundation
Sarah Elliston	Glasgow University
Heather Gardener	Gartnavel Royal Hospital
Eve-Marie Haydock	Penumbra Youth Project
Linda Kerr	ENABLE
Louie Larkin	Renfrewshire Association for Mental Health
Patrick Little	Penumbra
Gwynedd Lloyd	University of Edinburgh
Shona McFarlane	Penumbra Youth Project
Dorothy Mackintosh	Highland Community NHS Trust
Eva Mathis	Penumbra Youth Project
Vijay Patel	British Agency of Adoption and Fostering
Karen Prentice	Scottish Association for Mental Health
Veronica Rattray	The National Deaf Children's Society
Sheila Riddell	Glasgow University
Joyce Wilson	Sense Scotland

Children in Scotland

Bronwen Cohen
Emily Gray
Sophie Pilgrim

Kay Tisdall	
Fiona Wager	
Lorraine Waterhouse	Vice-convenor

Millan Committee

Bruce Millan	Chairman
Caroline Blair	
Colin McKay	Secretary

2. The discussion centred around the following presentations:
 - ◆ Issues arising from cross-over legislation and recent policy recommendations
 - ◆ Drawing the distinction between adults and children/ young people.
 - ◆ Mental health and 'social, emotional and behavioural difficulties' (SEBD).
 - ◆ Issues of Consent: Children and the Mental Health (Scotland) Act 1984.
 - ◆ Provision of Services: transitional issues and issues of minimum standard setting.
 - ◆ Adolescent self-poisoning in Edinburgh – past and present.
 - ◆ Young Peoples Perspective.

Summary of discussion

Over-arching principles

- 3 The seminar identified the need for a legal enunciation of principles promoting the protection of the rights of children and young people. These principles should be in accordance with the UN Convention on the Rights of the Child and should be compatible with the Children (Scotland) Act 1995. These principles should be enshrined in the revised mental health legislation.

Harmonising legislation

- 4 The seminar recommended consistency across all legislation affecting children and young people. New legislation should be compatible with the Children (Scotland) Act 1995 and the UN Convention on the Rights of the Child. This would assist in clarifying the rights of children, young people, their parents and carers. It would further elucidate the responsibilities of all authorities and promote integrated services.

Code of practice

- 5 The seminar supported the idea of a mandatory Code of Practice to ensure that new legislation is fully and effectively implemented. Such a code should pay special attention to the needs of children and young people experiencing mental health problems and their families. It was further concluded that minimum standard setting should be included in the Code of Practice, to ensure an operable

level of services and standards. This should specifically protect children and young people from being treated on adult psychiatric wards and ensure educational opportunities are not unnecessarily affected by treatment or caring responsibilities.

Compulsory powers

- 6 All participants attending the seminar agreed that any interventions in the lives of a child or young person should be kept to a minimum. Wherever possible children and young people should be enabled and encouraged to participate in decision-making procedures and should have their views taken into account. Within any new legislation participants would want to see it made explicit that no child is considered 'untreatable'.

Compulsion - the decision to utilise compulsory powers should be taken by a multi-disciplinary team and in consultation with parents or carers. All compulsory treatments for children and young people should have regular and full reviews. Certain decisions that have an irreversible effect (for example, ECT) should be avoided for young people without capacity.

Consent – should be sought from any child or young person who is capable of understanding the nature and possible consequences of the treatment. How, when and who judge a child's competence needs further attention, in guidance and training with consideration of what is judged as competent for the particular decision being made.

Detention - may be a necessary but extreme procedure. Therefore safeguards to ensure a child or young person's access to adequate and effective consultation and representation are essential. Children and young people should be treated within an age-appropriate environment.

Special groups

- 7 In order to ensure services reflect the full spectrum of needs, legislation must explicitly cover the diverse and differing requirements of all children affected by mental illness. The seminar emphasised that legislation must address the specific needs of the following:
 - ◆ Children and young people with caring responsibilities,
 - ◆ Children and young people with disabilities,
 - ◆ The changing needs of young people through the stages of transition,
 - ◆ Recognition of the differing requirements of male and female service users.

Communication and information

- 8 The seminar was of the view that communication and information were of key importance. Effective information and advice should reflect the distinct needs of

each different client group. Information regarding mental health issues should also be provided in age-appropriate language to be more accessible and be made widely available for all children and young people. The views and opinions of all children utilising mental health services should be effectively sought and taken into account in any decisions which will affect them.

Independent representation

- 9 Provision for independent advocates to support children and young people in making decisions is further recommended. Any child or young person should also have the right to select or reject an appointed advocate. Advocacy services should also be available for parents and carers who require support and guidance in decision-making.

Implementation of legislation

- 10 Joint guidance should be issued for health, social care, education, the Children's Hearing System and child and adolescent mental health services. The Scottish Executive should establish an implementation group with specific responsibility for assisting with disseminating and promoting good practice relating to children and young people. The example of Children in Scotland's 'Implementation Forum' for the Children (Scotland) Act 1995 was raised by participants; this Forum, funded by the National Lottery Charities Board, was able to support and promote the participation of professionals and practitioners in the implementation of the Act.

Early intervention

- 11 Research indicates that early involvement prevents many children and young people from developing more severe mental health difficulties. The Millan Committee should thus advocate the development and improvement of provisions for early intervention. To achieve best results in this area, early assessment and a holistic approach to treatment are vital.

ANNEX 7

An evaluation of section 18 of the Mental Health (Scotland) Act 1984 Executive Summary Scottish Executive Central Research Unit

CHAPTER 1 BACKGROUND TO THE RESEARCH

1. This research was commissioned to provide information about the operation of section 18 of the Mental Health (Scotland) Act (MH(S)A) for the review of the Mental Health (Scotland) Act.
2. The MH(S)A allows people to be detained compulsorily if they have a mental disorder that requires treatment in hospital, either for their health or safety or the protection of others and they are unwilling or unable to accept this treatment voluntarily. If a psychiatrist wishes to detain a person for longer than 31 days an application must be made to the sheriff court for an order under section 18 of the Act. This allows people to be detained for up to 6 months with the possibility of subsequent renewal. Between 1 April 1998 and 31 March 1999, 1055 section 18 detentions were granted by the sheriff court.
3. Most applications are made by local authority Mental Health Officers (MHOs) (although nearest relatives can also make them). The application is accompanied by two medical reports: one from the patient's psychiatrist and one normally from the patient's GP. Legal Aid is available for applications to allow the patient to be represented in the hearing, but until April 2000 this was means-tested.

CHAPTER 2 RESEARCH METHODOLOGY

4. The primary aim of this research was to find out as much as possible about the way section 18 operates in the courts. The research was carried out between July 1999 and January 2000.
5. One year was chosen as a focus for the study, April 1998 to March 1999. The study involved an analysis of the Mental Welfare Commission (MWC) database, which held information about these 1055 orders. This was supplemented by a survey of local authority Mental Health Officers who had been involved in these cases. More in-depth information was collected through an analysis of the case records in three courts and from interviews with professionals, patients and support groups with experience of the section 18 process.

CHAPTER 3 MENTAL WELFARE COMMISSION DATA

6. Eighty-eight per cent of patients who were detained under section 18 were already in hospital when the order was granted. Nearly all of them had a mental illness; very few were said to have a learning disability. Glasgow had the greatest number of orders, followed by Edinburgh, then Fife and Aberdeen. A sample was taken of 936 cases that were discharged by August 1999. Of these, about half (52%) lasted six months or less. In 31 per cent of cases the section 18 expired without renewal. 57 per cent of patients were on Leave of Absence when the order was discharged and 25 per cent of patients remained informally in hospital. In this year 2005 section 18 orders were renewed.

CHAPTER 4 MENTAL HEALTH OFFICER QUESTIONNAIRE

7. A sample of all the section 18 applications granted in this year was taken (739 of the 1055 orders) and a questionnaire sent to the MHOs who had dealt with the cases. Five hundred and twenty-two questionnaires were returned, a response rate of 71 per cent.
8. Section 18 orders were split roughly equally between men and women. Seventy-six per cent of patients were said by MHOs to be able to communicate their wishes and feelings and 84 per cent were said to understand that they were or had been subject to the section 18 order. On average, patients had been known to Social Work departments because of their mental health for 57 months. Thirty-five per cent had been so known for 18 months or less.
9. In 81 per cent of cases the patient's nearest relative was said to have been involved in the application. In 79 per cent of cases this involvement took the form of discussing the application with the MHO. Only six per cent of nearest relatives attended court for the hearing.
10. Twenty-seven per cent of patients were said to have been legally aided. The main reason given for patients not receiving legal aid when they were eligible to do so was that they did not contest the application (67%). Twenty-eight per cent of patients attended court; the main reason given for patients not attending was that they did not wish to (81% of non-attenders).
11. Patients were said to have been represented in 39 per cent of cases, nearly all of them by a solicitor, although some were said to have been represented by family members. Sixty per cent of those who were represented were said to have chosen their own solicitor; in 28 per cent of represented cases, the court chose the patient's solicitor. Twenty-four per cent of patients who were represented had a curator ad litem. The local authority was represented in 41 per cent of cases.
12. Oral evidence was said to have been given in 50 per cent of cases, mostly by MHOs (in 44% of cases). Other witnesses appeared in fewer cases. The patient was said to have given evidence in only 18 per cent of cases, as was the

psychiatrist, while GPs appeared in 13 per cent of cases. Nearest relatives were said to have given evidence in only three per cent of the hearings. Twenty-seven per cent of applications were said to have been contested.

13. The impact of the section 18 process appeared to be very similar for both sexes. The most significant differences were that 27 per cent of men chose their own solicitor, compared to 18 per cent of women, and a curator ad litem was appointed for 13 per cent of women and six per cent of men.
14. There was a link between being represented in court and the patient's attendance at court; 76% of those who were said to have representation, attended court. However, a significant number of patients were also represented in court, but did not attend themselves. Over half the sample (52%) were said neither to have attended court nor to have been represented. In 44 per cent of cases, the patient either attended court or was represented (data was missing for the other four per cent). Patients were more likely to give evidence if they were represented and the application was more likely to be contested.
15. The MHO data were analysed to see how the section 18 process varied across different local authority areas. Practice varied a great deal in different local authorities, particularly in the areas of patient attendance and patient representation.

CHAPTER 5 CASE STUDIES

16. Three courts were chosen to provide a more in-depth picture of the operation of section 18. Two courts were in cities and the other served a mainly rural area. The researchers analysed court records from the three courts and conducted interviews with court personnel. The main foci of the analysis were the court process, the problems faced by the courts in administering the Act and the brevity and content of the medical reports written on the court forms. Court personnel suggested that for them, one of the biggest challenges was working within the statutory time-limits, which leave little time available to the court or the patients to prepare for these applications.
17. Court A is a large urban court that hears applications from several local authorities and hospitals. The court reported no difficulties in administering the Act, possibly aided by the ease with which hearings can be placed before a sheriff on any day of the week. In roughly a third of cases, the patient had fewer than three days' notice of the hearing.
18. The patient was definitely represented in about half of all cases (though data were missing and this figure could have been higher) with a *curator ad litem* appointed in just three cases. Patients attended court in about a third of cases (again data were missing) and in nearly two-thirds of cases no oral evidence was heard. Continuations were widespread, occurring in half of all the cases looked at, mainly to obtain an independent psychiatric opinion. However, few of these reports appear to have been seen subsequently by the court.

19. Non-compliance with medication or treatment was given as a reason for the detention in over half of all psychiatrists' and GPs' reports. Lack of insight was given in about a third of reports. Risk to others or to self was mentioned in less than 20 per cent of doctors' reports. Just under a third of doctors' reports were very brief (12 words or fewer).
20. Court B is an urban court that hears applications from one large local authority and mostly from one local hospital. A highly efficient hospital administrator and close relations between court and hospital ensured that there were no major problems in administering the Act. In just under a half of all cases, applications came into the court when the section 26 order was due to expire in four days or less. In just over a quarter of cases the patient was given fewer than three days' notice of the hearing.
21. Eighteen per cent of patients were represented by a *curator ad litem* and solicitors or *curators ad litem* were appointed to act for patients in just under 40 per cent of cases. Most cases were heard in hospital rather than in the courthouse. Uncontested cases were heard in chambers with only the sheriff and clerk present. Continuations occurred in just over 20 per cent of cases.
22. In the medical reports, non-compliance was given as a reason for the detention in just under 60 per cent of psychiatrists' reports and over 40 per cent of GPs' reports. Lack of insight was cited equally by psychiatrists and GPs in just under 40 per cent of cases. Risk to others was cited in just over 10 per cent of psychiatrists' reports and just over 20 per cent of GPs' reports. The corresponding figures for risk to self were just over 30 per cent of psychiatrists and a half of all GPs. A quarter of reports consisted of 12 words or fewer and nearly half consisted of 12 to 20 words.
23. Court C dealt with cases from a large, mainly rural area. The court reported the greatest difficulties in administering cases, caused in part by the distance doctors are required to travel to attend court and to visit patients. Despite this, Court C had the highest percentage of cases in which five to eight days remained of the section 26 order when the application was filed. However, in just under 60 per cent of cases, the patient was given less than three days' notice of the hearing. In a third of cases the patient was informed of the hearing the day before.
24. About 40 per cent of patients were legally represented but no curators ad litem were appointed in Court C. Patients attended the hearing in just over a third of cases and oral evidence was called in just under a quarter of cases. Continuations were used in just under a third of cases. Court C was distinguished by the relatively high number of appeals against both section 26 and section 30 orders.
25. In the medical reports, non-compliance with medication or treatment was cited in just under three-quarters of psychiatrists' reports and two-thirds of GPs' reports and lack of insight in just over a half of psychiatrists' reports and about 40 per cent of GPs' reports. Risk to self was cited in about 30 per cent of both doctors' reports and risk to self in 38 per cent of psychiatrists' reports and 36 per cent

of GPs reports. About a third of doctors' reports consisted of 12 words or fewer and just under 20 per cent were illegible in part or in whole.

CHAPTER 6 EXPLANATIONS

26. Interviews were conducted with about 50 individuals with experience of the Act from different areas. Ten of these were service users. The interviews appeared to show that there are considerable variations in practice across the country (something already suggested by the data from the MHO survey). Although the interviews were not drawn from a representative sample, they did provide some explanations for the findings from the MWC data analysis, the MHO survey and the case studies and they offered another perspective on the section 18 process.
27. The interviews suggested that the section 18 process is more efficient where there are agreed procedures for filing applications and notifying patients about the hearing. This is made more difficult by doctors' lack of knowledge of the procedural requirements of the Act. The need to identify an effective treatment within the 28 days allowed by the section 26 order also appears to lead to the late filing of applications.
28. There were mixed views about the appropriate venue for these hearings. Patients interviewed for this study preferred cases to be heard in courts as they were perceived to be independent. Medical personnel preferred cases to be heard in hospitals because they thought they were less intimidating for patients and more convenient for hospital staff. There was some support amongst solicitors for a wider choice of venues than the court and one solicitor thought the courts should be replaced by a tribunal system.
29. Some solicitors expressed concerns about the brevity of the evidence provided by doctors on the court forms. One psychiatrist reported that he felt obliged to present reports to court that emphasised the patient's more abnormal behaviour, to ensure that the order was granted. GPs were reported to play a generally peripheral role in these proceedings, due to their lack of specialist knowledge of mental health.
30. Obtaining an independent psychiatric opinion was felt to be crucial to a successful challenge to the application. This was said to be easier to do in some courts than in others. In Court C problems were said to arise because of the difficulty of obtaining reports from doctors who live far from the court. Inevitably, the court case will be continued to allow time for an independent opinion to be obtained. According to interviewees from two areas of the country, doctors in their area are reluctant to treat patients during continuations. The evidence from the cases studies suggests that in fact, independent opinions appear to have little impact on the outcome of the case. It is only in very few cases that applications are unsuccessful.
31. The general impression gained from the interviews was that many patients find the prospect of attending court to be an intimidating one and are too ill to take part.

Some solicitors suggested that patients are deterred from seeking legal advice by medical staff. MHOs and patients reported that patients were unaware of their legal rights when they were first detained and afterwards. One interviewee had been surprised at the number of patients who appeared not to know what their rights were and had started a course in her hospital to inform them and their families.

32. Nearest relatives appear to play very little part in section 18 hearings. One MHO suggested that family members are protected from participating because they are under so much pressure already. There was a suggestion that family members are marginalised and do not know a great deal about their rights. One interviewee felt that many carers and relatives do not wish to have to make the decision about detaining a family member as their involvement can destroy family relationships. They would prefer a professional to make the decision. A patients' support group worker pointed out that some patients also do not want their family members to play any part in their cases because of the strains that already exist in family relationships.
33. Nurses were identified as being the key provider of information to patients and carers. Interviewees suggested that because they are so busy, this is difficult for them and lay advocates could fulfil this role instead. Some hospitals were reported to have good protocols to ensure that patients are given proper notice of hearings but this is not the case everywhere. While professionals thought that they did their best to ensure that people had access to legal advice, patients and their supporters were less positive. Medical staff reported that it was difficult to inform patients about their rights because they were often too ill to absorb the information. Patients suggested that they felt they had been unlawfully detained by hospital staff and felt powerless to enforce their rights or opinions. When solicitors are involved in the case, they reported that they often have 48 hours or less to prepare for the hearing.
34. Psychiatrists suggested that they often do not expect patients to remain in hospital for the full six months of the order. Rather, patients leave hospital on Leave of Absence shortly after the section 18 order is granted.

CHAPTER 7 CONCLUSIONS AND SUGGESTIONS

35. The researchers concluded that the section 18 process, as designed has the potential to be independent, effective, appropriate and accountable. However, at present, the provisions designed to protect patients' rights, such as access to information and legal representation, may not work as effectively as they might.

ANNEX 8

LITERATURE REVIEW – SUMMARY

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1. Review methodology

The aim of the review was to identify and report on the literature relating to mental health legislation, as it might be relevant to discussions of reform of the legislation. Other literature informed some of the sections but the search was limited to that involving the law.

2. Overarching principles

The legal justifications for civil commitment are protection of the public and public responsibility. These allow persons to be detained both for their own protection and the protection of others. There are broad underlying principles to compulsory detention which have been suggested: dangerousness, due process, treatability and reciprocity.

Dangerousness and due process underpin American mental health legislation. Dangerousness as the criterion for detention has had less impact than was expected on detention because self-neglect, and welfare considerations, remain important. Dangerousness is a feature of a substantial number of detentions in Britain.

Due process is particularly important in the USA, in large part as a result of the civil rights movement. The role of the court is to ensure 'fairness' and to be independent. There is evidence from both Britain and the USA that both the courts and clinicians make 'common sense' judgements about who needs to be detained. They frequently act in what they believe to be 'the person's best interests', interpreting the law in ways that allow such decisions to be taken. There is evidence that the short-term effects of changes to the law diminish and that previous patterns of decision-making re-establish themselves.

Treatability has been proposed as an underlying principle of mental health law. Treatability is often seen only in terms of medication and co-operation with treatment remains an issue in other forms of treatment such as psychotherapy.

This is of particular relevance to people with a diagnosis of personality disorder.

Reciprocity is still to be fully explored as an underlying principle but includes concepts such as equality of treatment and the provision of 'the best' in terms of services, and treatment in compensation for removing a person's liberty.

3. Definitions of mental illness

Although mental illness or mental handicap (learning disability) may be necessary conditions for detention they are never sufficient conditions. Other factors, such as dangerousness or treatability (discussed above) are also necessary. These and other factors may broaden or restrict the number of people to whom the law applies. Availability of services may influence this as well as issues of civil liberties.

Some legislation has introduced specific diagnoses into parts of the Act with attendant problems. New South Wales, for example, allows the detention of a financially irresponsible person with a diagnosis of manic depression but not schizophrenia.

Most legislation has exclusion criteria, such as illegal or immoral conduct, religious or philosophical beliefs or opinions, sexual preference or orientation, promiscuity and the use of alcohol or drugs.

4. Community detention

The main debate in community detention is between orders which allow for enforced treatment (usually medication) while someone lives in the community and orders which do not.

Community treatment orders (CTOs) have been challenged as an infringement of a person's civil liberty and as problematic under Article 5.1 of the European Convention on Human Rights. Other arguments put forward against CTOs are that they are a response to a political agenda rather than clinical argument, that they turn staff into 'parole agents', that they may put staff at more risk, that people may be kept on CTOs for unacceptably long periods of time, and that problems with enforcement and sanctions make them unworkable.

Even where CTOs exist (such as in most of the USA and Australia) what sanctions can be imposed on patients on a CTO who still refuse treatment, beyond readmitting them to hospital, is unclear. Where there is data there is some suggestion that CTOs were not enforced or there were problems with enforcement when a patient refused treatment.

The impact of CTOs is difficult to establish as there is little good research. Their effectiveness cannot be divorced from the adequacy of community services and generally CTOs have been introduced with no additional resources. CTOs may be used to prioritise patients for services and there is some suggestion that it was increased use of services which accounted for improved outcomes rather than community detention *per se*.

Patients who are put on a CTO are likely (according to Australian research) to be non-compliant with medication in the community, and this might affect 3%-5% of in-patients.

In Britain leave of absence (LOA) has operated as a *de facto* CTO. It was limited to 12 months in Scotland by the Mental Health (Patients in the Community) Act. It had previously been limited to six months in England & Wales and this was extended to 12 months. Evidence from studies on LOA which go back to the 1980s need to be interpreted with care, since community services have changed considerably since then. Patients who were placed on LOA were more likely to have a recent history of dangerousness, be non-compliant with medication, have a recent history of loss to follow-up and have had more formal detentions than patients not on LOA.

Most (60%) LOAs were allowed to expire, 19% were formally discharged and 2% by a MHRT decision in England. Being recalled to hospital was most likely to be linked to non-compliance with medication. Outcome from LOA is variable with it seeming to improve outcome for about half the patients on LOA but an increase in admissions for about 20%. It is not a universal answer to poor compliance in the community.

The numbers of people on extended LOA in Scotland prior to their time limitation was steadily increasing. Services for people on extended LOA appear limited.

The 1995 legislation introduced supervised discharge (SD) in England and Wales and community care orders (CCOs) in Scotland. Supervised discharge was predated by the supervision register.

The number of people on a CCO in Scotland is small, although the number is slowly increasing. This may reflect opposition to their introduction by psychiatrists in Scotland. This was based on their lack of power to compel compliance with treatment. CCOs are seen as bureaucratic. There is concern that health boards or local authorities could be held liable in the event of not providing services or therapies laid down as conditions of a CCO.

Supervised discharge has been used predominately for male patients with a diagnosis of schizophrenia. Supervised discharge was used more by psychiatrists in general, forensic and rehabilitation settings than by old age psychiatrists. All supervised discharge orders surveyed had a condition relating to compliance with medication, 50% conditions about residence and 59% conditions about allowing access to supervisors.

5. Guardianship

The numbers of people on guardianship in Scotland has remained fairly constant for people with a learning disability, but has increased steadily for people with mental illness, dementia, pre-senile dementia and alcohol-related brain damage (Korsakov's psychosis). For elderly people guardianship orders are frequently being used as a means of transferring people into residential care. Local authority

guardians are often not clearly identified and this creates a lack of clarity in respect of their powers and responsibility. Few people are represented by a *curator ad litem*.

A similar increase in the use of guardianship is shown in England. There is concern that some social services departments are not using guardianship due to lack of resources. It has been noted that guardianship may be preferred by Responsible Medical Officers (RMOs) to supervised discharge since initiation of guardianship is the responsibility of the approved social worker (ASW) whereas supervised discharge is the responsibility of the RMO.

Elsewhere guardianship exists in various forms. The hogosha system in Japan places great responsibility on the guardian to protect the community from the patient and is criticised both for this and its infringement of patients' rights. Conservatorship in the USA is based on substituted consent, which is also the model used in a number of states in Australia. It is a model which is increasingly being used as a protective system for people with disabilities other than mental illness. Similar to this is the system of decision making by proxy established in New Zealand. This is also used for a wide range of people who are deemed to lack competency. It incorporates the principle of least restrictive alternative as does Canada's model of guardianship which includes substituted consent.

6. Detention in Scotland

Knowledge about detention and patients' rights by patients, psychiatrists or GPs is generally poor. This includes doctors' knowledge of their duty to inform patients of their rights, issues of consent and understanding of particular sections of the Mental Health Act.

Despite section 18 being intended as the main route to detention it is rarely implemented direct from the community. Emergency admission under sections 24 and 25 predominates. This is in contrast to England. Section 18 is seen as inappropriate or burdensome by GPs. Since a significant proportion of emergency detentions result in discharges to voluntary status there is concern that voluntary admission is not sought as rigorously as it might be.

Detention under all sections of the Mental Health (Scotland) Act continues to rise steadily.

7. Secure provision in Scotland

There are a number of concerns regarding the provision of secure accommodation across Scotland. Facilities are variable as is level of security. Facilities for women are sometimes inadequate, particularly where hospitals are contracting. Most patients admitted to intensive psychiatric care units are male with a diagnosis of schizophrenia and a history of physical violence to others.

A particular problem at the State hospital is entrapment due to lack of medium secure facilities, with some patients being admitted there who are not in need of maximum security. The population of the State hospital continues to grow.

8. Mortality and morbidity in Scotland

The number of suicides reported to the MWC continues to increase, and comes mainly from an increase in men and outpatients, the numbers for women and in-patients remaining constant. The dominant diagnosis is schizophrenia. The MWC recommends greater standardisation of procedures and risk communication.

There has been a dramatic rise in first psychiatric admissions for young men with a diagnosis of paranoid states, non-organic psychosis and, to a lesser extent, affective disorders. This may be linked to a greater incidence of substance abuse.

9. Electroconvulsive therapy

One small study found no difference between consenting and non-consenting patients and formal and informal patients in the perception of ECT's helpfulness and their willingness to repeat the treatment.

In Britain ECT can be given to non-consenting patients. This is not the case everywhere. In New South Wales, for example, it can only be given to a non-consenting patient if it is considered to be immediately necessary as a life saving measure.

10. Voluntary patients

Voluntary patients do not have the same rights as detained patients to information or recourse to the safeguards provided by the Act. This is important given that many informal patients do not know their rights, including their right to leave hospital and to refuse medication. Where a patient seeks to discharge him/herself against medical advice, current mental state is a more important factor than what has happened to the patient in the past.

There is concern in Britain and elsewhere about the hospitalisation and treatment of patients who lack capacity but who do not object to treatment. The new legislation on incapacity in Scotland addresses some of these concerns. The majority of psychiatrists agree that lack of safeguards for this patient group is a problem. Although the number of patients being formally detained rose slowly after the Bournemouth case this trend has stopped and detentions have returned to previous levels. There appears still to be confusion over the treatment of incapable but non-objecting patients.

11. Patients' rights

Different countries base issues of patients' rights on their individual legislation or constitution, e.g. the American Constitution, Canada's Charter of Rights and the European Convention on Human Rights. Articles 3, 5 (1)(e), 5(4), 12 and 13 of the ECHR are thought to be particularly relevant.

One 'right' argued for is the right to treatment or services. This is generally underpinned by an assumption that people want to be 'well'. Without appropriate

treatment a patient may be detained for a longer period (if then allowed to refuse treatment although detained). It is argued that this is not in the patient's best interests. It is also expensive for the service.

A number of States and countries allow patients to refuse treatment when they are detained. This has been argued for under a variety of 'rights', including freedom of thought, freedom of religion, individual privacy, autonomy, bodily integrity and informed consent. Pragmatically, the right of refusal is often overruled and treatment is permitted, particularly where a patient has been violent.

12. Capacity, competency and consent

This section only deals with these issues in relation to people with mental illness.

In Britain the Mental Health Act allows competent people who have a mental illness to be treated against their will. There is a balance to be struck between the right to freedom of decision making and the right to protection from harm.

There is no single operationalised standard of competency. Tests of capacity seek to establish a threshold. The main approaches to defining capacity are: outcome, status and function, or some integration of these. The main characteristics of capacity are communicating a choice, understanding relevant information, retaining information, understanding/appreciating the personal significance of the information and arriving at a decision through reasonable and rational manipulation of the information. Tests of capacity need to be related to specific situations and cannot be applied generically.

There is some confusion between concepts of lack of insight and competency. Lack of insight seems to be equated with lack of appreciation of the personal significance of information for most practical purposes. In common law, irrationality is not, in and of itself, indicative of incapacity. In assessing rationality it is difficult to separate the decision from outcome.

The MacArthur Treatment Competency Study was an attempt to develop a reliable and valid way of addressing competency in people with a mental illness, that would be useful both in relation to clinical and policy questions. The measures developed were not intended to be used as legal definitions of competency. It found that although patients with a mental illness performed less well than other groups, and people with schizophrenia less well than other groups of psychiatric patients, the majority of people with schizophrenia did not perform more poorly in competent decision making than other groups of people. The study highlighted the heterogeneity of people with a mental illness and raised a number of questions regarding the measurement of competency in people with a mental illness.

13. Minority groups

A number of groups are singled out for special consideration under mental health legislation.

The elderly population with senile dementia is seen as presenting special problems not addressed fully by the UK Mental Health Acts. Section 47 of the National Assistance Act 1948 does not have the same safeguards as mental health law. 90% of the people for whom it is used are over 65 years, in poor physical health and have a psychiatric disorder. Few Mental Health Review Tribunals are held in England for people over 65 years who are formally detained. The possibility of conducting hearings for the elderly along the lines of Children's Hearings has been supported by some groups. Detention increases for women with age.

The Mental Health Acts refer to 'mental impairment', rather than mental handicap, in relation to guardianship, and there is some suggestion that this may have limited its use. Patients with a diagnosis of learning disability who are detained are likely to be young, male and detained for violent or challenging behaviour. Patients with a diagnosis of learning disability are likely to be detained for a longer period of time than patients with a mental illness.

There are problems in commenting on the use of mental health law in relation to ethnic minorities as there is little monitoring of ethnicity at key points in the criminal justice system and by the statutory bodies such as the MWC.

There is almost no research or data in relation to mental health legislation and homelessness.

14. Attitudes to psychiatric illness

Some limited research was found relating to attitudes to people with mental illness in Scotland. A small survey of the public in Lothian, using vignettes, suggested that people with schizophrenia were treated similarly to a healthy control whereas people with depression or diabetes were treated more positively. Fewer people knew someone with schizophrenia than the other illnesses, but those who did know someone with schizophrenia were less likely to be sympathetic or sociable towards the hypothetical neighbour.

A similar finding was uncovered in a study of the media, which also demonstrated that people with a psychiatric illness are viewed as violent, even when this is contrary to experience.

Surveys indicate that GPs were less willing to treat people with schizophrenia than other illnesses and suggested that patients with a psychotic illness expected to be subject to more discrimination from GPs and psychiatrists than from the general public.

Although there is often local community opposition to facilities being sited in a particular area, there is some evidence that central planning control and a low key approach to the development of supported accommodation by voluntary agencies may be helpful.

15. Research and mental health law

There is a general dearth of good research on, or audit of, mental health legislation in Scotland and elsewhere in terms of both outcomes and process. Some suggestions are made as to why this might be the case, which includes methodological difficulties, including problems of consent, the lack of a national data base geared towards research or audit, funding issues, publication issues and the impact of the research assessment exercise in universities.

ANNEX 9

SCOTTISH LAW COMMISSION - REPORT ON VULNERABLE ADULTS

LIST OF RECOMMENDATIONS

1. The recommendations set out in the rest of this report should apply in relation to individuals aged 16 or over.
(Paragraph 2.11)
2. A vulnerable adult should be defined for the purposes of this report as an adult who is unable to safeguard his or her personal welfare, property or financial affairs, and is:
 - (a) in need of care and attention arising out of age or infirmity, or
 - (b) suffering from illness or mental disorder, or
 - (c) substantially handicapped by any disability.
(Paragraph 2.11)
3.
 - (1) No intervention in relation to an adult should be authorised or carried out if the adult objects unless those authorising or carrying out the intervention reasonably believe that the adult is vulnerable and is either mentally disordered or subject to undue pressure.
 - (2) For this purpose an intervention does not include mere enquires or authorised inspections carried out to determine whether it is necessary to intervene to protect the welfare and property of adults who are, or who may be, vulnerable.
(Paragraph 2.26)
4.
 - (1) Local authorities should have the primary role in dealing with vulnerable adults who are, or are thought to be, mentally disordered. The Mental Welfare Commission should be entitled to act but should not be bound to do so.
 - (2) Local authorities and the Mental Welfare Commission should be under a duty to collaborate with each other in relation to investigations and other matters concerning such vulnerable adults.
(Paragraph 2.29)
5. Without prejudice to the existing powers and duties of other persons:
 - (a) A local authority should be under a duty to enquire as to whether steps need to be taken to protect the welfare or property of adults who are, or whom it believes to be, vulnerable.

- (b) The Mental Welfare Commission should retain its existing duty under section 3(2) of the Mental Health (Scotland) Act 1984 to investigate cases of suspected ill-treatment, deficiency in care or treatment, improper detention or loss or damage to property of persons who may be mentally disordered. It should also be entitled to enquire as to whether steps need to be taken to protect the welfare or property of adults who are, or it believes to be, vulnerable by reason of mental disorder.

(Paragraph 3.12)

- 6. (1) A mental health officer or other prescribed officer of the local authority should be entitled to demand admission to premises if he or she reasonably believes that entry to the premises would assist him or her with the enquiries under Recommendation 5. A commissioner or officer of the Mental Welfare Commission should be similarly entitled but only in relation to adults who are, or are reasonably believed to be mentally disordered.
- (2) The person demanding admission should be required to show written authority from the Commission or local authority as the case may be. Admission may be demanded at all reasonable times and the person should be entitled to be accompanied by one or more other individuals.
- (3) The Secretary of State should have power to make regulations prescribing other categories of officers of the local authority for the purpose of paragraph (1) above and the form of written authority referred to in paragraph (2) above.
- (4) This power to demand admission should be in addition to other statutory powers under the Social work (Scotland) Act 1968 or other legislation, but should replace existing powers of mental health officers and medical commissioners under section 117 of the Mental Health (Scotland) Act 1984.

(Paragraph 3.23)

- 7. (1) A warrant for forcible entry to specified premises where a vulnerable adult or suspected vulnerable adult is should be capable of being granted if a person from the local authority entitled to demand admission under Recommendation 6 has been refused admission or a refusal is apprehended.
- (2) A sheriff (including an honorary or a temporary sheriff) should be empowered to grant a warrant. A justice of the peace should be similarly empowered but only if a sheriff is not reasonably available and delaying until a sheriff is available would be likely to be prejudicial to the adult.
- (3) The application should be made in writing signed by a duly authorised person from the local authority. It should no longer be a requirement that the applicant swears to the truth of the information in the application. The applicant should have to appear personally before the sheriff or justice dealing with the application.

- (4) A warrant should authorise the police to take such steps (including the use of reasonable force) as are necessary to ensure that a duly authorised person from the local authority and those accompanying that person can enter and carry out their functions in Recommendation 8.
- (5) A warrant should cease to be effective 72 hours after it was granted.
- (6) Paragraphs (1) to (5) above should apply to a duly authorised person from the Mental Welfare Commission but only in relation to a mentally disordered adult or a suspected mentally disordered adult. They should replace the existing provisions for forcible entry in section 117 of the Mental Health (Scotland) Act 1984.

(Paragraph 3.35)

- 8. (1) The duly authorised person from the local authority and other persons (including any police constable) who have gained admission to premises under Recommendations 6 and 7 should be entitled:
 - (a) to inspect the premises
 - (b) to have access to the vulnerable adults or suspected vulnerable adult and to other adults present.
 - (c) to interview in private any adult on the premises
 - (d) if the duly authorised person or other person is a medical practitioner, to examine in private any adult on the premises who is or appears to be vulnerable.
- (2) Where the duly authorised person is from the Mental Welfare Commission only an adult who is, or appears to be, mentally disordered should be liable to be examined.

(Paragraph 3.39)

- 9. (1) The sheriff should be empowered, on an application by the local authority, to grant an order authorising a private interview and a private examination by a doctor of an adult reasonably believed to be vulnerable in order to assess the adult's medical or care needs, or whether services or protective measures are necessary. The Mental Welfare Commission should be entitled to apply but only in relation to adults reasonably believed to be mentally disordered.
- (2) Rules of Court should provide for intimation of the application to the adult, the adult's nearest relative and any other person thought appropriate by the sheriff. All those receiving intimation should be given an opportunity of making representations.
- (3) At any hearing the adult should be permitted to be accompanied by a friend. The sheriff should consider whether to appoint a safeguarder to the adult.

- (4) Before granting the order the sheriff should have to be satisfied that there is reasonable cause to believe that the adult is vulnerable and that the examination or interview will assist the applicant with its enquiries.
- (5) An order should last for a specified period of not more than seven days. The period should start on a date specified in the order.
- (6) Those conducting the assessment should have power to interview (and in the case of a doctor examine) the adult in private.
- (7) The sheriff should have power on granting the order or subsequently to make any ancillary order required to make the principal order effective.
- (8) The sheriff may dispense with intimation and grant the order forthwith but only if satisfied that the delay if the normal procedure were to be followed would be prejudicial to the adult.

(Paragraph 4.8)

- 10. (1) Where documents, records or accounts belonging to or relating to the vulnerable adult are not produced voluntarily, inspection of such material should require an order to that effect from a sheriff. An application by the local authority should be made to a sheriff who should have the power to grant an order for a duly authorised person to inspect (and if necessary search for) specified material or material of a specified class if satisfied that there is reasonable cause to believe that the adult is vulnerable and that the material is likely to be of substantial value to the investigation. Only a doctor should be allowed to inspect medical records. The premises in which inspection and search are authorised should have to be specified in the order.
- (2) The Mental Welfare Commission and persons authorised by it should have the above functions, but only in relation to adults who are, or who are reasonably believed to be mentally disordered.

(Paragraph 4.15)

- 11. The provision in section 47 of the National Assistance Act 1948, the National Assistance (Amendment) Act 1951 and section 117 of the Mental Health (Scotland) Act 1984 dealing with compulsory removal of people from premises to hospitals and other places of safety should be replaced by the following provisions:

- (1) A local authority should be entitled to apply to a sheriff for an order authorising the removal of an adult, whom it reasonably believes to be vulnerable, from premises to a specified place within 72 hours of the granting the order. The Mental Welfare Commission should be entitled to apply only in relation to adults reasonably believed to be mentally disordered.
- (2) The order should further authorise the adult's detention in the specified place for a specified time, not exceeding seven days.

- (3) An application for a removal order should be required to be intimated to the adult sought to be removed. Rules of Court should provide for intimation to his or her nearest relative and any other person the sheriff thinks should receive it. The Mental Welfare Commission should receive intimation of an application by the local authority and vice versa. All those receiving intimation should be given an opportunity to make representations.
- (4) The sheriff may dispense with intimation and grant the order forthwith but only if satisfied that the delay if the normal procedure were to be followed would be prejudicial to the adult.
- (5) At any hearing the adult should be permitted to be accompanied by a friend. The sheriff should have to consider whether to appoint a safeguarder to an otherwise unrepresented adult.
- (6) The sheriff should not grant an order unless satisfied that the adult sought to be removed is vulnerable and is at risk of significant harm unless removed.
- (7) The order should authorise the police to take such steps (including the use of reasonable force) as are necessary to ensure that a duly authorised person from the applicant authority and other personnel can gain entry to the premises and remove the adult from there to the specified place.
- (8) A justice of the peace may deal with an application for the immediate grant of an order dispensing with intimation only if a sheriff is not reasonably available. A justice should not be empowered to deal with any other kind of application for removal.

(Paragraph 4.35)

12. The sheriff should, on application, have power to make an order excluding a person living in the same house as a vulnerable adult if satisfied that:
 - (a) the vulnerable adult is entitled to occupy the home by virtue of ownership, tenancy or otherwise;
 - (b) the vulnerable adult is suffering, or is likely to suffer, significant harm to health as a result of any conduct, or any threatened or reasonably apprehended conduct, of the person sought to be excluded; and
 - (c) the making of an exclusion order -
 - (i) is necessary for the protection of the vulnerable adult, irrespective of whether he or she is for the time being residing in the home, and
 - (ii) would better safeguard the vulnerable adult's welfare than removal of the vulnerable adult from the home.

(Paragraph 4.45)

13. The sheriff should not grant an exclusion order if the vulnerable adult objects unless he or she considers that the vulnerable adult's objections should be disregarded because of mental disorder or undue pressure.
(Paragraph 4.48)
14. (1) An exclusion order under Recommendation 12 should be granted for a period not exceeding six months as specified by the sheriff. An excluded person who occupied by permission of the vulnerable adult should not become re-entitled to occupy merely because the period has elapsed.
(2) There should be no statutory provisions preventing an excluded person from disposing of the home or bringing an action for its division and sale.
(Paragraph 4.5)
15. The sheriff should have power pending the making of an exclusion order under Recommendation 12 to make an interim exclusion order, provided the person sought to be excluded has been afforded an opportunity of being heard.
(Paragraph 4.51)
16. (1) The sheriff granting an exclusion order or an interim exclusion order should have power to grant an interdict against re-entry, a warrant for summary ejection and other appropriate orders (including attaching a power of arrest to any interdict and granting the interdict against re-entry subject to conditions).
(2) The sheriff should have power to vary or recall any exclusion order, interim order or associated ancillary order.
(Paragraph 4.56)
17. (1) Where the vulnerable adult is able to apply for an exclusion order only he or she may do.
(2) Where the vulnerable adult is not so able, an application may be made on the adult's behalf by a curator bonis or other legal representative, or by the local authority. The local authority should have a duty to apply if satisfied that:
 - (a) the grounds for exclusion set out in recommendation 12 exist, and
 - (b) that no application or other proceedings for removal of the abuser were pending or consideration.
 (3) The court should consider appointing a safeguarder to the vulnerable adult in an application made by the local authority.
(Paragraph 4.59)
18. A person who is entitled to occupy a home which he or she shares with the vulnerable adult and any other person should be able to apply for that other person's exclusion on the same grounds as in Recommendation 12.
(Paragraph 4.6)

19. The duty of a local authority under section 48 of the National Assistance Act 1948 to protect property of people admitted to hospital etc. should be extended to those removed to a place of safety under section 118 of the Mental Health (Scotland) Act 1984 and vulnerable adults removed under Recommendation 11.
(Paragraph 5.9)
20. A warrant granted under section 117(3) of the Mental Health (Scotland) Act 1984 authorising a constable to enter premises by force to retake a patient absent without leave should be addressed to the police force for the area and should not be required to name the constable.
(Paragraph 5.1)
21. The Secretary of State for Scotland should, after consultation with appropriate bodies, prepare, publish and keep under review a Code of Practice containing guidance to local authorities, medical practitioners and the managers and staff of hospitals as to the exercise of their functions under our recommendations.
(Paragraph 5.12)
22. It should be an offence for any person, other than the vulnerable adult concerned, to obstruct or hinder a duly authorised person from the local authority or Mental Welfare Commission in carrying out the functions recommended in this report in relation to that adult.
(Paragraph 5.14)
23.
 - (1) The decision of a sheriff or justice of the peace in relation to warrants for forcible entry to premises (Recommendation 7), a sheriff's order for assessment and examination of vulnerable adults and associated ancillary orders (Recommendation 9), and a sheriff's order for production and inspection of documents and records relating to vulnerable adults (Recommendation 10) should be final.
 - (2) The granting by a sheriff or justice of an order for the removal of a vulnerable adult (Recommendation 11) should be capable of being reviewed. The vulnerable adult or any person with an interest in the vulnerable adult's welfare should be entitled to apply for review. The review application should be determined within three working days of its being made or as soon as practicable thereafter
 - (3) An order granted by sheriff excluding a person living with a vulnerable adult (Recommendation 12) should be appealable either to the sheriff principal or the Court of Session in accordance with sections 26 and 27 of the Sheriff Courts (Scotland) Act 1907. Any appeal against an interim exclusion order should require the leave of the sheriff whether or not the interlocutor contains one or more interdicts.
(Paragraph 5.18)
24.
 - (1) In general, the local authority to take action under the recommendations in this report should be the local authority for the area in which the vulnerable adult or suspected vulnerable adult is habitually resident.

- (2) The local authority in whose area the vulnerable adult or suspected vulnerable adult is present should be able to take action if the adult has no habitual residence, if the adult's habitual residence can not be readily determined, or if urgent action requires to be taken.
- (3) The local authority in whose area property belonging to a vulnerable adult or a suspected vulnerable adult is situated should be able to take action in relation to that property if urgent action requires to be taken.

(Paragraph 5.2)

- 25. An application to the sheriff under the recommendations in this report (except for an assessment order under recommendation 9) should be made to the sheriff in whose sheriffdom the premises concerned are situated. An application for an assessment order should be made to the sheriff in whose sheriffdom the adult to be assessed is present.

(Paragraph 5.21)

ANNEX 10

MENTALLY DISORDERED OFFENDERS AND CRIMINAL PROCEEDINGS

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(RE-PRINTED FROM Crime and Criminal Justice Research Findings No. 27)

This study was undertaken to monitor and assess the operation and impact of the provisions contained within Part VI of the Criminal Procedure (Scotland) Act 1995, (the 1995 Act), relating to unfitness to plead, examination of facts and the insanity defence.

Main Findings

- ◆ The legislation was invoked in 52 cases during the research period. Three quarters of the cases (n=39) were heard in Sheriff Courts; 9 (23%) were on indictment and 30 (77%) were summary complaints. The remaining 13 cases were heard in the High Court.
- ◆ 37 (71%), of the cases involved a plea in bar of trial. The accused was found unfit to plead in 29 cases. In 5 cases the accused was found sane and fit to plead, and 2 cases were deserted by the Crown before the fitness of the accused was determined. In one case the plea was withdrawn by the defence.
- ◆ 3 cases (6%) involved both a plea in bar of trial and an insanity defence and in all 3 cases the accused was found unfit to plead.
- ◆ 12 cases (23%) involved an insanity defence. The accused was successful in establishing the defence and acquitted on the grounds of insanity in 10 cases.
- ◆ In all but 3 of the 37 plea in bar of trial cases the issue of the accused's unfitness to stand trial was identified and raised by the defence solicitor at an early stage, normally before the first court diet.
- ◆ A total of 30 examination of the facts (E.O.F.) hearings were conducted during the research period. The facts were held to be established in 22 cases; in 3 cases the facts were held to be established but on the balance of probabilities the accused was insane at the time of the offence and in the remaining 5 cases the facts were held not to be established.
- ◆ Hospital orders were imposed in a total of 26 cases (9 had restriction orders attached); Supervision and Treatment orders were made in 5 cases, a Guardianship order in one case, and in 3 cases no order was made.
- ◆ Five cases involved appeal proceedings. All of the appeals focused on the issue of fitness to plead. No appeals arose against disposal during the research period.
- ◆ Both legal and medical personnel largely welcomed the new provisions.

Introduction

The main aim of the research was to assess the operation and impact of the provisions contained within the 1995 Act relating to unfitness to plead, examination of facts and the insanity defence.

The key objectives of the research were to:

- ◆ review the pattern of use of the legislation;
- ◆ examine the stages at which the accused's mental state was determined to merit a plea in bar of trial;
- ◆ examine the use of the disposal options and investigate any problems arising from their use;
- ◆ ascertain the views of both legal and medical practitioners on the interpretation and use of the legislation; and
- ◆ assess the impact of the reforms, particularly in relation to defence submissions of unfitness to plead and the use of the insanity defence in solemn and summary proceedings.

The research period was from 1 April 1996, when the provisions of the 1995 Act came into force, until August 1998. A notification procedure in respect of all cases invoking the legislation was established with the Sheriff Clerks in all Sheriff Courts across Scotland and with the Justiciary Office of the High Court. Researchers attended courts throughout Scotland to observe cases involving a plea in bar of trial and recorded the proceedings, beginning with the proof dealing with the issue of fitness to plead, following each case through the E.O.F. (where this took place), up until the disposal of the case. The insanity defence cases were followed up by telephone or in writing to obtain information on the success of the defence and the disposal chosen by the court. The use of the appeal provisions contained within the 1995 Act were also monitored as part of the study. Formal Interviews were carried out with Judges, Sheriffs, Advocates Depute, Procurators Fiscal and defence agents. In addition, psychiatrists and psychologists were interviewed. In all cases the individuals had experience of the 1995 Act provisions and some had experience of the previous provisions contained within the Criminal Procedure (Scotland) Act 1975. The individuals interviewed were involved in cases which raised issues particularly relevant and of interest to the research and were located across Scotland. In addition to these formal interviews, informal discussions with court personnel took place while attending court hearings, providing further insight into the operation of the legislation.

The pattern of the use of legislation and the impact of the reforms

A total of 52 cases in which the legislation was invoked were notified to the researchers. Three quarters of these cases (n=39) were heard at the Sheriff Court level and of these 9 (23%) were on indictment and 30 (77%) were summary complaints. The remaining 13 cases were heard at High Court level. It was

originally estimated that the 1995 legislation would be invoked in approximately 12 cases per annum.

Cases invoking the legislation involved a wide spread of crimes and offences, of varying levels of seriousness from breach of the peace to murder. All but 2 of the cases involved a single accused. In the majority of cases (81%) the accused was male and the majority of male accused were aged between 21 and 35 years. In 6 cases, the accused was from an ethnic minority and 3 cases involved an accused who was deaf and dumb. In 70% of cases, information regarding previous convictions was available and of these, 30% (11 cases) were first time offenders and 69% (25 cases) had a previous conviction. In 52% (27 cases), the accused had some form of documented history of psychiatric or psychological problems.

Of the 52 cases, 37 (71%) involved a plea in bar of trial, 12 (23%) involved an insanity defence and 3 (6%) involved both a plea in bar of trial and an insanity defence. In most of the cases involving a plea in bar of trial, the plea was raised by the defence and unopposed by the Crown. In several cases a joint minute was lodged to this effect.

In 29 of the 37 cases involving a plea in bar of trial, the accused was found unfit to plead. In 5 cases the accused was found sane and fit to plead, and in 2 cases the Crown deserted the cases *pro loco et tempore* before the fitness of the accused was determined. In one case the plea was withdrawn by the defence. In 10 of the 12 cases where an insanity defence was lodged, the accused was successful in establishing the defence and acquitted on the grounds of insanity. In all 3 cases involving both a plea in bar of trial and an insanity defence both pleas were successful.

The examination of the facts

E.O.F.s were conducted in 27 of the 29 cases where the accused successfully pled unfitness to plead. Of the 2 remaining cases, in one the Crown deserted the case prior to the E.O.F. and in the other the E.O.F. was still ongoing at the end of the research period. E.O.F.s also took place in the 3 cases where both a plea in bar of trial and an insanity defence were lodged.

Of the 30 E.O.F.s which were conducted, the facts were held to be established in 22 cases, in a further 3 cases the facts were held to be established but on the balance of probabilities the accused was insane at the time of the offence and in the remaining 5 cases the facts were held not to be established. The reasons for this were due to insufficiency of evidence and problems of identification of the accused when his presence had been dispensed with by means of s.54(5) of the legislation. A key issue which arose in relation to the E.O.F. was the difficulties caused where there was a co-accused.

The issue of mental impairment complicated plea in bar of trial cases. There was never any clear consensus from legal or medical personnel on mental impairment as a reason for unfitness to plead and these cases prompted much contention and debate. In almost all cases where mental impairment was involved, clinical

psychologists were called upon to provide written or oral evidence, however, there was little consensus amongst judges and sheriffs as to the relevance of psychological evidence in relation to determining fitness to plead.

Psychiatrists in all but a few instances appeared in court to speak to their written reports. Approximately a third of plea in bar of trial cases were characterised by problems concerning the interpretation of the legal tests determining fitness to plead. In a small number of cases there was the additional problem of the language used in reports, which was highly technical and largely inaccessible to the courts. In some instances the presiding judge or sheriff expressed extreme dissatisfaction with the psychiatric evidence that was presented, describing it as unhelpful or misleading.

The stage at which the issue of the accused's mental state was raised

In all but 3 of the 37 cases in which a plea in bar of trial was made, the issue of the accused's unfitness to stand trial was identified and raised by the defence solicitor at an early stage, normally before the first court diet. In 2 cases the issue of fitness to plead was raised by the Crown under s.52(1) of the legislation. In one case the presiding magistrate in the District Court detected something was wrong and remitted the case to the Sheriff Court. In most cases the accused was present for the plea in bar of trial diet.

The use of disposals

Of the 22 plea in bar of trial cases where the facts were held to be established at the E.O.F., a Hospital order was imposed in 16 cases (4 of these had restriction orders attached), a Supervision and Treatment order was made in 4 cases; a Guardianship order was made in one case, and in the remaining case no order was made. In the 3 cases which involved both a plea in bar of trial and an insanity defence, Hospital orders were imposed (one with a restriction order). In 7 of the 10 successful insanity defence cases a Hospital order was imposed (4 with a restriction order), in one case a Supervision and Treatment order was imposed and in 2 cases no order was made. In the vast majority of cases, resource issues did not affect the choice of disposal.

A consistent pattern of disposal in relation to previous psychiatric history or offending was not evident. In many cases the disposal corresponded to the seriousness of the offence, however, there were exceptions to this where community based disposal were used for relatively serious offences and hospital disposals for less serious offences.

Appeal Proceedings

Five cases involved appeal proceedings. All of the appeals focused on the issue of fitness to plead; all were initiated by the defence and all but one were unsuccessful. One case involved two appeals. No appeals arose against disposal during the research period.

Interviews with legal and medical personnel

Interviews were carried out with legal personnel that focused on general views on the legislation, the drafting of the legislation and issues arising from the medico-legal interface. All interviewees welcomed the legislation. In particular the introduction of E.O.Fs and the subsequent establishment of the accused's liability for the offence, together with the wider range of disposals were welcomed. Psychiatric evidence was viewed positively for the most part, though there was some comment in relation to psychiatrist's knowledge of the legal tests of insanity and unfitness to plead. The treatment of accused suffering from mental impairment as opposed to mental illness and the lack of recognition of psychologists as the appropriate expert witness in such cases attracted mixed opinion.

Formal interviews and informal discussions were carried out with 28 psychiatrists and 3 psychologists. All of the psychiatrists had experience of the new legislative provisions and the main issues which arose in these interviews included, the lack of notification of psychiatrists of the new legislation, the quality of instructions received by psychiatrists from solicitors, the relationship between legal and medical personnel, knowledge and understanding of the relevant legal tests, issues around mental impairment, giving evidence in court and general views on the workings of the legislation including the E.O.F. and disposals. Interviews with psychologists focused on their role in mental impairment cases, namely the assessment of the accused, giving oral evidence and their general views on the working of the legislation.

The Need for Further Research

The issue of trial upon recovery for those accused found unfit to plead requires to be monitored in future research. The issue of trial upon recovery did not arise during this study. Of particular interest would be the characteristics of cases where such trial upon recovery occurs, whether it only relates to accused who have been deemed to have feigned mental illness and the procedural difficulties encountered in pursuing such a prosecution.

Resource implications of the new range of disposals requires future monitoring. The Crime and Punishment (Scotland) Act 1997 reduced the period within which a bed must be available before a hospital disposal can be made, from 28 to 7 days. This change came into effect on 1 January 1998. The effect of this change on hospital orders was not marked in the remaining period of the research project, however, changes in health board policy could affect the number of beds available and consequently resource implications could arise.

RECOMMENDATIONS

List of Recommendations

Chapter 1

- 1.1 The Mental Health (Scotland) Act 1984 should be repealed and replaced with a new Act of the Scottish Parliament

Chapter 2

- 2.1 The new Mental Health Act should, so far as possible, be consistent with the Adults with Incapacity (Scotland) Act 2000. In due course, mental health and incapacity legislation should be consolidated into a single Act.

Chapter 3

- 3.1 The Mental Health Act should contain a Statement of Principles.
- 3.2 Interventions under the Act, and the Code of Practice, should have regard to the stated Principles.
- 3.3 The Principles should be as follows:

1. Non discrimination

People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.

2. Equality

All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.

3. Respect for diversity

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. Reciprocity

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and

social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

5. Informal care

Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

6. Participation

Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

7. Respect for carers

Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. Least restrictive alternative

Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. Benefit

Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

10. Child welfare

The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Chapter 4

- 4.1 The provisions of the new Mental Health Act should apply where there is the presence of mental disorder.
- 4.2 There should be three categories of mental disorder: mental illness, learning disability and personality disorder.
- 4.3 These terms should not be defined further in the legislation, but guidance should be given as to their application in the Code of Practice.
- 4.4 It should only be possible for a person to be subject to compulsory measures of care under the Mental Health Act where the person has a mental disorder.

- 4.5 Mental illness should be taken to include psychotic conditions, and non-psychotic mental illnesses such as anorexia nervosa, obsessive compulsive disorders, and disorders of mood. It should also include dementia and acquired brain injury with associated mental symptoms.
- 4.6 There should be an expert review at an early date of the position of learning disability within mental health law. This review should consider
- ◆ the implications of the Scottish Executive's review of learning disability services for legislation affecting people with learning disability, including mental health law
 - ◆ experiences from jurisdictions with different arrangements in respect of learning disability and compulsory care
 - ◆ whether it is feasible and desirable to make separate provision for the compulsory care of people with learning disabilities, outwith the Mental Health Act
 - ◆ the experiences of people with learning disabilities who have been detained under the 1984 Act, including their treatment and outcomes
 - ◆ what measures might be taken to ensure that arrangements for people with learning disabilities who offend meet the needs of the offenders and society.
- 4.7 Pending any change arising from such a review, there should continue to be provision for learning disability within the Mental Health Act.
- 4.8 The definition of mental disorder for the purposes of compulsory measures of care, should include learning disability.
- 4.9 Learning disability should include autistic spectrum disorders.
- 4.10 The categories of 'mental impairment' and 'severe mental impairment' should be abolished.
- 4.11 Personality disorder should be specified as a category of mental disorder in the Mental Health Act, separate from mental illness and learning disability.
- 4.12 The definition of mental disorder for the purposes of compulsory measures of care, should include personality disorder.
- 4.13 The definition of mental disorder should specifically prevent people being included within the definition by reason only of sexual orientation or behaviour, alcohol or substance misuse, anti-social behaviour, or 'acting as no prudent person would act'.
- 4.14 Where on renewal of long term compulsion the diagnosis of a patient changes from one of the categories of mental illness, learning disability and personality disorder to another, or there is a change in one aspect of a dual diagnosis, there should be an automatic review of the case by a mental health tribunal.

- 4.15 In the case of a restricted patient, there should be a review by the Restricted Patients' Review Board where a report by the responsible medical officer contains such a change in diagnosis.
- 4.16 The recommended definition of mental disorder should be incorporated into the Adults with Incapacity (Scotland) Act 2000, the Social Work (Scotland) Act 1968, and the Criminal Procedure (Scotland) Act 1995.
- 4.17 Other legislation which currently makes reference to the definition of mental disorder in the 1984 Act should be reviewed, and new definitions which are appropriate to the intended purpose substituted.

Chapter 5

- 5.1 The current criteria in respect of compulsory measures of 'appropriateness' and 'necessity' should be replaced.
- 5.2 It should only be possible to impose compulsory measures when it has been established that the necessary care and treatment cannot be provided by agreement with the patient.
- 5.3 It should only be possible for a person to be subject to long term compulsion where it can be shown that, as a consequence of the person's mental disorder, the person's judgement is impaired to a nature or degree which would justify compulsory measures.
- 5.4 In relation to emergency or short term measures, it would only be necessary to show a reasonable likelihood that the person's judgement is impaired.
- 5.5 The care and treatment proposed under compulsory measures should be the least restrictive and invasive alternative available, compatible with the delivery of safe and effective care.
- 5.6 It should only be possible for a person to be subject to long term compulsory measures where the treatment proposed to be administered under the plan of care for the patient is likely to provide a benefit for the patient, by alleviating or preventing deterioration in the patient's mental disorder, or associated symptoms of that disorder.
- 5.7 In relation to emergency and short term measures, it should be shown either, that compulsion is necessary to receive treatment for the above purpose, or that compulsion is necessary to assess the possible need for such treatment.
- 5.8 'Treatment' should be defined broadly, to include medical, nursing, psychotherapeutic and other interventions.

- 5.9 It should be a requirement of compulsory measures that there should be either:
- ◆ a significant risk of harm to the health or safety or welfare of the person for whom compulsion is sought, or
 - ◆ a significant risk of harm to other persons.
- 5.10 The specific provision for a treatability test relating to those whose mental disorder is classified as mental impairment or a persistent disorder “manifested only by abnormally aggressive or seriously irresponsible conduct” should be repealed.

Chapter 6

- 6.1 The exclusive linking together of admission to hospital and compulsory treatment should be changed, to allow some patients subject to compulsory care and treatment to remain in the community.
- 6.2 The authorisation of compulsory measures should require consideration of the treatment proposed.
- 6.3 The basis of long term compulsory interventions should be a plan of care, which should be submitted to and approved by the tribunal.
- 6.4 The plan of care should specify:
- ◆ the interventions which require authority to be administered on a compulsory basis, and
 - ◆ the proposed plan of medical treatment, care and support from health, social work and other agencies.
- 6.5 A community order should be introduced, and should be available where:-
- ◆ a patient meets the criteria for compulsory measures; and
 - ◆ such an order would be more appropriate than a hospital based order, having regard to the principle of least restrictive intervention.
- 6.6 It should not be possible to administer treatment forcibly anywhere other than a clinic or hospital.
- 6.7 The Code of Practice should identify treatments which should normally only be administered in hospital.
- 6.8 The Code of Practice should identify general standards of care which should be observed for persons subject to compulsory treatment in the community.
- 6.9 Regulations should specify the range of compulsory measures which could be imposed in a community order.

- 6.10 Before authorising compulsory interventions, the tribunal should require to be satisfied that the plan of care contained provision for an adequate and appropriate level of services, consistent with the compulsory measures sought.
- 6.11 If not so satisfied, the tribunal should be entitled either:
 - ◆ to refuse to make an order, or
 - ◆ to make a temporary order lasting no more than 28 days authorising such interventions as it sees fit, pending submission of a revised plan of care.
- 6.12 The Mental Welfare Commission should be entitled to remit the case of a patient under compulsion to the tribunal on the basis that there is evidence that essential elements of the plan of care are not being delivered.
- 6.13 It should be possible for a mental health tribunal to transfer a person subject to a hospital based order to a community order, and vice-versa.
Where such a transfer between different types of order takes place, time limits for renewals of, and appeals against, the new order should be those which were applicable to the original order.
- 6.14 Where a patient subject to a community order fails to comply with a compulsory aspect of the plan of care, and there is a significant risk of deterioration in the patient's health, the responsible medical officer should notify the patient that the consequence of further breaches may be admission to a clinic or hospital for treatment.
- 6.15 Should the patient still fail to comply, the responsible medical officer should be able to require the person to be compulsorily admitted to a hospital or clinic for treatment.
- 6.16 This admission should be for a maximum period of two months after which it would be necessary to refer to the tribunal. The tribunal would be entitled to transfer the order to a hospital based order.
- 6.17 It should be possible for patients subject to a community order to be admitted to hospital on an urgent basis, where there is an immediate risk of harm to the patient or others. The admission should be authorised by the responsible medical officer, with the consent of the mental health officer.
- 6.18 An emergency admission should be authority to detain the patient for up to 28 days.
- 6.19 The Act should provide that any person in breach of a community order by reason of removing from his or her place of residence may be returned to the area where he or she was receiving services, whether he or she is in Scotland or elsewhere in the UK.

- 6.20 It should continue to be possible to grant leave of absence for a patient subject to a hospital based order.
- 6.21 A continuous period of leave of absence should last no longer than six months.
- 6.22 Before granting a period of leave of absence lasting more than 28 days, the responsible medical officer should be required to inform the patient's GP and mental health officer.
- 6.23 The total periods of leave of absence in any 12 month period should not exceed nine months.
- 6.24 Community care orders should be abolished.

Chapter 7

- 7.1 Relatives/nearest relatives should no longer have the right to consent to emergency or short term detention under the Mental Health Act.
- 7.2 The right of nearest relatives to make an application for long term detention should be abolished.
- 7.3 Greater training in mental health issues should be a routine expectation for GPs in training, and the continuing professional development of GPs should include elements relating to mental health, including the use of the Mental Health Act.
- 7.4 Any doctor should be able to undertake an emergency detention, as at present.
- 7.5 The second medical recommendation for long term compulsory orders should continue to be provided by the patient's GP, where possible.
- 7.6 The first recommendation for long term compulsion, and the recommendation for short term detention, should be by a doctor approved by a health board as having special experience in the treatment of mental disorder.
- 7.7 Regulations should specify the criteria to be applied by health boards in approving such doctors.
- 7.8 NHS trusts should ensure that a patient subject to compulsion has an available responsible medical officer at all times to fulfil the relevant statutory responsibilities, including giving evidence to a mental health tribunal.
- 7.9 The Act should require that no second medical recommendation, for long term compulsory measures, should be made by a person working directly to the person giving the first medical recommendation.
- 7.10 The Code of Practice should provide guidance on means to ensure that the second medical recommendation for long term compulsion should be given by a doctor independent from the doctor giving the first recommendation, as far as possible.

- 7.11 Mental health officers should continue to be appointed by the local authority. Regulations should provide that mental health officers should be specially trained social workers.
- 7.12 Local authorities and health boards should give consideration to ways in which the availability of mental health officers to respond to emergency detentions may be better ensured.
- 7.13 A mental health officer should continue to be required to give consent to an emergency detention 'where practicable', with reasons being given where consent has not been obtained.
- 7.14 Consent by a mental health officer should be required for a short term detention in all circumstances.
- 7.15 A mental health officer should be entitled to apply for long term compulsory measures on his or her own initiative, and required to do so when requested by a doctor who has made a recommendation for such measures.
- 7.16 A mental health officer should be required to prepare a report when a decision on renewal of long term detention is being made by the responsible medical officer. Should the report not support renewal, the question should be referred to the tribunal.
- 7.17 The Code of Practice should provide that GPs should wherever possible discuss any proposed detention of a mentally disordered person with a community psychiatric nurse.
- 7.18 NHS Trusts should have a responsibility to ensure that all nurses who have to deal with patients subject to compulsion have a basic understanding of the Mental Health Act.
- 7.19 The Code of Practice should contain guidance on the responsibilities of nurses under the Mental Health Act.
- 7.20 The requirements as to the grades of nurses who may exercise the nurse's holding power should be reviewed.

Chapter 8

- 8.1 The nurse's holding power should be retained, to allow the arrival of a doctor and to allow time for the doctor to assess the patient's condition and decide whether emergency or short term detention procedures should be undertaken.
- 8.2 In the event that no doctor has arrived within the period of two hours, the holding power should cease at the end of the two hours.

- 8.3 In the event that a doctor is already present or that a doctor arrives within the period of two hours, the holding power should continue for a period of one hour from the time of the arrival of the doctor, or until the end of the period of two hours, whichever is longer, to allow the doctor to assess the patient and decide whether detention procedures should be undertaken, and to contact a mental health officer where appropriate.
- 8.4 During the period of the holding power all practicable steps should be taken to contact and obtain the approval of a mental health officer in any decision relating to detention.
- 8.5 Emergency detention should continue to be for a maximum of 72 hours in duration, and not immediately renewable.
- 8.6 Emergency detention from the community and from hospital should continue to be separately recorded.
- 8.7 As at present, there should be no appeal against the imposition of an emergency detention.
- 8.8 Short term detention should continue to be for a maximum of 28 days in duration, and not be immediately renewable.
- 8.9 There should be provision for the continuation of short term detention for a brief period, to allow the determination of an application for long term compulsory measures. This should be similar to the provisions in s26A and s21(3A) to (3C) of the 1984 Act. The power to continue to detain where an application for long term compulsory measures has been adjourned should be limited to 28 days. The court should have discretion to extend this period at the request of the patient or patient's representative.
- 8.10 An appeal to a mental health tribunal by the patient and the named person (as provided for in Chapter 16) should be available against a short term (28 day) detention.
- 8.11 Any appeal against a short term detention should be initiated within 14 days of the commencement of detention, and the tribunal should be required to consider the appeal within seven working days of the appeal having been made.
- 8.12 Long term compulsion should be for six months in the first instance, renewable for a further six months and then annually.
- 8.13 Long term compulsion should require the prior authorisation of a mental health tribunal.
- 8.14 The patient and the named person should have a right to appeal to a mental health tribunal against renewal of long term compulsion.

- 8.15 An application to a mental health tribunal for a variation of the order should be available to the patient and the named person after the first three months of a long term compulsory order.
- 8.16 A mental health tribunal should automatically undertake a review of compulsory measures every three years, if the patient or named person has not appealed during that time.
- 8.17 The patient, named person, legal representative and other interested parties should be given the opportunity to contribute to the review.
- 8.18 When a plan of care is before a tribunal, the named person as well as the patient should have the right to challenge or ask for clarification on one or more elements of the patient's plan of care.
- 8.19 The Act should provide that the condition of a patient should be kept under constant review by the responsible medical officer, and, if the patient no longer meets the criteria for compulsion, he or she should be discharged.
- 8.20 The mental health officer should be consulted by the responsible medical officer prior to the discharge of a patient from compulsion, where it is anticipated that aftercare services may be required.
- 8.21 The requirement for a review of detention by the responsible medical officer after four weeks of long term detention should be abolished.
- 8.22 Hospital managers should no longer have the right to make an order for discharge.
- 8.23 The right of the nearest relative to discharge a patient subject to long term compulsion should be removed.
- 8.24 It should be possible to move directly from the community on to short term detention, with the approval of both a medical practitioner approved as having special experience in mental disorder, and a mental health officer. This procedure should be used in preference to an emergency detention wherever practicable.
- 8.25 The Act should require that written reasons for the use of an emergency detention, explaining why alternatives were not available or suitable, should always be given to the Mental Welfare Commission by the detaining doctor.
- 8.26 The Mental Welfare Commission should monitor the level of use of emergency detentions. Once the new Act has been in force for a period of time, the Mental Welfare Commission should consider commissioning research into the written reasons given for the use of an emergency detention.
- 8.27 It should be possible to transfer a patient subject to emergency detention onto a short-term detention as soon as the procedural requirements for the short-term detention have been completed.

- 8.28 The Act should provide that the responsible medical officer should assess the patient as early as possible in an emergency detention, with a view to removing the patient from emergency status.
- 8.29 It should be possible to treat a patient subject to short term detention for his or her mental disorder without consent, subject to the safeguards in relation to special treatments set out in Chapter 10.
- 8.30 It should only be possible to treat a patient subject to emergency detention for his or her mental disorder on a similar basis to the provision for emergency treatment in s102 of the 1984 Act, namely where such treatment is either –
- ◆ immediately necessary to save the patient's life, or
 - ◆ not being irreversible or hazardous, is immediately necessary to prevent a serious deterioration of his or her condition or to alleviate serious suffering by the patient, or
 - ◆ not being irreversible or hazardous, is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or presenting a serious danger to him or herself, or others.
- 8.31 Where a patient is given treatment without consent during an emergency detention, the prescribing doctor should notify the Mental Welfare Commission of the fact, and the reasons why treatment was felt to be necessary.
- 8.32 It should continue to be possible for a patient, who has been detained on an emergency basis, to move directly onto a long term detention.
- 8.33 Mental health service managers should be under a duty (so far as practicable) to ensure that patients subject to any form of compulsion are aware of the nature and effect of the compulsion, and their rights in relation to this. The fact that this has been done should be recorded.
- 8.34 During mental health hearings, evidence should be led to the tribunal as to the steps that have been taken to inform the patient of his or her rights.
- 8.35 The Code of Practice should give guidance on the most effective implementation of these duties, including the need for:
- ◆ clear and comprehensible information;
 - ◆ information being given as often as necessary;
 - ◆ steps to be taken to seek to ensure that service users feel able to exercise their rights, including rights to legal representation and
 - ◆ the involvement of an advocate if the service user so wishes.

Chapter 9

- 9.1 There should be a requirement that all members of the forum for mental health hearings receive ongoing training in mental health issues.
- 9.2 There should be statutory rules of procedure, drawn up after consultation with service user, carer and professional interests.
- 9.3 The rules of procedure and practical arrangements should encourage the attendance of patients.
- 9.4 There should be a procedure for straightforward access to free legal representation by solicitors accredited in mental health law.
- 9.5 A curator ad litem should be appointed in every case where the forum is satisfied that the patient is unable to instruct legal representation. The responsible medical officer should have a duty to advise the forum as to the ability of the patient to instruct representation.
- 9.6 Hearings should be in private, unless the patient or patient's representative requests otherwise, but doctors and other professional staff may be present as appropriate for training purposes.
- 9.7 Hearings should be in hospital, unless the patient or patient's representative requests otherwise. Health boards should have a statutory duty to provide suitable facilities for the holding of hearings.
- 9.8 The forum should have the right to compel the attendance of parties concerned with the care and treatment of the patient.
- 9.9 There should be a right of appeal to the Court of Session on a point of law. For restricted patients, the right of appeal should remain, as now, available on issues of both fact and law.
- 9.10 The forum for mental health hearings should be a new mental health tribunal.
- 9.11 There should be a national structure for mental health tribunals, with a senior member of the judiciary at its head.
- 9.12 Mental health tribunals should be funded by the Scottish Executive Department of Justice.
- 9.13 Tribunal members should be appointed by the Minister for Justice.
- 9.14 Each tribunal should have three members: a legal chair, a medical member, and a member with professional and/or personal experience of mental health services.
- 9.15 The medical member should examine the patient prior to the hearing. Any findings should be given to the hearing, and the medical member should be able to be questioned by the parties or their representatives.

Chapter 10

- 10.1 The Act should specify that the factors to be taken into account when considering whether a treatment for mental disorder should attract special safeguards should include the extent to which the treatment:
- ◆ may be hazardous
 - ◆ may be irreversible
 - ◆ is novel
 - ◆ may involve significant physical distress
 - ◆ may carry a high risk of serious side effects
 - ◆ is perceived as controversial by society, or significant sections of society.
- 10.2 The Act should continue to distinguish broadly between
- ◆ certain treatments which should require both the patient's consent and approval from an independent doctor and others representing a non medical opinion (the present s97); and
 - ◆ treatments which should require either the patient's consent or a second medical opinion, (the present s98).
- 10.3 The current procedures in s97 for neurosurgery for mental disorder should apply by specific provision in the Mental Health Act to all patients, whether or not subject to compulsion.
- 10.4 It should only be possible to carry out neurosurgery for mental disorder on a patient who is not capable of consenting to the treatment if:
- (a) the patient does not oppose the treatment being carried out, and
 - (b) the treatment has been approved by the Court of Session.
- 10.5 The Scottish Executive should implement the outstanding recommendations of the Central Research Audit Group (CRAG) Working Group on neurosurgery for mental disorder. These recommendations should be incorporated in the Code of Practice.
- 10.6 The provision in current regulations governing approval surgical implantation of hormones to reduce male sexual drive should be removed, on the basis that the procedure is obsolete.
- 10.7 The administration of oral medication to reduce sexual drive should be specified as a special treatment by specific provision in the Mental Health Act requiring either consent or a second opinion as in the present s98, and in the case where a second opinion is required, treatment should begin only after that has been obtained.

- 10.8 ECT should be specified as a special treatment by specific provision in the Mental Health Act. This should normally be authorised by consent or a second opinion, as under the present s98, but it should not be lawful to administer ECT to a patient who is refusing the treatment, and who is competent to make such a decision.
- 10.9 The administration of medication for mental disorder after the expiry of two months from the date of the imposition of compulsory measures should be specified as a special treatment in the Mental Health Act, requiring consent or a second opinion as in the present s98.
- 10.10 Forcible feeding should be specified as a special treatment in the Mental Health Act, requiring a second opinion, consent not having been obtained.
- 10.11 The administration of dosages of medication for mental disorder should be specified in regulations as a special treatment requiring consent or a second opinion where they
 - ◆ are above the maximum levels specified in the British National Formulary, or
 - ◆ involve the administration of more than one neuroleptic drug in dosages which, when expressed as percentages of the maximum recommended dose, add up together to more than 100%, or
 - ◆ are used for a purpose other than the normal recommended purpose;
- 10.12 Consideration should be given as to whether regulations should specify particular types of behavioural or psychotherapeutic intervention as special treatments requiring consent or a second opinion.
- 10.13 The Mental Welfare Commission should have a statutory responsibility to consider from time to time whether there are treatments which should be added to the list of special treatments under the Act, and to advise Scottish Ministers accordingly.
- 10.14 The second opinion doctor should be required to consider whether the proposed treatment is appropriate, bearing in mind the principles of the Act, and any possible alternative treatment approaches.
- 10.15 The Code of Practice should set out the responsibilities of the second opinion doctor, and all approved second opinion doctors should receive training in these.
- 10.16 A second opinion should be renewed at least every two years.
- 10.17 Before approving long term compulsion based on a plan of care involving the use of special treatments, a mental health tribunal should be entitled to be satisfied that the statutory safeguards for such treatments have been or will be followed, but should not impose additional special requirements in relation to such treatments.
- 10.18 Provisions similar to those of s102 should continue to apply to urgent treatments administered to patients subject to compulsion.

- 10.19 The Code of Practice should highlight the importance of the requirement to notify the Mental Welfare Commission of urgent treatments administered to patients subject to compulsion.
- 10.20 The same safeguards in relation to special treatments should apply to children who are incapable of consenting to treatment on their own behalf as would apply to children subject to compulsion under the Mental Health Act.
- 10.21 The second opinion for any treatment which is a special treatment in terms of the Act which is to be administered to a person aged 18 or under, should be given by a specialist in child and adolescent psychiatry. Where the responsible medical officer in relation to any such treatment is not a specialist in child and adolescent psychiatry, a further opinion by such a specialist should be obtained.
- 10.22 The Code of Practice should emphasise that neurosurgery for mental disorder should not normally be considered for patients aged under 20.

Chapter 11

- 11.1 There should continue to be provisions to allow patients subject to compulsion to be transferred between hospitals, by agreement between the managers of the respective hospitals.
- 11.2 There should be a requirement to notify a patient subject to long term compulsion and the named person of an impending transfer. Wherever practicable, the notice should be at least seven days in advance.
- 11.3 Unless the patient objects, the primary carer (if not also the named person) should also be entitled to notice. The Code of Practice should set out circumstances where the primary carer should be given notice, notwithstanding objections by the patient.
- 11.4 Details of the transfer should be provided to the Mental Welfare Commission within seven days of it taking place. This should include confirmation that at least seven days prior notice had been given to the patient, the named person and, where appropriate, the primary carer; or a note of the reasons why such notice was not practicable.
- 11.5 Where a patient is subject to long term compulsion, the patient and the named person should have the right to appeal to a mental health tribunal against a transfer. The appeal should be initiated within 28 days. This right should not apply in cases where the transfer has already been considered and approved by a mental health tribunal as part of its consideration of the patient's plan of care.
- 11.6 The Code of Practice should contain guidance on responding to requests by patients for transfer.

- 11.7 The Scottish Health Advisory Service should consider monitoring the extent to which patients subject to emergency and short term detention are transferred for non clinical reasons.
- 11.8 Withholding of the correspondence of patients should continue to be dealt with on a similar basis to that outlined in s115 of the 1984 Act, with the safeguards currently in s116.
- 11.9 The restrictions on the powers of the State Hospital to withhold correspondence should be extended to correspondence with recognised advocacy groups, MSPs and MEPs.
- 11.10 Similar provisions should apply to the transmission of written communications by other means, including electronic mail and faxes.
- 11.11 Legislation should regulate the extent to which detained patients should have a right of access to mobile telephones, the internet, and other forms of electronic communication. It should only be possible to restrict access where it can be demonstrated that this is in the interests of the health or safety of the patient or for the protection of other persons from harm or distress. The patient should have the right to have any such restriction of access reviewed by the Mental Welfare Commission, who should be entitled to require that access be given.
- 11.12 The State Hospital should have the right to restrict access to mobile telephones, the internet and other forms of electronic communication, in accordance with directions by Ministers. A patient should have a right to appeal to the Mental Welfare Commission.
- 11.13 All detained patients should have a legal right to obtain access to a telephone.
- 11.14 Directions by Ministers to the State Hospital, under s4(6) of the Regulation of Investigatory Powers Act 2000, should
 - ◆ take account of the recommendations of the Inquiry into Ashworth Special Hospital
 - ◆ provide that decisions regarding the monitoring of telephone calls or control of access to telephone calls should take account of individual circumstances
 - ◆ provide for review by the Mental Welfare Commission of decisions to monitor telephone calls or restrict access to a telephone.
- 11.15 Hospitals other than the State Hospital should only be entitled to restrict use of a telephone, or monitor calls, of a detained patient where
 - ◆ this is necessary to protect other persons from harm or distress, or
 - ◆ the recipient of the calls has requested that such calls should be restricted, or
 - ◆ making the calls would be in breach of a court order, or

- ◆ this is necessary to prevent nuisance calls, or
- ◆ to do so is necessary in the interests of the health, safety or welfare of the patient

Any such restriction or monitoring in respect of an individual patient should be reported to the Mental Welfare Commission who should have the power to require that the decision be changed.

- 11.16 It should not be lawful to restrict or monitor telephone calls to or from the parties to whom correspondence from a detained patient cannot be withheld, except where the recipient has requested that any such calls be monitored or prevented, or such calls are unlawful under any other provision.
- 11.17 The Act should contain provisions regarding patients absent without leave similar to those contained in sections 28, 31, 31A, 31B, 120 and 121 of the 1984 Act.
- 11.18 For patients detained under civil procedure, the period of absence during which the patient may be taken into custody and returned to hospital should be reduced to three months.
- 11.19 There should continue to be an offence of assisting or inducing a detained patient to be absent without leave, similar to s108 of the 1984 Act.
- 11.20 The Code of Practice should contain general guidance on searching of patients and visitors.
- 11.21 All services which accommodate detained patients, and who on any occasion search patients or visitors should be required to have a policy on searches.
- 11.22 The Mental Welfare Commission should monitor individual searching policies, and their implementation.
- 11.23 The Code of Practice on Personal Health Information should be revised as a matter of urgency, and should give general guidance on disclosure for risk assessment purposes.
- 11.24 The Mental Health Act Code of Practice should contain more detailed guidance on disclosure of information with regard to patients subject to compulsion.
- 11.25 Local protocols on patient confidentiality should take account of issues of risk assessment and intelligence gathering.

Chapter 12

- 12.1 The Codes of Practice for the new Act and for the Adults with Incapacity (Scotland) Act 2000 should provide guidance on the circumstances when it is appropriate to admit, detain or treat a patient compulsorily under mental health legislation, rather than under the Adults with Incapacity Act.

- 12.2 The Mental Welfare Commission should issue guidance on best practice in relation to the use of compulsory measures of care and treatment when patients are reluctant to accept treatment on a voluntary basis.
- 12.3 The Code of Practice should contain general guidance on restraint, including an expectation that care providers will develop policies on restraint, which will be monitored by the Mental Welfare Commission.
- 12.4 The provisions to be made for 'exceptional treatments' under s48 of the Adults with Incapacity (Scotland) Act 2000 should be the same as those which we recommend for special treatments under the Mental Health Act, except in the case of patients in the community, for the provisions relating to drug treatment for mental disorder which lasts for over two months.
- 12.5 Where a patient in the community receives drug treatment for over two months on the basis of an authority to treat conferred by s48 of the Adults with Incapacity (Scotland) Act 2000, the nearest relative, or primary carer, or any other person with an interest in the welfare of the patient should be able to require that a second opinion be obtained by a medical practitioner appointed for the purpose by the Mental Welfare Commission.

Chapter 13

- 13.1 There should be a duty on health and social work services to participate in an assessment of needs for patients subject to compulsion under the terms of the Mental Health Act.
- 13.2 In these circumstances, this assessment should form the basis of a plan of care.
- 13.3 The right to assessment for people subject to compulsion should be framed in a manner to make it compatible with the relevant provisions of the Social Work (Scotland) Act 1968.
- 13.4 The Code of Practice should give guidance on how the responsiveness of primary care service providers may be improved with respect to requests for assessment by service users and carers during the user's first period of suspected mental illness.
- 13.5 Service users and carers should have a right to request an assessment of needs for a user who has previously had contact with mental health services. Mental health services would not be bound to undertake such an assessment, but would be required to give reasons for a refusal to do so.
- 13.6 There should be a duty on health boards and local authorities to provide appropriate services to those subject to compulsion under the provisions of the Mental Health Act, as assessed and detailed in their plan of care.

- 13.7 There should continue to be a duty on local authorities to provide or arrange care and support services to persons who are, or have been, suffering from a mental disorder.
- 13.8 There should be a duty on local authorities to ensure provision of or arrange day activities for people with mental disorders.
- 13.9 These 'day activities' should include support for employment, training and education, and social activities. This duty should include a duty to arrange transport, where appropriate, including where patients are in hospital.
- 13.10 There should be a provision in the Act which requires agencies to co-operate in the provision of care to people with mental disorders. The Code of Practice should give guidance to service providers on the most appropriate means by which this may be achieved.

Chapter 14

- 14.1 The Mental Health Act should give a right to all mental health service users to obtain access to an advocate.
- 14.2 There should be an obligation on service providers to inform service users about the availability of advocacy services, and to take steps to ensure that the user has an advocate if the user so wishes.
- 14.3 There should be a joint duty on health boards and local authorities to ensure that advocacy services are available.
- 14.4 The duty to ensure that advocacy is of a reasonable standard should fall on the commissioning services.
- 14.5 The Scottish Executive should give consideration of what steps it should take to promote advocacy for carers.
- 14.6 There should be a statutory obligation on service providers to provide support services to collective advocacy groups as required.
- 14.7 There should be a statutory obligation on service providers to recognise collective advocacy groups, whether in hospital or elsewhere, as a legitimate voice of service users and involve them in decisions on service development and policy.

Chapter 15

- 15.1 Service users should be entitled to make advance statements, setting out their wishes in relation to future care and treatment, but these should not be legally binding when the relevant treatment is authorised by the Mental Health Act.

- 15.2 In considering the validity of an advance statement, account should be taken of whether
- ◆ the person was able to understand the implications of the statement at the time the statement was entered into;
 - ◆ the statement covers the treatment which is being considered and
 - ◆ there has been any material change of circumstances since it was entered into.
- 15.3 The Code of Practice should contain guidance on advance statements, including guidance as to
- ◆ the preferred format of such statements
 - ◆ how such statements should be drawn up and recorded
 - ◆ the requirements for execution of an advance statement
 - ◆ the requirements for establishing the validity of an advance statement
 - ◆ the circumstances in which it would be appropriate not to implement an advance statement.
- 15.4 Advance statements should not be legally enforceable by patients subject to compulsory measures under mental health law, but the tribunal considering such measures, and any person authorised to act under such measures, should be required to take a valid advance statement into account.
- 15.5 Where the responsible medical officer authorises any treatment for mental disorder on a patient subject to compulsion which appears to contradict the terms of a valid advance statement, the responsible medical officer should record the reasons for doing so in writing.
- 15.6 Professionals should not be legally liable for any actions or omissions which are inconsistent with an advance statement, or for failure to make adequate enquiry into the validity of an advance statement whose terms they have followed, provided they have acted in good faith and with reasonable care.

Chapter 16

- 16.1 There should be a 'named person', who should exercise powers comparable to those of the nearest relative under the 1984 Act (other than the power to consent to detention or to order discharge).
- 16.2 A service user should have the right, when able to do so, to nominate a person to take on the functions of the 'named person'.
- 16.3 A nomination by a service user of a person to take on the functions of a 'named person' should be in writing, and should be witnessed by a person from a prescribed class, who should certify that the nominating person appeared to

understand the nature and effect of the document, and appeared not to be acting under any form of undue influence.

- 16.4 Where no nomination has been made by the service user, or the nominated person declines to act, the named person should be the primary carer, as determined by the mental health officer.
- 16.5 Where there is no primary carer, or the primary carer declines to act, the named person should be the nearest relative.
- 16.6 The definitions of primary carer and nearest relative should be in similar terms to those contained in the Adults with Incapacity (Scotland) Act 2000.
- 16.7 Any person who can demonstrate an interest should be entitled to request that the tribunal remove the appointment of a named person, and, if appropriate, appoint a new named person.

The tribunal would be entitled to appoint any individual whom it deemed suitable to the role of named person.

- 16.8 The named person should be entitled to be notified of
 - ◆ the service user's legal status under the Mental Health Act, and any compulsion to which he or she is subject
 - ◆ any application for compulsory measures
 - ◆ any hearing by the tribunal in relation to the service user
 - ◆ any decision to discharge the service user from compulsory measures.
- 16.9 The Code of Practice should contain guidance on
 - ◆ the nature of information that should be provided to the primary carer of a person subject to compulsory measures, whether or not the primary carer is the named person, and
 - ◆ when it is appropriate to provide information to the primary carer without the consent of the service user.
- 16.10 The Act should provide that the named person should, when practicable, be consulted where compulsion is being considered.
- 16.11 The Scottish Executive should formulate a central information strategy for carers of mentally disordered persons, including giving consideration to a single contact point for carers seeking information.
- 16.12 Carers should continue to have the right to an assessment of their needs by social work services. Local authorities should consider how carers might be better informed of their right to such an assessment.

- 16.13 In considering compulsory measures of care, the tribunal should be required to consider the extent to which any informal carer is willing and able to undertake any caring responsibilities which may be implied by any order they make.
- 16.14 Young carers should be given the right to an assessment of needs, whether or not a new type of carers' assessment is introduced by the Scottish Executive.
- 16.15 The Scottish Executive should consider strengthening the legal position of carers seeking respite.

Chapter 17

- 17.1 The Scottish Executive should develop guidance on positive action and non-discriminatory practice in relation to the housing needs of people with mental disorders. This guidance should be developed in collaboration with mental health organisations, and its implementation overseen by the proposed Housing Regulator.
- 17.2 There should be a review of the extent to which the rules regarding Social Security benefits may adversely affect people with mental disorders, particularly those who are subject to detention. The Scottish Executive should seek to ensure that such a review is undertaken by the Department of Social Security, and that it takes due account of the implications of mental health law in Scotland.
- 17.3 The Scottish Executive should consider the introduction of an offence of harassment which would protect people with disabilities, including mental disorders.
- 17.4 The Scottish Executive should promote a major campaign of public education to improve public understanding of mental disorder, and attitudes towards people with mental disorders.
- 17.5 All establishments under the Mental Health Act which accommodate patients subject to compulsion should have a written policy on visits to the establishment, and the Code of Practice should provide guidance on such policies.

Chapter 18

- 18.1 Local authorities and health boards should be required to secure access to services for interpretation and assisted communication for mental health service users and carers who have particular communication needs as a result of physical or sensory disability.
- 18.2 Where a person, who has particular communication needs as a result of disability, is subject to compulsory measures, the mental health officer (in emergency detentions, the detaining doctor) should be required to take all reasonable steps to ensure that the person has been made aware of the implications of the

compulsory measures, and the person's rights in relation to those measures. In any appeal, or application for long term compulsory measures, the mental health officer should be required to demonstrate to the tribunal that this has been done.

- 18.3 Children subject to compulsory measures of care under the Mental Health Act should have a legal right of access to an independent advocate.
- 18.4 The Code of Practice should contain guidance on
 - ◆ the circumstances in which treatment without the consent of the child should be provided under mental health law, rather than on the basis of consent by an adult with parental responsibilities,
 - ◆ how the principles underlying the Children (Scotland) Act 1995, and the UN Convention on the Rights of the Child, should be applied to mental health interventions, and
 - ◆ how mental health and child protection systems should interact.
- 18.5 Health boards should be placed under a statutory obligation to provide or secure age-appropriate mental health services including secure services, for children and young people in their area.
- 18.6 The provisions of s131 of the Education (Scotland) Act 1980, insofar as they remove the duties of education authorities towards children and young people subject to compulsion under mental health law, should be repealed.
- 18.7 Any young person who is subject to compulsory measures of care under the Mental Health Act should have a named social worker.
- 18.8 Single sex accommodation should be available to men and women with a mental disorder.
- 18.9 Local authorities and health bodies should have a statutory responsibility to promote personal relations and direct contact between mental health service users and children for whom such service users have parental responsibility, where this is in the interests of the child.
- 18.10 Local authorities and health boards should be required to obtain information regarding the mental health service needs of people from black and ethnic minority communities in their area. Such information should be obtained using standardised methodologies.
- 18.11 Arrangements should be made by the Scottish Executive to obtain information regarding the extent to which compulsory measures under the Mental Health Act are applied to particular minority ethnic communities.
- 18.12 Local authorities and health bodies should be required to promote racial awareness training amongst staff employed in mental health services.

- 18.13 Local authorities and health boards should be placed under a statutory obligation to develop policies for meeting the needs of service users from ethnic minorities in their area.
- 18.14 Local authorities and health boards should be required to ensure that they have access to services for interpretation and translation for service users and carers whose first language is not English.
- 18.15 Where a person whose first language is not English is subject to compulsory measures, the mental health officer (or, in the case of emergency detention, the detaining doctor) should be required to take all reasonable steps to ensure that the person has been made aware of the implications of the compulsory measures, and the person's rights in relation to those measures. In any appeal or application for long term compulsory measures, the mental health officer should be required to demonstrate to the tribunal that this has been done.

Chapter 19

- 19.1 The Scottish Law Commission proposals, contained in their Report on Vulnerable Adults, should be implemented in respect of adults with mental disorder.
- 19.2 Rules of Court for proceedings under the Vulnerable Adults proposals should be broadly consistent with those which we recommend for hearings concerning compulsory measures of care, under the Mental Health Act.
- 19.3 Where a person is removed from home under the Vulnerable Adults proposals, and it is determined that the person requires compulsory measures of care under the Mental Health Act, the normal procedures under that Act should apply.
- 19.4 It should not be possible to be made subject to emergency (72 hour) detention under the Mental Health Act immediately following a period of removal from home under the Vulnerable Adults proposals.
- 19.5 The Mental Health Act Code of Practice should include guidance as to the exercise of functions under the Vulnerable Adults proposals.
- 19.6 It should be an offence for a person wilfully to ill-treat or neglect a person with mental disorder who is in his or her care.
- 19.7 The following persons would be among those who could potentially commit the offence of wilful ill-treatment or neglect of a person with mental disorder:
 - ◆ any member of staff or manager at any hospital or healthcare facility, where the patient is receiving treatment, whether as an in-patient or out-patient;
 - ◆ any manager or member of staff, whether paid or unpaid, in any residential care facility where the mentally disordered person is living;

- ◆ any person employed to deliver care services in the community to the mentally disordered person; or
 - ◆ any other person who undertakes substantial responsibilities for the care of the mentally disordered person.
- 19.8 There should be a provision in the Act which protects any person from liability in civil or criminal proceedings for acts purporting to be done in pursuance of the Act, unless done in bad faith or without reasonable care. This protection should also apply to liability under the above offence of wilful ill treatment or neglect.
- 19.9 There should continue to be an offence relating to obstruction, similar to that contained in Section 109 of the 1984 Act.
- 19.10 It should not be possible for a mentally disordered person to be prosecuted for obstruction, in relation to compulsory measures of care or protective measures directed at the mentally disordered person.
- 19.11 The definition of vulnerable person in s271 of the Criminal Procedure (Scotland) Act 1995 should be amended to include any person with a mental disorder, as defined in Chapter 4.

Chapter 20

- 20.1 The police should retain the power granted by s118 of the 1984 Act to take persons appearing to be suffering from mental disorder to a place of safety. The duration of the power should be limited to 24 hours.
- 20.2 Where a person has been removed to a place of safety, the constable should be required to notify the person or persons who appears to be the primary carer and nearest relative of the person so removed, whom failing, any responsible person who appears to reside with or provide support to the person. If no such person can be identified, the social work department should be notified. Such notification should take place within six hours of the person being removed.
- 20.3 Health boards should be under a legal duty to secure the provision of places of safety, to accommodate people detained by the police, under Mental Health Act powers.
- 20.4 A place of safety should not be a police station except in an emergency, or where it is impossible to safely accommodate the mentally disordered person in the facilities provided under arrangements made with health boards.
- 20.5 The Code of Practice should set out minimum standards for such places of safety.
- 20.6 The police should be required to report to the Mental Welfare Commission any use of police powers to detain a mentally disordered person, and provide details of the place of safety which was used.

- 20.7 The Mental Welfare Commission should monitor the development of local protocols and joint training initiatives concerning the detention and assessment of mentally disordered persons who come to the attention of the police.
- 20.8 The police should be required to notify the Mental Welfare Commission of the use of CS gas on any person who is, or appears to be, mentally disordered.

Chapter 21

- 21.1 Sections 106 and 107 of the 1984 Act, and s13 of the Criminal Law (Consolidation) (Scotland) Act 1995, should be replaced by two new statutory offences: sexual abuse of a mentally disordered adult, and sexual abuse by staff and formal carers.
- 21.2 Both new offences should apply to male and female perpetrators and victims, and to perpetrators of any age (above the age of criminal responsibility).
- 21.3 Both new offences should apply to all types of mental disorder, as defined in Chapter 4.
- 21.4 Both offences should apply to sexual intercourse, and other acts which could constitute sexual offences at common law.
- 21.5 The offence of sexual abuse of a mentally disordered adult would be committed where
 - (a) because of a mental disorder, the adult is unable to understand, or make a decision about, the nature of the sexual act or its consequences, or
 - (b) the adult has a mental disorder and is unable to give free agreement to the relationship.
- 21.6 It should be an offence to procure a mentally disordered adult to commit a sexual act.
- 21.7 In establishing whether an adult is able to give free agreement to a relationship the court should have regard to the nature and degree of the adult's mental disorder, and the nature of the relationship between the parties.
- 21.8 It should be a defence to the crime of sexual abuse of a mentally disordered adult to show that the accused person did not know, and could not be expected to know, that the adult came within the category protected by the provisions of the legislation.
- 21.9 The Crown Office should issue guidance on its policy in relation to sexual activity between adults with mental disorders, and sex education for people with learning disabilities.
- 21.10 The offence of sexual abuse by staff and formal carers would be committed where there is a sexual relationship between

- (a) a patient with a mental disorder, whether inpatient or outpatient, and a member of staff, whether paid or unpaid;
- (b) a mentally disordered person in residential care and a member of staff, whether paid or unpaid;
- (c) a mentally disordered person and a person employed to deliver care services in the community to that person; or
- (d) a mentally disordered person and a doctor or therapist involved in a professional relationship with that person.

21.11 The offences of sexual abuse of a mentally disordered adult and sexual abuse by staff and formal carers should be included in Schedule One of the Sex Offenders Act 1997.

Chapter 22

- 22.1 The role of Ministers in regulating private mental hospitals, currently in Part IV of the 1984 Act should be abolished.
- 22.2 Should the Scottish Commission for the Regulation of Care be given responsibility for registration of private hospitals, it should be the primary regulatory body for all private hospitals caring for psychiatric patients, whether subject to compulsion or not.
- 22.3 The Scottish Commission for the Regulation of Care should be permitted to designate nursing and residential care homes as appropriate accommodation for mentally disordered patients subject to compulsion, if the care and facilities available are of an appropriate standard.
- 22.4 The Scottish Commission for the Regulation of Care should issue appropriately rigorous standards of care relating to the care of people with mental disorders, including those subject to compulsory measures of care under mental health law. The CRC should address the question of whether these standards should be the same or different for groups of mentally disordered persons with different status in law.

Chapter 23

- 23.1 The Mental Welfare Commission should continue to exercise protective functions in respect of people with mental disorders, whether or not they are subject to compulsory measures.
- 23.2 There should be a requirement in the Act for three psychiatrists and one experienced legally qualified person to be members of the Commission.
- 23.3 The Act should require that at least two members of the Commission should have personal experience of mental disorder, and at least two members should have personal experience of caring for a person with mental disorder.

- 23.4 The minimum number of members of the Commission should be increased from 10 to 18.
- 23.5 There should be a statutory requirement that Commissioners receive such induction and training as may be specified by Ministers.
- 23.6 The requirement to consult interested parties prior to appointment of Commissioners should be removed.
- 23.7 All vacant Commissioner posts should be publicly advertised.
- 23.8 The Mental Health Act should continue to be flexible regarding the structure and internal management arrangements of the Mental Welfare Commission.
- 23.9 There should be a review of the structure and internal management arrangements of the Commission, and the current Memorandum of Agreement with the Scottish Executive, to consider changes which might be desirable in the light of a proposed new Mental Health Act, and other recent developments. The review should involve other interested parties.
- 23.10 The Memorandum of Agreement between the Commission and the Scottish Executive should be published.
- 23.11 The Commission's Annual Report should be submitted jointly to Scottish Ministers and the Scottish Parliament, and arrangements should be made for it to be debated in Parliament.
- 23.12 The Commission should be specifically entitled to draw matters concerning the welfare of people with mental disorder to the attention of the Scottish Parliament (and, where appropriate, the UK Parliament).
- 23.13 The Mental Welfare Commission should have a responsibility to promote the principles of the Mental Health Act, as set out in Chapter 3.
- 23.14 The Commission should continue to be entitled to revoke compulsory measures on non-restricted patients under the Mental Health Act or to recall guardianship under the Adults with Incapacity (Scotland) Act 2000.
- 23.15 The Commission should not be obliged to review, with a view to considering whether discharge is appropriate, every request for discharge from compulsory measures.
- 23.16 There should be no appeal against a decision by the Commission in relation to compulsory measures under the Mental Health Act, other than by judicial review.
- 23.17 The Mental Welfare Commission should publish reports on issues arising from its visiting programme.

- 23.18 The Commission should continue to have a duty to visit psychiatric and learning disability hospitals, and a power to request interviews with patients.
- 23.19 The Commission should also have the power to visit community services and facilities, and to conduct private interviews with service users at such facilities.
- 23.20 The Commission should have a statutory duty to conduct unannounced visits to hospitals and community psychiatric facilities.
- 23.21 The Commission should have a statutory duty to visit prisons.
- 23.22 Commissioners, and Commission staff, should have the power to inspect medical and other records relating to a person with mental disorder, whether in hospital, prison or community based mental health services.
- 23.23 The Commission should continue to have the power to hold enquiries into deficiency in care, either on a formal or informal basis.
- 23.24 The Commission should have the power to publish reports of its enquiries. Such reports should attract qualified privilege.
- 23.25 The Commission should continue to publish an Annual Report.
- 23.26 The Commission should publish an accessible summary of its Annual Report.
- 23.27 In addition to the Annual Report, the Commission should be specifically entitled to publish and disseminate from time to time information, guidance and advice about any matters relevant to the Mental Health Act.
- 23.28 The Commission should strengthen its efforts to make its own work more widely known, and to ensure that its information, guidance and advice reaches all who would benefit from it.
- 23.29 The Memorandum of Understanding between the Mental Welfare Commission and the Health Service Commission should be published.
- 23.30 The investigation of the handling of complaints by NHS bodies under the NHS complaints procedure concerning people with mental disorders should be the responsibility of the Health Service Commissioner.
- 23.31 Where the Health Service Commissioner or the Commissioner for Local Administration in Scotland deals with a complaint, which includes issues concerning the provision of care for a person with a mental disorder, the Commissioner should be required to consult with the Mental Welfare Commission. The Commission should offer such advice and support as it deems appropriate.
- 23.32 As part of its responsibility to promote the principles of the Mental Health Act, the Commission should be entitled to offer advice and guidance on dealing with

complaints affecting mental health service users, and may make enquiries as to the way in which such complaints are dealt with.

- 23.33 The Commission should have a responsibility to monitor the implementation and operation of the Mental Health Act, and the degree to which this is consistent with the principles of the Act.
- 23.34 The Commission should have the power to follow up enquiries into deficiency in care, and publish reports on whether and how its recommendations have been implemented.
- 23.35 The Commission should be under a duty to collect and publish such statistical and other information as it deems appropriate in relation to the operation of the Act.
- 23.36 The Code of Practice should set out guidance on the reporting of significant incidents to the Commission.

Chapter 24

- 24.1 Consideration should be given to consolidating the provisions of Part VI of the Criminal Procedure (Scotland) Act 1995 within the Mental Health Act.
- 24.2 If the Criminal Procedure (Scotland) Act continues to contain provisions regarding mentally disordered offenders, the Scottish Executive should ensure that information is made available in a single document to professionals, service users and carers, which deals with both pieces of legislation and how they interact. This document should be regularly updated.

Chapter 25

- 25.1 It should continue to be possible for a court to commit an accused person to hospital on the basis of a single medical recommendation.
- 25.2 Following admission, the responsible medical officer should assess the patient to determine whether the patient meets the criteria for compulsory admission to hospital under the Mental Health Act.
- 25.3 The responsible medical officer should be required to report to the court, as soon as possible, but no later than 28 days after the admission to hospital as to whether the grounds for compulsory admission to hospital under the Mental Health Act are met. Should the court be satisfied that this is the case, it may authorise continuing detention in hospital. Should it not be so satisfied, it should revoke the order.
- 25.4 Where a remanded prisoner is admitted to hospital, he or she may be treated compulsorily, subject to the protections contained in the Mental Health Act for treatment of patients subject to compulsion but it should not be possible to administer medication for mental disorder to such a prisoner, except in an

emergency, without first obtaining the consent of the prisoner or a second medical practitioner with experience in the assessment and treatment of mental disorder.

- 25.5 It should be possible for a court to authorise the transfer of a prisoner who is on remand in custody to hospital to assess whether his or her mental state warrants admission to hospital.
- 25.6 Before authorising such a transfer, the court should be satisfied that a suitable hospital is available for the prisoner's admission, and should receive evidence from a medical practitioner that the prisoner appears to have a mental disorder which may require treatment in hospital.
- 25.7 When a prisoner is admitted to hospital under this procedure, similar arrangements should apply to those set out in recommendations 25.3-25.4 for prisoners admitted at the initial remand hearing.
- 25.8 Where a court
- ◆ has received recommendations which would have entitled it to make a hospital order or hospital direction on the conviction of an accused person, and
 - ◆ that person is acquitted, other than by reason of insanity, and
 - ◆ it appears to the court that it may be urgently necessary for the person to be detained in hospital to assess whether he or she requires compulsory measures under the Mental Health Act,
- the court should be entitled to order the detention of the person in a place of safety for a period of up to six hours to allow examination by a registered medical practitioner.

Chapter 26

- 26.1 For any mental health disposal in a criminal case which currently requires the evidence of two medical practitioners, a court should also be required to receive a report from a mental health officer.
- 26.2 For any mental health disposal in a criminal case which currently requires the written or oral evidence of two medical practitioners, the court should be entitled to require further evidence from a chartered clinical psychologist with appropriate expertise.
- 26.3 All agencies dealing with offenders with mental disorders should ensure that professionals who evaluate risk, or make decisions based on risk, are appropriately trained.
- 26.4 It should be possible to appeal against an order for remand of a convicted person to hospital for enquiry into his or her medical condition at any time during the period of remand.

- 26.5 The provisions for compulsory treatment which apply to untried prisoners remanded to hospital (see recommendation 25.4) should also apply to convicted offenders remanded to hospital for enquiry into their mental condition.
- 26.6 An interim hospital order should be possible where-
- ◆ the offender is suffering from mental disorder, and
 - ◆ there is reason to suppose that the mental disorder from which the offender is suffering is such that it may be appropriate for a hospital order with restrictions or a hospital direction to be made.
- 26.7 Where a psychiatric report recommends the imposition of a hospital order with restrictions, the psychiatrist should be required to address in the report the question of why an interim hospital order is not appropriate.
- 26.8 The time limit for renewal of an interim hospital order, after the initial 12 week duration, should be increased from every 28 days to every 90 days.
- 26.9 The criteria for a hospital direction should be amended to include, in addition to the existing criteria, that either
- ◆ there is not considered to be a strong association between the offender's mental disorder and the offence, or
 - ◆ the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.
- 26.10 It should be possible for conditions of treatment attached to a probation order to last for up to a maximum of three years.
- 26.11 Before imposing a requirement of treatment specifying that the offender attend a particular service, the court should obtain written or oral evidence from a person who would have responsibility for the delivery of the service, that it is appropriate and available.
- 26.12 It should be possible for a court to remit a mentally disordered offender to a mental health tribunal, for consideration of a community order.
- 26.13 In relation to any such referral, the tribunal should consider the appropriateness of such an order, and its nature, and should report back to the court as to whether it recommends a community order.
- 26.14 On receiving such a report, the court would be entitled to
- ◆ approve a recommended community order, or
 - ◆ substitute any other disposal it is entitled to make where the court does not approve a recommendation for a community order, or such an order is not recommended.

- 26.15 The right of appeal against a transfer direction should be to a mental health tribunal.
- 26.16 Where a prisoner has been assessed by two medical practitioners as meeting the criteria for admission to hospital under the Mental Health Act, there should be a right of appeal to a mental health tribunal against a decision by Scottish Ministers not to authorise a transfer direction.
- 26.17 The time limit for an appeal against a transfer direction, or the refusal to make a transfer direction, should be ten weeks.
- 26.18 It should continue to be possible for Scottish Ministers to return transferred prisoners who no longer require hospital treatment to prison to serve the remainder of their sentence.
- 26.19 Where a person subject to a transfer direction or hospital direction would be entitled to be released from prison, but the responsible medical officer is satisfied that the prisoner requires continued detention under the Mental Health Act, it should be necessary for the continued detention to be authorised by the normal civil procedures.
- 26.20 The provisions of s32 of the 1984 Act should continue to apply to persons who are liable to detention in hospital under the Mental Health Act and detained in custody in pursuance of an order of a court.
- 26.21 Where a person who is subject to a community order is detained in custody in pursuance of an order of a court for less than six months, the community order should continue in operation on the discharge from custody.

Chapter 27

- 27.1 Scottish Ministers should no longer have responsibility for the management and discharge of restricted patients.
- 27.2 The Parole Board, sitting as the Restricted Patients Review Board, should take over the responsibility of Ministers for decisions concerning the discharge of restricted patients.
- 27.3 The Risk Management Authority, if established as proposed by the MacLean Committee, should be given responsibility for those aspects of Ministers' responsibility for restricted patients which are currently delegated to officials, namely the authority to approve leave of absence for restricted patients, transfers between hospitals (other than transfers to lower levels of security, and cross border transfers), and urgent recalls from conditional discharge.
- 27.4 The responsible medical officer should report on the patient's progress to the Restricted Patients Review Board at least annually, and should furnish additional reports where there is a significant change of circumstances.

- 27.5 Restricted patients should have a right of appeal to a mental health tribunal once in the period between six and 12 months from the commencement of the relevant order, and once in any subsequent period of 12 months.
- 27.6 The Memorandum on Procedure regarding Restricted Patients should be revised and made publicly available.
- 27.7 A tribunal dealing with a restricted patient should be chaired by a sheriff.
- 27.8 The tribunal and the Restricted Patients Review Board should be under a duty to discharge the patient absolutely if satisfied that the criteria for detention in hospital are no longer met, and it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.
- 27.9 If satisfied that the criteria for compulsory care continue to be met, but that the patient does not currently require to be detained in hospital, the tribunal or Restricted Patients Review Board should be under a duty to grant a conditional discharge.
- 27.10 The Risk Management Authority should have responsibility for ensuring that adequate arrangements are in place in respect of patients subject to conditional discharge, on the basis of a risk management plan.
- 27.11 The Risk Management Authority should issue guidance on best practice in managing patients subject to conditional discharge.
- 27.12 Where a patient subject to conditional discharge breaches any of the conditions of discharge, there should be a review of the case by the Restricted Patients Review Board.
- 27.13 It should be possible to recall patients subject to conditional discharge to hospital on the grounds of continuing mental disorder and evidence of risk of harm to members of the public. Breaches of conditions of discharge could be considered as evidence of increased risk.
- 27.14 The Mental Welfare Commission should be required to visit patients subject to conditional discharge from time to time.
- 27.15 The Mental Health Act should set out specific criteria for admission to the State Hospital.
- 27.16 The criteria for admission to the State Hospital should be that the patient suffers from mental disorder of a nature or degree such that
 - ◆ he or she presents a significant risk of harm to self or others, and
 - ◆ requires treatment under conditions of special security, and
 - ◆ cannot be suitably cared for in a hospital other than a State Hospital.

- 27.17 Urgent consideration should be given to the possible need for appropriate services offering intensive support to prisoners or patients at high risk of self harm, as an alternative to admission to the State Hospital.
- 27.18 The period during which a patient can appeal against transfer to the State Hospital should be extended from 28 days to 10 weeks.
- 27.19 Patients should have a right of appeal to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security.
- 27.20 The procedures and time limits for such appeals should be consistent with the rights of patients to appeal to a tribunal seeking absolute or conditional discharge, as set out in Recommendation 27.5.
- 27.21 Should the tribunal uphold such an appeal, it could order the relevant health board to make the necessary arrangements for the patient within a specified time, not exceeding three months.
- 27.22 Should the necessary arrangements not have been made by the end of the specified time, the tribunal would be entitled to require the health board to appear before it. The tribunal would have power to extend the time for arrangements to be made for a further period, not exceeding three months.
- 27.23 At the expiry of this further period, the tribunal would have the power to order that arrangements be made for the patient within 14 days.
- 27.24 The Restricted Patients Review Board and the Risk Management Authority should take over from Scottish Ministers the oversight of prisoners made subject to restriction directions.

Chapter 28

- 28.1 The 'public safety' test provided under s1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should be abolished.
- 28.2 For patients subject to mental health disposals under a new Mental Health Act, including restricted patients, the grounds for discharge from the mental health disposal should be the same as the grounds for admission.
- 28.3 S74(1A) and s74(1B) of the Mental Health (Scotland) Act inserted by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should be repealed.
- 28.4 If the Scottish Executive and Parliament judge it to be necessary to retain any of the provisions of Section 1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 as a transitional measure to deal with the very limited group of patients detained under current mental health law who present a high risk to public safety and who would not be detainable under the new Act, the transitional

provisions should be drawn in such terms as to ensure that their effect does not reach beyond this group.

- 28.5 Should the provisions of s1 of the Mental Health (Public Safety and Appeals) Act 1999 be retained in respect of any group of patients, they should be amended to allow such patients to benefit from the possibility of conditional discharge.

Chapter 29

- 29.1 The Scottish Executive should consider reforms to the procedures for persons who plead insanity, or are found insane, to address the practical difficulties identified in the research into Mentally Disordered Offenders and Criminal Proceedings.
- 29.2 The Scottish Law Commission should be invited to review the special defence of insanity, and insanity in bar of trial.
- 29.3 As part of this review, the Scottish Law Commission should consider whether section 54 of the Criminal Procedure (Scotland) Act should be amended to allow evidence as to fitness to plead to be given by chartered clinical psychologists as well as by psychiatrists.
- 29.4 Supervision and treatment orders should be amended to allow compulsory treatment and other interventions, as specified in the order, with procedures for admission to hospital in appropriate cases in the event of non-compliance.
- 29.5 The range of disposals available to a court in relation to a person charged with murder and acquitted by reason of insanity should be the same as for persons charged with other offences who are acquitted on that basis.
- 29.6 The Scottish Law Commission should be invited to review the defence of diminished responsibility.

Chapter 30

- 30.1 Research should be commissioned by the Scottish Executive into the operation of appropriate adults schemes for mentally disordered people who come into contact with the criminal justice system. This should investigate
- ◆ the extent to which such schemes are operating effectively
 - ◆ any difficulties arising from current guidance.
- 30.2 The Scottish Executive should make arrangements for the ongoing monitoring of appropriate adult schemes, and the sharing of information between such schemes.
- 30.3 The Scottish Executive should keep under review the possibility of formalising the appropriate adult scheme on a statutory basis.

- 30.4 The Scottish Executive should develop, in consultation with the Association of Chief Police Officers (Scotland) and agencies concerned with mental disorder, a training strategy for police officers on dealing with members of the public who have mental disorder, and the use of the police's statutory powers under mental health law. This strategy should be published and regularly reviewed.

Chapter 31

- 31.1 There should be liaison between the Scottish Executive Health Department, the Department of Health and the Northern Ireland Health and Social Services Department to ensure that the provisions on cross-border transfers in the various Mental Health Acts remain complementary.
- 31.2 The grounds for transfer of a patient subject to compulsion outwith Scotland should continue to be 'the best interests of the patient', not further defined.
- 31.3 The specific grounds for transfer should be recorded.
- 31.4 There should be a requirement for Scottish Ministers to notify the patient, the named person and the Mental Welfare Commission of an impending transfer from Scotland. At least seven days advance notice should be given, unless the patient agrees to an earlier transfer, or there are strong clinical reasons for an earlier transfer. Where seven days notice is not given, the reasons for this should be recorded on the notification of the transfer to the Mental Welfare Commission.
- 31.5 Unless the patient objects, the primary carer (if not also the named person) should also be entitled to notice. The Code of Practice should set out circumstances where the primary carer should be given notice, notwithstanding objections by the patient.
- 31.6 Details of the transfer of a patient to Scotland should be provided to the Mental Welfare Commission and the named person by the responsible medical officer within seven days of it taking place.
- 31.7 Ministers should retain responsibility for approving the transfer of non-restricted patients between Scotland and other parts of the UK.
- 31.8 The responsibility for approving transfer of restricted patients between Scotland and other parts of the UK should be transferred from Ministers to the Restricted Patients Review Board. The proposed Risk Management Authority should be consulted prior to a transfer of a restricted patient to or from Scotland being arranged.
- 31.9 Patients being transferred outwith Scotland should have a right to appeal to a mental health tribunal at any time between notification to the patient and named person and the date of transfer, or within 28 days following the transfer.
- 31.10 Following a transfer of a patient to Scotland, the Mental Welfare Commission should arrange to visit the patient within three months.

- 31.11 Patients should be transferred onto compulsion under the terms of the law of the receiving country, but that compulsion should be deemed to have started on the date of compulsion under the law of the previous jurisdiction.
- 31.12 Consideration should be given by the Northern Ireland Health and Social Services Department as to whether there should be an appeal available to Northern Irish patients against detention in the State Hospital.
- 31.13 There should also be consideration given to how the difficulties of transferring Northern Irish patients out of the State Hospital may be addressed.
- 31.14 Should orders similar to our recommended community order be introduced in other parts of the UK, regulations should allow a patient subject to such an order who moves between jurisdictions to be subject to the equivalent order in the receiving jurisdiction.
- 31.15 There should continue to be arrangements to allow Ministers to transfer in-patients receiving treatment for mental illness, who do not have a right of abode in the UK, to countries outside the United Kingdom.
- 31.16 Such transfers should only take place if Ministers are satisfied that the patient will receive adequate care in the receiving country.
- 31.17 Unless he or she consents to early removal, a patient should be given at least 28 days notice of the intention to remove him or her from the UK.
- 31.18 The patient should have the right to appeal to a mental health tribunal against such a decision.
- 31.19 Specialist advocacy should be provided to asylum seekers and refugees with mental disorders to assist them in understanding their legal position and to provide liaison with their legal representatives and/or immigration officials.
- 31.20 The amendments to the 1984 Act introduced by the Immigration and Asylum Act 1999 should be repealed.

Chapter 32

- 32.1 The new Mental Health Act should, as far as possible, be drafted on the relevant issues in line with the provisions of the Hague Convention on the International Protection of Adults.
- 32.2 The Mental Health Act should make clear that emergency and short term detentions are on the basis of recommendations to the hospital managers.
- 32.3 There should be a specific provision attached to detention orders for patients not habitually resident in Scotland, which states that these orders may apply during the period of transfer to a country with jurisdiction over the patient.

- 32.4 The orders should apply until the patient has been transferred to the control of the judicial or administrative authorities in the country with jurisdiction, or until the end of the period of detention, whichever is the earlier.

Chapter 34

- 34.1 The Scottish Executive should initiate a co-ordinated programme of statistical and other information gathering and of research relating to the new Mental Health Act.
- 34.2 The statutory forms which support procedures under the Act should be drafted to ensure that
- ◆ they provide adequate information for the relevant purpose
 - ◆ they assist the process of information gathering and research into the use of the Act, and
 - ◆ they can be used efficiently by professionals.
- 34.3 There should be statutory forms to support mental health disposals in cases before the criminal courts.
- 34.4 The Scottish Executive should develop a strategy to ensure that all who have to operate the new Mental Health Act are appropriately trained.

Chapter 35

- 35.1 Part VIII of the 1984 Act should be repealed.

Chapter 36

- 36.1 The Act should require Scottish Ministers to prepare a Code of Practice.
- 36.2 The Code should operate as follows:
- ◆ It should be a guide to the Principles of the Act and their implications for care and treatment.
 - ◆ It should be a practical guide for service-providing agencies and medical and other professional staff on the provisions of the legislation.
 - ◆ It should give advice on best professional practice in relation to the Act.
 - ◆ It should wherever practical, be written in straightforward non-legal language, that users and carers and other non-specialists may refer to.
- 36.3 The Scottish Executive should develop and implement a strategy to promote awareness of the Code amongst all those with an interest.
- 36.4 The Code of Practice should not be legally binding, but a failure to apply the Code should require to be justified if challenged in legal proceedings.

- 36.5 It should be a requirement of the Act that the Code of Practice should be published within a year of the Act receiving Royal Assent and should be drafted in consultation with relevant parties.
- 36.6 Updates of the Code should be undertaken on a regular basis.
- 36.7 There should be a five-year maximum period within which a full revision of the Code must be undertaken, in consultation with relevant parties.
- 36.8 Notes on the new Mental Health Act should be published by the Scottish Executive, and any changes to the Act should be reflected in changes to the Notes on the Act.

Chapter 37

- 37.1 A Mental Health Act Implementation and Monitoring Group should be set up to oversee the implementation of the new Act and any associated Regulations and Guidance.
- 37.2 The Mental Health Act Implementation and Monitoring Group should represent user, carer, voluntary sector, service provider and professional interests.
- 37.3 The Mental Health Act Implementation and Monitoring Group should have an ongoing monitoring role relating to the Act.